Calendar Year 2023 Hospital Outpatient Prospective Payment System Final Rule

On November 1st, 2022, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2023 Hospital Outpatient Prospective Payment System (HOPPS) final rule. The finalized changes are effective January 1st, 2023.

Conversion Factor Update

CMS will increase the conversion factor by 3.8 percent bringing it up to $ 85.585 for CY 2023. This increase is based on the hospital inpatient market basket percentage increase of 4.1 percent for inpatient services paid under the hospital inpatient prospective payment system (IPPS) reduced by a productivity adjustment of 0.3 percentage point. CMS will further adjust the conversion factor to ensure that any revisions made to the wage index and rural adjustment are made on a budget neutral basis. CMS will calculate an overall budget neutrality factor of 0.9998 for wage index changes by comparing the total estimated payments from simulation model using the FY 2023 IPPS wage indexes to those payments using the FY 2022 IPPS wage indexes, as adopted on a calendar year basis for the OPPS. CMS will calculate an additional budget neutrality factor of 0.9996 to account for the policy to cap wage index reductions for hospitals at 5 percent on an annual basis. CMS will maintain the current rural adjustment policy, and therefore finalized the budget neutrality factor for the rural adjustment to be 1.0000.

Hospitals that fail to meet the reporting requirements of the Hospital Outpatient Quality Reporting (OQR) Program would be subject to a further reduction of 2.0 percentage points. Hospitals that fail to meet the requirements will result in a conversion factor for CY 2023 of $ 83.934.

CMS finalized the proposal to use CY 2021 claims data to set CY 2023 OPPS and ASC rates. To mitigate the impact of some of the temporary changes in hospitals cost report data from CY 2020 due to the COVID-19 public health emergency, CMS will use cost report data from the June 2020 extract from Healthcare Cost Report Information System (HCRIS), which includes cost report data from prior to the PHE. This is the same cost report extract that was used to set OPPS rates for CY 2022.

Estimated Impact on Hospitals

CMS estimates that OPPS expenditures, including beneficiary cost-sharing will be approximately $86.5 billion, which is approximately $6.5 billion higher than estimated CY 2022 OPPS expenditures.

PROPOSED AMBULATORY PAYMENT CLASSIFICATION GROUP POLICIES

Imaging Ambulatory Payment Classifications

CMS did not make any new changes to the APC structure for imaging codes. The seven payment categories remain. However, CMS has moved codes within these payment categories which would cause changed pricing for 2023. CMS is making reassignments to the codes within the series to resolve and/or prevent any violations of the two times rule.

CY 2023 Imaging APCs

APC	Group Title	SI	Relative Weight	CY 2022 Payment Rate	CY 2023 Finalized Payment Rate
5521	Level 1 Imaging without Contrast	S*	1.0151	$82.61	$88.88
5522	Level 2 Imaging without Contrast	S	1.2488	$111.19	$106.88
5523	Level 3 Imaging without Contrast	S	2.7285	$235.00	$233.52
5524	Level 4 Imaging without Contrast	S	5.8787	$493.48	$503.13
5571	Level 1 Imaging with Contrast	S	2.1071	$182.43	$180.34
5572	Level 2 Imaging with Contrast	S	4.3048	$376.09	$368.43
5573	Level 3 Imaging with Contrast	S	8.6551	$730.67	$740.75

*****Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment.

APC Exceptions to the 2 Times Rule

CMS sets exceptions to the 2-times rule based on the following criteria: resource homogeneity; clinical homogeneity; hospital outpatient setting utilization; frequency of service (volume); and opportunity for up-coding and code fragments. Table 8, found below, lists the 23 APCs that CMS will exempt from the 2 times rule for 2023 based on claims data from January 1, 2021, through December 31, 2021, and processed on or before December 31, 2021.

Table 8. APC Exceptions to the 2 Times Rule for 2023

APC	APC Title
5012	Clinic Visits and Related Services
5071	Level 1 Excision/ Biopsy/ Incision and Drainage
5301	Level 1 Upper GI Procedures
5521	Level 1 Imaging without Contrast
5522	Level 2 Imaging without Contrast
5523	Level 3 Imaging without Contrast
5524	Level 4 Imaging without Contrast
5571	Level 1 Imaging with Contrast
5611	Level 1 Therapeutic Radiation Treatment Preparation
5612	Level 2 Therapeutic Radiation Treatment Preparation
5627	Level 7 Radiation Therapy
5673	Level 3 Pathology
5691	Level 1 Drug Administration
5692	Level 2 Drug Administration
5721	Level 1 Diagnostic Tests and Related Services

5731	Level 1 Minor Procedures
5734	Level 4 Minor Procedures
5741	Level 1 Electronic Analysis of Devices
5791	Pulmonary Treatment
5811	Manipulation Therapy
5821	Level 1 Health and Behavior Services
5822	Level 2 Health and Behavior Services
5823	Level 3 Health and Behavior Services

Comprehensive APCs

For CY 2023, CMS finalized the proposal to create 1 new comprehensive APC (C-APC): C-APC 5372 (Level 2 Urology and Related Services). Table 2 in the rule lists the finalized C-APCs.

