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Abstract

The Centers for Medicare and Medicaid Services have increased Outpatient Prospective Payment System (OPPS) payments by 2.6 percent for 2026. However, this percentage is a national average before local adjustments are made. After incorporating these adjustments, we predict that Kentucky's urban hospitals will see a 0.3 percent decrease in OPPS payments from expansions in site-neutral payments and only a 0.8 percent increase overall. We predict that Kentucky's rural hospitals will see a 0.1 percent decrease in OPPS payments from site-neutral payment expansions and an overall 0.6 percent decrease. The expansion of site-neutral payments could represent a $7.42 million revenue reduction for Kentucky hospitals. Considering other concurrent payment reductions as well, Kentucky's rural hospitals could experience a reduction of $4.97 million. With recent evidence suggesting that 35 rural hospitals in Kentucky could be at risk of closure, reductions to Medicare reimbursements may jeopardize access to hospital services.

Keywords: Site-Neutral Payments, Hospitals, Medicare, Rural Health Care, Physician Vertical Integration

JEL Codes: I11, I13, H51, L22

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I. Introduction

Reforms to the OPPS issued by the Centers for Medicare and Medicaid Services (CMS) took effect in January 2026. CMS increased Medicare OPPS payments by 2.6 percent overall, but they also made adjustments that represent increases or decreases for sub-national geographies. Of these adjustments, some are applied in a manner that is nationally budget-neutral, while others are non-budget-neutral and unambiguously decrease OPPS payments for the fiscal year. One particularly noteworthy adjustment was the non-budget-neutral expansion of site-neutral payments for certain drug administration services covered under Medicare Part B (CMS 2025). Site-neutral payments involve equalizing payment rates for the same outpatient service regardless of where it is performed. Historically, payment rates have been higher for hospitals than for freestanding facilities such as ambulatory surgery centers that are not expected to make the same investments in emergency capacity and uncompensated care. In this paper, we explore the expected effects of the 2026 CMS adjustments expansion on Kentucky hospitals, placing a particular emphasis on site-neutral payments.

The availability of rural health care is particularly important in Kentucky. According to a 2025 report by the University of Kentucky's Martin-Gatton College of Agriculture, Food and Environment, about 40.7 percent of Kentucky's population lived in rural areas in 2023 (rural: 1,847,237; urban: 2,690,117). Kentucky's rural population has been growing after reversing a downward trend from 2011-2019 (Blueprint Kentucky 2025). The report notes that Kentucky's rural areas have a somewhat older population compared to urban areas, as 18.4 percent of rural residents —just under 340,000— are over the age of 65. This share is about 16 percent (slightly over 430,000 residents) in urban areas, meaning that roughly 44 percent of Kentucky's elderly population lives in rural areas. Thus, rural health care providers are relied upon to serve a large

portion of Kentucky's elderly residents, and changes in Medicare that can impact rural providers are nontrivial for Kentuckians.

Health care jobs comprise 15.8 percent of employment in rural Kentucky compared to about 14 percent in urban areas (Blueprint Kentucky 2025). However, health care is not as secure a form of employment in rural areas as it is in urban areas. Of significant concern in the past two decades has been the financial resilience of rural hospitals, given their key role as care providers and employers. In a recent letter to Congress concerning the expiration of federal financial support for various aspects of the Affordable Care Act, information from the Cecil G. Sheps Center at the University of North Carolina suggested that those changes could put 35 rural Kentucky hospitals at risk of closure (Markey 2025). Five of these highlighted rural hospitals had three-year negative margins, indicating a particular financial vulnerability. Another source suggests that about 15 rural hospitals in Kentucky are at risk, with two of them in immediate risk of closure, while 21 hospitals reduced their service offerings (CHQPR 2026). Both of these reports illustrate the heightened concern about rural hospitals in Kentucky that often operate on thin margins and are therefore particularly vulnerable to even seemingly small financial setbacks.

II. Background

Medicare's differential reimbursement for similar services performed in hospital outpatient departments (HOPDs) versus independent physician offices has been a source of policy contention since the initiation of the Outpatient Prospective Payment System (OPPS) in August 2000. Medicare's Physician Fee Schedule (PFS), which it uses to pay for care occurring in physician offices, began in 1992. Under these two systems, certain services are reimbursed differently if they occur in an office-based or HOPD setting. In both settings, a payment is made for a physician's services under the PFS. A key difference, however, is in the compensation for

overhead costs, called practice expenses. Facility-based HOPD practice expenses are compensated at a lower rate to partially offset the fact that HOPDs also bill Medicare for a separate facility fee under the OPPS. The facility fee and PFS payment make the HOPD's combined reimbursement significantly higher than an independent physician would receive. The intent of the facility payment is to compensate HOPDs for the higher costs of maintaining standby capacity, meeting Medicare participation requirements, and providing a wide variety of services that might otherwise be financially unviable and that physician offices do not provide (CMS 2013).

