REPORT Site-Neutral

Where the facility fee goes

Medicare and private insurers pay more for a visit, an infusion or a scan when a hospital owns the office. This report follows the fee from the statute to the patient's bill, and to the bills in Congress that would end it.

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IN BRIEF

Three things to take from this piece.

01

A primary care visit billed through a hospital outpatient department cost $217 in 2022 commercial claims. The same visit in a physician office cost $116, so the hospital setting cost 87 percent more.

02

Congress equalized payment for new off-campus departments in 2015 and exempted every department already billing, so the fee survived at the sites that generate it.

03

CMS has equalized three services by rule since 2019. MedPAC's 66 service groups would have saved $7.5 billion on 2021 data. CBO scores the full policy at $156.9 billion over ten years.

THE NUMBERS

87%

More for the same primary care visit in a hospital outpatient department than in a physician office, 2022 commercial claims

Health Care Cost Institute, 2025

$7.5B

One-year saving if Medicare paid the same rate across settings for MedPAC's 66 service groups, 2021 data

MedPAC, June 2023

$156.9B

Federal saving over 2025 to 2034 from site-neutral rates for most services at all hospital outpatient departments

Congressional Budget Office, December 2024

The fee in one visit

One visit, two prices. In 2022 commercial claims, a primary care visit cost $116 in a physician office. In a hospital outpatient setting, the same visit cost $217.[2]

$116

Primary care visit, physician office

$217

The same visit, hospital outpatient department

87 percent more for the same visit. The difference is the facility fee, a second charge for the building on top of the physician's fee.

Health Care Cost Institute, 2022 commercial claims, May 2025

Two payment systems for one service

Medicare built the structure. A physician office is paid under the physician fee schedule. A hospital outpatient department is paid under the hospital outpatient prospective payment system.[1] The two systems price the same service differently, and the hospital system pays more.

When a hospital buys a practice and designates it a department, the practice crosses from one system to the other without moving. The physician’s fee is unchanged. The facility fee is new. Private insurers are billed the same way, which is why the 87 percent gap above is a commercial figure.[2]

What Congress did in 2015, and what it left out

Congress fixed the fee for new sites and kept it for every old one. Section 603 of the Bipartisan Budget Act of 2015 ended the two-system arrangement for new off-campus departments. From January 1, 2017, an off-campus department is paid as if it were a physician office. Off-campus means outside the hospital’s main buildings and more than 250 yards from them.[3]

The law then exempted everything that already existed:[3]

- any department billing before November 2, 2015, which kept the hospital rate
- dedicated emergency departments
- departments under a binding construction agreement signed before the 2015 date, added by the 21st Century Cures Act
- departments of cancer hospitals, added by the same Act

The result is a fee that no new off-campus site can earn and every established site keeps. The practices bought before 2015 still bill it.

What has been equalized, and when

Where Congress stopped, CMS has moved one service at a time. It has used its authority to control unnecessary volume at the exempted departments.

2015

Congress: new off-campus departments

Paid at the physician-office rate from 2017. Existing departments exempt.

2019 TO 2020

CMS: the clinic visit

$800 million saved in 2020, $160 million of it by beneficiaries in lower copayments.

2026

CMS: drug administration

Infusions and injections. $290 million in 2026, $70 million of it by beneficiaries.

2027

CMS: imaging without contrast

$260 million in the first year, $70 million of it by beneficiaries.

2028

Congress: a separate identifier

Each off-campus department bills under its own identifier, with hospital attestations.

Hospitals sued over the clinic-visit rule. The D.C. Circuit upheld it in July 2020 and the Supreme Court declined review in June 2021.[4] The drug administration rule took effect January 1, 2026.[5] The imaging rule, published November 6, 2026, takes effect January 1, 2027.[6] Rural sole community hospitals are exempt from both recent rules.[56] The identifier requirement is law, effective January 1, 2028.[10]

> Three services in eight years. Every other service at the grandfathered clinics still carries the fee.

What is left on the table

The federal advisers have already drawn the list. MedPAC identified 66 of the 169 outpatient service groups that are safe to provide in any setting and recommended that Congress align their rates. On 2021 data, the alignment would have lowered Medicare spending by $6.0 billion and beneficiary cost sharing by $1.5 billion, $7.5 billion in one year.[7]

CBO scored the broader policy, site-neutral rates for most services at all off-campus and on-campus departments. The saving: $156.9 billion in federal spending over 2025 to 2034.[8]

Where the fee goes

The fee changes what gets ordered. A Massachusetts study followed physicians who moved into hospital employment. After the move, the odds that a patient received an inappropriate MRI referral rose by more than 20 percent. Most of those scans were done at the employing hospital.[9] A payment that rewards the building rewards sending patients to the building.

The fee also prices the practice. A hospital that buys an independent office gains a charge the office could never bill on its own. The independent physician across the street competes against that charge every day.

The fix

Congress has the text in front of it. S. 1629, the Same Care, Lower Cost Act, would apply site-neutral payment to at least 66 service groups from 2027. H.R. 3023, the Preventing Hospital Overbilling of Medicare Act, would end the 2015 exemptions and require a unique identifier on commercial claims. Both were referred to committee in spring 2025. Neither has advanced.[11]

The Alliance's position is the plain one. Same service, same price, regardless of who owns the building. Every service, every site. The rules CMS has written show the mechanism works. Putting it in statute finishes the job.

SOURCES

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3. Bipartisan Budget Act of 2015, Pub. L. 114-74, § 603, 129 Stat. 584, 597 (Nov. 2, 2015), codified at 42 U.S.C. § 1395l(t)(21); 42 C.F.R. § 413.65(a)(2) (campus means the main buildings and the area within 250 yards of them); 21st Century Cures Act, Pub. L. 114-255, §§ 16001 and 16002 (Dec. 13, 2016).
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