Changes to New-Technology APCs

Payment Rate for the MRgFUS Procedures

There are currently four CPT/HCPCS codes that describe magnetic resonance image-guided, high-intensity focused ultrasound (MRgFUS) procedures. CMS finalized their proposals to keep standard APCs for three of the codes and to modify the placement of code 0398T to APC 5463: (Level 3 Neurostimulator and Related Procedures).

CY 2023 Status Indicator (SI), APC Assignment, And Payment Rate for MRgFUS Procedures

CPT/ HCPCS Code	Long Descriptor	CY 2022 OPPS SI	CY 2022 OPPS APC	CY 2022 OPPS Payment Rate	Final CY 2023 OPPS SI	Final CY 2023 OPPS APC	Final CY 2023 OPPS Payment Rate
0071T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata volume less than 200 cc of tissue.	J1*	5414	$ 2,679.56	J1	5414	$ 2,827.44
0072T	Focused ultrasound ablation of uterine leiomyomata, including mr guidance; total leiomyomata	J1	5414	$ 2,679.56	J1	5414	$2,827.44

	volume greater or equal to 200 cc of tissue.						
0398T	Magnetic resonance image guided high intensity focused ultrasound (mrgfus), stereotactic ablation lesion, intracranial for movement disorder including stereotactic navigation and frame placement when performed.	S**	1575	$11,483.38	J1	5463	$11,952.59
C9734	Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (mr) guidance.	J1	5115	$12,593.29	J1	5115	$13,048.08

*Hospital Part B Services Paid Through a Comprehensive APC; aid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS status indicator of "F","G", "H", "L" and "U"; ambulance services; diagnostic and screening mammography; rehabilitation therapy services; new technology services; self-administered drugs; all preventive services; and certain Part B inpatient services.
** Procedure or Service, Not Discounted When Multiple; Paid under OPPS; separate APC payment.

Cardiac Positron Emission Tomography (PET)/Computed Tomography (CT) Studies

Effective January 1, 2020, CMS assigned three CPT codes (78431- 78433) describing services associated with cardiac PET/CT studies to New Technology APCs (APCs 1522, 1523, and 1523, respectively). CMS did not receive any claims data for these services for either of the CY 2021 or CY 2022 OPPS proposed or final rules. For CY 2023, CMS finalized the proposal to use CY 2021 claims data to determine the rates. The final APC placements are detailed in Table 12 of the final rule, found below.

Table 12: Final CY 2022 and CY 2023 OPPS New Technology APC and Status Indicator Assignments for CPT Codes 78431, 78432, and 78433

CPT Code	Long Descriptor	Final CY 2022 OPPS SI	Final CY 2022 OPPS APC	Final CY 2023 OPPS SI	Final OPPS CY 2023 APC
78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	S	1522	S	1523
78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	S	1523	S	1520
78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	S	1523	S	1521

Brachytherapy

Universal Low Volume APC Policy for Clinical and Brachytherapy APCs
In the CY 2022 HOPPS final rule with comment period, CMS adopted a universal Low Volume APC policy for CY 2022 and subsequent calendar. This policy states when a clinical or brachytherapy APC has fewer than 100 single claims that can be used for ratesetting, under the low volume APC payment adjustment policy CMS determines the APC cost as the greatest of the geometric mean cost, arithmetic mean cost, or median cost based on up to 4 years of claims data. CMS finalized the proposal to designate four brachytherapy APCs and four clinical APCs as low volume APCs. The four brachytherapy APCs and four clinical APCs meet CMS's criteria of having fewer than 100 single claims in the claims year used for rate setting and therefore, CMS finalized that they would be subject to the low volume APC policy. Table 32 in the final rule lists the final cost statistics for low volume APCs.