A few examples illustrate the added background costs HOPDs contribute to and for which they seek compensation. Under Medicare's conditions of participation, hospitals must maintain emergency plans that would include a means to provide food, water, medical, and pharmaceutical supplies for staff and patients in the event of an emergency, whether they evacuate or shelter in place (42 CFR 482.15(a)). Other requirements under this plan require alternate sources of power, training staff, and testing (42 CFR 482.15(e)). Hospitals providing emergency services must maintain the provisions and equipment to meet emergency conditions (42 CFR 482.55(c)). Hospitals' Medicare patients must be under the care of a doctor of medicine, osteopathy, podiatry, or dentistry, or under the care of a licensed chiropractor or clinical psychologist (42 CFR 482.12(c)(1)). A doctor of medicine or osteopathy must be on duty or on call at all times (42 CFR 482.12(c)(3)). Under 42 U.S. Code § 1395dd(h), when a person presents themselves with a medical emergency in an emergency department, hospitals participating in Medicare cannot "delay provision of an appropriate medical screening examination required under subsection (a) or further medical examination and treatment required

under subsection (b) in order to inquire about the individual's method of payment or insurance status."

The policy focus on differential reimbursements over the last decade has largely centered around HOPDs that are not located on the parent hospital's campus and therefore may not need to provide 24-hour services or emergency care. Such considerations led to policy action in the mid and late 2010s, when the federal government and the Center for Medicare and Medicaid Services (CMS) introduced multiple pieces of legislation/regulation that adjusted HOPD payments. The Bipartisan Budget Act of 2015 introduced site-neutral payments for off-campus HOPDs, reducing reimbursements to be on par with those for office-based services. However, this change came with key exceptions, including off-campus HOPDs that had billed Medicare under the OPPS before the law's enactment on November 2nd, 2015, grandfathering in many off-campus HOPDs. Other exceptions, some of which were later introduced under the 21st Century Cures Act of 2016, included off-campus HOPDs that had emergency departments, were related to cancer hospitals, or were under construction before the 2015 act's implementation. In 2019, the CMS further expanded site-neutral payments to cover all off-campus HOPD clinic visits. This was challenged in court but was ultimately upheld in 2020, and the Supreme Court declined to hear the appeal in 2021. In 2023, however, sole-community hospitals were granted an exception to this change (Levinson et al. 2024).

The policy trend of the federal government has been toward lowering HOPD reimbursement to match that of the PFS. This reduces the price paid for care at an HOPD both for the patient and the government. Site-neutral payments may also discourage physician integration with hospitals that occur due to differences in reimbursement, which, in turn, may reduce site-of-care transfers from private offices to HOPDs. However, if reduced Medicare

hospital reimbursements in rural Kentucky translate to reduced access to care due to increased financial strain on providers, then, while fewer Medicare bills will be generated, it would not necessarily mean lower costs for the same care for rural Kentuckians. Reduced access would mean longer travel and wait times for care or foregoing care completely.

III. Quantitative Analysis

The CMS stated in their 2026 Final Rule for OPPS "we are finalizing our proposal to … apply an amount equal to the site-specific PFS payment rate for nonexcepted items and services furnished by a nonexcepted off-campus PBD (the PFS payment rate) for HCPCs codes assigned to the drug administration services APCs, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act … without modification. In addition, we are finalizing our proposal to implement this policy in a non-budget-neutral manner without modification." In short, the CMS reduced the payments received by previously excepted off-campus HOPDs for drug administration services covered by Medicare Part B, now basing them on the PFS. This reduction is applied in a non-budget-neutral manner, meaning there are no offsetting increases in OPPS payments elsewhere.