Table 32: Final Cost Statistics for Low Volume APCs Using Comprehensive (OPPS) Ratesetting Methodology for CY 2023

APC	APC Description	CY 2021 Claims Available for Rate Setting	Geometric Mean Cost without Low Volume APC Designation	Final Median Cost	Final Arithmetic Mean Cost	Final Geometric Mean Cost	Final CY 2023 APC Cost
2632	Iodine I-125 sodium iodide	10	$167.11	$31.74	$44.35	$37.26	$44.35
2635	Brachytx, non-str, HA, P-103	28	$130.24	$34.04	$52.09	$43.30	$52.09
2636	Brachy linear, non-str, P-103	0	---*	$49.65	$53.38	$38.80	$53.38
2647	Brachytx, NS, Non-HDRIr-192	14	$144.37	$180.76	$355.64	$141.57	$355.64

* For this final rule, there are no CY 2021 claims that contain the HCPCS code assigned to APC 2636 (HCPCS code C2636) that are available for CY 2023 OPPS/ASC ratesetting.

CT Lung Cancer Screening

In the CY 2023 HOPPS final rule, CMS placed CPT code 71271 (Low Dose CT for Lung Cancer Screening) in APC 5522 with payment rate of $106.88. In addition, CMS placed code G0296 (visit to determine lung LDCT eligibility) in APC 5822, with a payment rate of $75.85. The ACR has raised

concerns about the inadequate payments for CT lung screening based on flawed hospital data in the past comment letters to CMS.

Medical Physics Dose Evaluation
In the CY 2023 proposed rule, CMS proposed to place 76145 (Medical Physics Dose Evaluation for Radiation Exposure That Exceeds Institutional Review Threshold, Including Report) in APC 5612 with payment rate of $365.15. The issue of payment for this code was brought to the HOP Panel in 2022 for CY 2023 rulemaking, and a new APC placement was requested: APC 1505 (New Technology – Level 5 with payment rate $301-400). In the final rule, CMS placed CPT code 76145 in APC 5723 (Level 3 Diagnostic Tests and Related Services) with payment rate of $483.43, citing that they did not have claims data to support a new technology APC placement.

Supervision by Nonphysician Practitioners of Hospital and CAH Diagnostic Services Furnished to Outpatients
For CY 2023, to improve clarity, CMS finalized the proposal to replace cross references at § 410.27(a)(1)(iv)(A) and (B) and § 410.28(e) to the definitions of general and personal supervision at § 410.32(b)(3)(i) and (iii) with the text of those definitions. CMS also finalized the proposal to revise § 410.28(e) to clarify that certain nonphysician practitioners (NPPs) may supervise the performance of diagnostic tests to the extent they are authorized to do so under their scope of practice and applicable State law.

OPPS Payment for Software as a Service
In CY 2018, HeartFlow was the first other Software as a Service (SaaS) procedure for which CMS made separate payment under the OPPS. Since then, there have been several SaaS products that CMS has made payment for. From 2021 to 2022, CMS has reviewed and approved New Technology applications for the LiverMultiScan, Optellum, and QMRCP SaaS procedures. CMS proposed not to recognize the select CPT add-on codes that describe SaaS procedures under the OPPS. CMS stated that despite the CPT Editorial Panel categorizing CPT codes 0649T, 0722T, and 0724T as add-on codes, these codes did not align with CMS's add-on code definition.

CY 2023 Proposal for SaaS Add-on Codes
CMS proposed to instead establish HCPCS codes, specifically, C-codes, to describe the add-on codes as standalone services that would be billed with the associated imaging service. CMS believed that the payment for the proposed C-codes describing the SaaS procedures with add-on CPT codes, when billed concurrent with the acquisition of the images, should be equal to the payment for the SaaS procedures when the services are furnished without imaging and described by the standalone CPT code because the SaaS procedure is the same regardless of whether it is furnished with or without the imaging service.

For the LiverMultiScan service, CMS proposed not to recognize CPT code 0649T under the HOPPS and instead proposed to establish C97X1 to describe the analysis of the quantitative magnetic resonance images that must be billed alongside the relevant CPT code describing the acquisition of the images. Below is the proposed long descriptor for the service:

- C97X1: Quantitative magnetic resonance analysis of tissue composition (e.g., fat, iron, water content), includes multiparametric data acquisition, preparation, transmission, interpretation and report, performed in the same session and/or same date with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure).

For the Optellum LCP service, CMS proposed not to recognize CPT code 0722T and instead proposed to establish C97X2 to describe the use of Optellum LCP that must be billed alongside a concurrent CT scan. Below is the proposed long descriptor for the service:

- C97X2: Quantitative computed tomography (CT) tissue characterization, includes data acquisition, preparation, transmission, interpretation and report, performed in the same session and/or same date with concurrent CT examination of any structure contained in the acquired diagnostic imaging dataset.

For the QMRCP service, CMS proposed not to recognize CPT code 0724T and instead proposed to establish C97X3 to describe the use of QMRCP that must be billed alongside a concurrent CT scan. Below is the proposed long descriptor for the service:

- C97X3: Quantitative magnetic resonance cholangiopancreatography (QMRCP) includes data acquisition, preparation, transmission, interpretation and report, performed in the same session and/or same date with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure).

Feedback from Stakeholders on SaaS

Some commenters, including MedPAC, opposed separate payment for services that do not necessarily provide a substantial clinical improvement. MedPAC stated that paying separately undermines the integrity of the prospective payment system (PPS) payment bundles and can limit the competitive forces that generate price reductions among like services, lead to overuse (to the extent that is clinically possible), and shifts financial pressure from providers to Medicare. Commenters urged CMS to engage further with stakeholders before finalizing a SaaS policy until all policy considerations have been fully vetted.

CMS replied to commenters that they believe it is appropriate to except certain SaaS add-on codes from the general policy of packaging add-on services. They believe payment for the SaaS procedures assigned CPT add-on codes, when billed concurrent with the acquisition of the images, should be made separately at an amount equal to the amount of payment for the SaaS procedure when the service is furnished without imaging and described by the standalone CPT code. They believe this final policy is appropriate because the SaaS procedure is the same and requires the same resources regardless of whether it is furnished with or without the imaging service. Therefore, CMS believes it is appropriate to assign SaaS CPT add-on codes to identical APCs and status indicator assignments as their standalone codes.

CY 2023 Finalized SaaS Add-on Codes

In the final rule, CMS is finalizing the proposals with modifications. Specifically, CMS is recognizing SaaS CPT add-on codes and will pay separately for them. CMS is not establishing HCPCS codes, specifically C-codes, to describe the add-on codes as standalone services that would be billed with the associated imaging service. Based on public comments, CMS believes that establishing a duplicative set of

codes in place of CPT add-on codes is unnecessary and would be burdensome for hospitals. The SaaS CPT add-on codes will be assigned identical APCs and have the same status indicator assignments as their standalone codes. Table 69 in the final rule lists the SaaS procedure codes and APC placements. This finalized policy breaks from CMS policy of not providing additional payment for add-on codes. The ACR will continue to monitor the ongoing developments in SaaS.

SaaS Procedure CPT Codes

CPT Code	Trade Name	Long Descriptor	APC	Status Indicator
0648T	LiverMultiScan	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1511	S
0649T	LiverMultiScan	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	1511	S
0721T	Optellum LCP	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging	1508	S
0722T	Optellum LCP	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)	1508	S

0723T	Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP)	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session	1511	S
0724T	Quantitative Magnetic Resonance Cholangiopancreatography (QMRCP)	Quantitative magnetic resonance cholangiopancreatography (QMRCP) including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)	1511	S

ICRs for Addition of a New Service Category for Hospital Outpatient Department (OPD) Prior Authorization Process

CMS established a prior authorization process for certain hospital OPD services in the CY 2020 OPPS final rule, with additional service categories being added in the CY 2021 final rule. For CY 2023, CMS will require prior authorization for a new service category: Facet Joint Interventions, effective for dates of service on or after March 1, 2023. The information collection requirement (ICR) associated with prior authorization requests is the required documentation submitted by providers. This includes all relevant documentation necessary to show that the service meets applicable Medicare coverage, coding, and payment rules and the request must be submitted before the service is provided to the beneficiary, and before the claim is submitted for processing. Table 103 in the final rule contains the full list of outpatient department services that require prior authorization.

Payment for Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals

Policy Packaged Drugs, Biologicals, and Radiopharmaceuticals

CMS currently pays for drugs, biologicals, and radiopharmaceuticals that do not have pass-through payment status in one of two ways: packaged into the payment for the associated service or separate payment (individual APCs). Hospitals do not receive a separate payment for packaged items and may not bill beneficiaries separately for any packaged items; these costs are recognized and paid within the OPPS payment rate for the associated procedure or service.

Threshold-packaged drugs under the OPPS are drugs, non-implantable biologicals and therapeutic radiopharmaceuticals whose packaging status is determined by the packaging threshold. If a drug's average cost per day exceeds the annually determined packaging threshold, it is separately payable and, if not, it is

packaged. For 2023, CMS finalized the proposal for a packaging threshold for drugs, biologicals, and radiopharmaceuticals that are not new and do not have pass-through status of $135.

Payment Policy for Therapeutic Radiopharmaceuticals
For CY 2023, CMS will continue paying for therapeutic radiopharmaceuticals at ASP+6 percent. For therapeutic radiopharmaceuticals for which ASP data are unavailable, CMS will continue to rely on the most recently available mean unit cost data derived from hospital claims data.