Site-neutral payment expansions, however, are not the only adjustments affecting OPPS payments. The CMS has also imposed a 0.5 percent payment reduction as part of a recoupment for previous payment adjustments centered around Medicare Part B prescriptions covered under the 340B drug pricing program.[2] The anticipated net effect on payments to hospitals in specific geographic regions also depends on adjustments to other payment factors such as ambulatory

[2] In 2018, the Centers for Medicare and Medicaid Services (CMS) reduced payments for 340B covered drugs under Part B. To comply with mandated budget neutrality, the CMS increased non-prescription-based reimbursement for other Part B services. After this change was struck down by the Supreme Court in 2022, the CMS had to reverse this change, paying back the reduced 340B payments but clawing back the increased payments. The 0.5 percent reduction in 2026 for drug administration services (not the drugs themselves) is part of this reversion.

payment classifications (APCs)[3] and the Medicare Area Wage Index[4], adjustments that are considered budget-neutral at the national level.

Percentage Impacts

Table 167 of the CMS Final Rule for 2026 provides an estimate of payment effects for hospitals by urban and rural status in the East South Central Census Division, the division containing Kentucky, Alabama, Mississippi, and Tennessee (CMS 2025). The nationally budget-neutral adjustments to APCs and the Medicare Area Wage Index reduce payments for Kentucky's urban hospitals by 1.1 percent. They reduce payments to Kentucky's rural hospitals by 2.6 percent, which means they fully cancel out the 2.6 percent general increase before any non-budget-neutral adjustments are made.

The expansion of site-neutral payments and the 340B recoupment reduction are expected to reduce payments to Kentucky's urban hospitals by a further 0.7 percent, resulting in a net increase of 0.8 percent after all reductions are subtracted from the 2.6 percent increase. Rural hospitals, however, are expected to see a net *decrease* of 0.6 percent in OPPS payments. This suggests that any struggling rural hospitals in Kentucky may face even greater strain if other elements of their revenue streams cannot offset this reduction. Urban hospitals will also face increased strain if their costs of caring for Medicare beneficiaries increase more than 0.8 percent.

Statewide Revenue

To quantify the effect of the CMS' recent OPPS changes for urban and rural hospitals in dollar terms, some additional information is needed. When the CMS and researchers publish

[3] APCs are how the CMS categorizes services and payments for those services under the OPPS, similar to diagnostic related groups (DRGs) for IPPS.

[4] The Medicare Area Wage Index values, alongside those for APCs, provide weights that scale the OPPS conversion factor (base payment amount), causing payment amounts to vary by the set of services and geography where the service was performed. The APC weight provides the weight for the particular service classification, while the area wage index does so based on geographically tied labor costs.

information on Medicare, they often use data from Traditional Fee-for-Service Medicare (Medicare FFS) exclusively. This is because Medicare Advantage plans (MA) are administered by private insurers, who do not have to provide as detailed of records to the CMS, and obtaining these records requires the permission of the private insurers.

While the CMS sets only Medicare FFS payment policies, MA plan providers often look to Medicare FFS to inform their own rates. Further, some MA providers, such as Blue Cross Blue Shield, advocate for site-neutral payment expansions (BCBS 2023). Robinson and Whaley (2025) suggest that Blue Cross Blue Shield plans could save over a billion dollars over three years from using site-neutral payments for cancer biologics. Due to this, it seems unlikely that private insurance companies advocating for site-neutral payments would ignore the opportunity to follow the CMS and employ a potential cost-saving measure. Therefore, we aim to quantify the potential effect for both Medicare FFS and MA, should MA plans follow the CMS in expanding site-neutral payments.

To establish how much Medicare outpatient revenue Kentucky hospitals receive and how much they would be affected by payment changes, we need an approximate value for both Medicare FFS and MA outpatient spending in the state. Unfortunately, the CMS does not publish an explicit table of state-level OPPS expenditures for Medicare FFS. However, total OPPS spending in the US is available and was $70 billion in 2023 (MedPAC 2025). To convert this to Kentucky-level spending, an approximation for the share of national outpatient spending that Kentucky hospitals receive is needed. To obtain this, we turn to Hospital Provider Cost Report data from the CMS for 2023 (CMS 2026).

While these data do not contain Medicare-specific outpatient revenues, they do include aggregate outpatient revenues for hospitals. We find Kentucky's share of total national outpatient

revenues for hospitals with a rural or urban designation in cost reports ending in fiscal year 2023.[5] We assume that the separate percentage shares of aggregate urban and aggregate rural outpatient revenues for Kentucky hospitals in this data are the same as their shares of Medicare OPPS revenue. We exclude hospital types, such as critical access hospitals, that are not reimbursed under the OPPS, ensuring their revenues are not included in our calculations.

In the cost report data, the national urban-rural split for outpatient revenues among hospitals we categorized as OPPS hospitals was approximately 58.3 to 41.7 percent. Kentucky hospitals' shares of national urban and rural outpatient revenues were approximately 3.03 and 2.43 percent, respectively. Using these values, we assume Kentucky's share of aggregate OPPS spending is about 1.77 percent for urban hospitals and 1.01 percent for rural hospitals.[6] These percentages can then be multiplied by the total of OPPS spending to approximate the amounts Kentucky hospitals received from FFS Medicare. However, obtaining an approximate amount of spending for MA requires an extra step.

While comprehensive outpatient spending in MA data is not accessible, we can generate an approximate value if an assumption is made about whether MA spending is generally similar to Medicare FFS. A review of the literature comparing utilization between MA and Medicare FFS enrollees suggests that MA enrollees may tend to use more preventive care services and make fewer trips to the emergency department (Agarwal et al. 2021). This suggests there are utilization trade-offs within outpatient spending categories. It is unclear what other trade-offs may occur and what the net effect is on spending.[7]

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[5] Recall from the above discussion that urban and rural hospitals in the East South Central Census Division are experiencing different changes in OPPS payments, so a separate measure for the share of urban spending and rural spending is needed.

[6] $0.583 \times 0.0303 \approx 0.0177$; $0.41.7 \times 0.0243 \approx 0.0101$.

[7] For example, MA plans have garnered a reputation for avoiding more expensive inpatient admissions by "downgrading" what might otherwise be an inpatient admission to an outpatient observation. Such avoidance inspired the CMS's 2023 reminder that its two midnight policy applied to more than just Medicare FFS, "…an MA

Further complicating the utilization/spending consideration is the increasing share of Medicare beneficiaries enrolled in MA plans, as outpatient spending may fluctuate with potential compositional changes in enrollee mixes. The Kaiser Family Foundation (KFF) notes that in 2007, about 19 percent of Medicare beneficiaries were enrolled in an MA plan, whereas 51 percent were enrolled in an MA plan in 2023 (Ochieng et al. 2025). Adding to this, the KFF also notes that in 2023, about half of all Medicare inpatient stays were comprised of MA patients, whereas Medicare FFS patients comprised nearly three-quarters of inpatient stays in 2015 (Godwin et al. 2025). This suggests evidence from as close to the period being examined as possible should likely be prioritized given the considerable change in MA market penetration and the composition of Medicare inpatient stays over the past decade. Schwartz et al. (2021), which was published after Agarwal et al.'s review, find that relative to Medicare FFS, beneficiaries entering MA plans saw significantly lower inpatient utilization/spending but no detectable spending difference for outpatient services. Leveraging this finding, we assume that outpatient spending was approximately equal between MA and Medicare FFS in 2023.

If we assume outpatient spending was roughly equal between MA and FFS beneficiaries in 2023, then aggregate outpatient spending between them would be about $140 billion. Multiplying this value by the share approximated to go to Kentucky's urban and rural hospitals results in OPPS and MA outpatient spending of about $3.89 billion combined: $2.47 billion for urban hospitals and $1.42 billion for rural hospitals.

plan must provide coverage, by furnishing, arranging for, or paying for an inpatient admission when, based on consideration of complex medical factors documented in the medical record, the admitting physician expects the patient to require hospital care that crosses two-midnights (§ 412.3(d)(1), the "two midnight benchmark");…" (CMS 2023). This points to MA plans being more likely to use outpatient services in such circumstances, clouding the utilization tradeoffs occurring even more.

With spending numbers for Medicare FFS and MA, we can assign a dollar value to the expected effects of the CMS' changes to reimbursement. Table 167 of the CMS' Final Rule for OPPS in 2026 indicates that rural hospitals in the East South Central Census Division would experience a 0.1 percent decrease in payments from site-neutral payments and, after accounting for all other adjustments, a roughly 0.6 percent decrease in aggregate payments. However, we do not expect MA plans to impose the 340B recoupment, meaning MA revenues should only fall by 0.1 percent for site-neutral payments to rural hospitals. Urban hospitals are expected to see a decrease from site-neutral payments of 0.3 percent, but not a net decrease in payments like rural hospitals. Statewide reductions from site-neutral payments are approximately $1,419,000 for Kentucky's rural hospitals and about $7,420,000 for urban hospitals. The combined net reduction in expected payments for Kentucky's rural hospitals could be approximately $4,967,000.[8]