Other HOPPS Payment Policies

Payment Adjustments to Cancer Hospitals
The ACA requires an adjustment to cancer hospitals' outpatient payments to bring each hospital's payment-to-cost ratio (PCR) up to the level of the PCR for all other hospitals, the target PCR. The changes in additional payments from year to year are budget neutral. The 21st Century Cures Act reduced the target PCR by 1.0 percentage point and excludes the reduction from OPPS budget neutrality. The cancer hospital adjustment is applied at cost report settlement rather than on a claim-by-claim basis.

CMS finalized the proposal to use cost report data from the June 2020 HCRIS data set, which does not contain cost reports from CY 2020, given CMS's concerns with CY 2020 cost report data as a result of the COVID-19 PHE. For CY 2023, CMS finalized the proposal to continue using the same target PCR that was used for CY 2021 and CY 2022 of 0.89. This final CY 2023 target PCR of 0.89 includes the 1.0-percentage point reduction required by section 16002(b) of the 21st Century Cures Act for CY 2023.

Table 6 in the final rule shows the estimated hospital-specific payment adjustment for each of the 11 cancer hospitals, with increases in OPPS payments for 2023 ranging from 12.9 percent to 69.2 percent. No additional budget neutrality adjustment is required for the cancer hospital adjustment in 2022 compared to 2021.

Table 6. Estimated CY 2023 Hospital-Specific Payment Adjustment for Cancer Hospitals to be Provided at Cost Report Settlement

Provider Number	Hospital Name	Estimated Percentage Increase in OPPS Payments for CY 2020 due to Payment Adjustment
050146	City of Hope Comprehensive Cancer Center	45.5%
050660	USC Norris Cancer Hospital	31.7%
100079	Sylvester Comprehensive Cancer Center	24.1%
100271	H. Lee Moffitt Cancer Center & Research Institute	23.1%
220162	Dana-Farber Cancer Institute	42.7%
330154	Memorial Sloan-Kettering Cancer Center	69.2%
330354	Roswell Park Cancer Institute	15.2%
360242	James Cancer Hospital & Solove Research Institute	12.9%

390196	Fox Chase Cancer Center	23.5%
450076	M.D. Anderson Cancer Center	49.4%
500138	Seattle Cancer Care Alliance	46.1%

Requirements for the Hospital Outpatient Quality Reporting (OQR) Program

Hospital OQR Program Quality Measures
CMS will retain the measures for the 2023 Hospital OQR performance year. The measures finalized in the 2022 Hospital Outpatient Prospective Payment System rulemaking process will be used during the 2023 and 2024 performance periods.

Public Display of Quality Measures
CMS will retain 2022 policies regarding the public display of quality measures during the 2023 calendar year.

Inpatient Only List
The IPO list was created based on the premise that Medicare should not pay for procedures furnished as outpatient services that are not reasonable and necessary to be performed in any other setting than inpatient. In the CY 2022 final rule, CMS halted the elimination of the IPO list and, after clinical review of the services removed from the IPO list in CY 2021 as part of the first phase of eliminating the IPO list used the five codified criteria, CMS returned most of the services back to the list beginning in CY 2022.

For 2023, CMS will remove 11 services from the Inpatient Only List, as well as add 8 newly created services. Table 65 in the rule details the final changes to the IPO list.

Changes to Beneficiary Coinsurance for Certain Colorectal Cancer Screening Tests
Medicare pays 100 percent of the payment amount for certain colorectal cancer screening tests that are recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B. Thus, a beneficiary pays no cost-sharing for these screening tests.

When the colorectal cancer screening test benefit category was enacted into law, the statute specifically provided that if, during the course of a screening flexible sigmoidoscopy or screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under Medicare Part B shall not be made for the screening flexible sigmoidoscopy, but rather shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal. The result was that beneficiaries faced unexpected coinsurance charges because the procedure was classified as a diagnostic test instead of a preventive service screening test.

Section 4104 of the ACA addressed this issue with respect to the deductible but not for any coinsurance that may apply. Section 122 of the CAA addresses this issue for the coinsurance by successively reducing, over a period of years, the percentage amount of coinsurance for which the beneficiary is responsible so

that for services furnished on or after January 1, 2030, the coinsurance will be zero. The phased-in increases in the amount the Medicare program pays for these services on or after January 1, 2023 are as follows:

Year	Medicare Payment Percent	Beneficiary Coinsurance Percent
2023 – 2026	85	15
2027 – 2029	90	10
2030 and subsequent years	100	0