Per-Hospital Revenue

Determining per-hospital impacts is not a straightforward proposition, as not all relevant hospitals appear to be represented in the cost reports. In its final rule for fiscal 2026, the CMS indicates that it expects there to be 170 and 132 affected urban and rural hospitals in the East South Central Census Division, respectively. However, a list by state is not given. To assign a per-hospital figure, we need the share of these hospitals that are in Kentucky. To find the answer for rural hospitals in Kentucky, we make use of the Center for Healthcare Quality and Payment Reform's list of open rural inpatient hospitals in each state (CHQPR 2026). We find that rural hospitals in Kentucky comprise about 29.2 percent of the rural inpatient hospitals in the East South Central Census Division. If we apply that share to the 132 hospitals in the CMS table, we

[8] This combines reductions of 0.6% for FFS OPPS payments and 0.1% for MA payments. $\frac{\$1.42 \text{ bil}}{2} \times 0.006 + \frac{\$1.42 \text{ bil}}{2} \times 0.001 = \$0.71 \text{ bil} \times 0.007 = \$4{,}970{,}000$.

get a count of roughly 39 rural Kentucky hospitals expected to be impacted by the OPPS payment changes. Unfortunately, we could not find an equivalent list for urban hospitals. Instead, we made use of a statistic from an early 2024 report by the Kentucky Hospital Association that indicated that the rural/urban split of hospitals in Kentucky was 56 and 44 percent, respectively (KHA 2024a). This suggests roughly 31 Urban hospitals are affected by OPPS payment changes.[9] Spread across 39 rural hospitals, the estimated revenue loss from expanded site-neutral payments would be just over $36,000 per hospital. The total revenue lost from all OPPS payment changes would be just over $127,000. Urban hospitals could see revenue losses from site-neutral payments of over $239,000. Relative to the size of hospitals' revenues and expenses, these amounts may seem modest. However, many Kentucky hospitals operate with thin or negative margins, meaning their revenues alone often barely cover or fail to cover their expenses, and even minor changes could mean an increased dependency on charitable donations or direct taxpayer support. Figures 1 and 2 display the operating margins and operating revenues net of total operating expenses for rural and urban hospitals in the cost report data that we categorized as reimbursed under the OPPS. Of note among rural hospitals is that the majority observed in the cost report data have negative operating margins. Further, one rural observation had a positive margin so small that a loss of $36,000 would cause it to become negative. Among the hospitals we examined, the combined urban and rural hospitals that reported negative margins were observed to have nearly 27,000 full-time employees, with just over 9,000 at rural hospitals.

Uncompensated Care

There is a possibility that added financial strain will reduce the availability of uncompensated care Kentucky hospitals provide. To illustrate, we perform a regression analysis

[9] Urban Hospitals = $\frac{44}{56} \times$ Rural Hospitals = $\frac{44}{56} \times 39 \approx 31$.

using the cost reports available for a panel of Kentucky hospitals we believe to be compensated under the OPPS for fiscal years ending 2015-2024. Our outcome is spending on uncompensated care given in the cost reports. This is equal to the sum of charity care and bad debt – care initially billed for but ultimately written off. Our primary explanatory variable is patient revenues net of total operating expenses. Our simple linear model also includes hospital, year, and rural status fixed effects with robust standard errors clustered at the hospital level. The coefficient estimate for net revenue is 0.033 with a standard error of 0.013, indicating statistical significance (*p=0.018*). The point estimate implies that hospitals spend three cents of every additional dollar of net revenue on charity care. This in turn implies that the estimated $127,000 loss of revenue per rural hospital would reduce uncompensated care by $4,191, while the estimated $239,000 loss of revenue per urban hospital would reduce uncompensated care by $7,887.

Again, these magnitudes may seem modest, but if site-neutral payments were applied more broadly, the magnitudes would presumably scale up accordingly. Moreover, these conditional associations likely understate the true causal effects due to reverse causality. An increase in uncompensated care mechanically reduces net revenue, biasing the estimator for the effect of net revenue downwards.

IV. Discussion

Service Reductions and Closures

These results combine with anecdotal evidence to paint a picture of an elevated risk of closure of unprofitable departments or even entire hospitals – particularly if site-neutral payments are adopted more broadly. One example is the South Lincoln Medical Center in Wyoming, which closed its operating room and obstetric services after nearly a decade of negative operating margins (Orozco Rodriguez 2024). When examining South Lincoln's margins

in cost report data for fiscal years ending in 2015- 2024, the only noticeable trend reversal in its worsening negative margins was in 2022, around the time the facility cut services, but this was not sufficient to create a positive operating margin, nor did the improvement persist. Somewhat similar stories among Kentucky hospitals include the closure of the Center for Autism at the Highland Medical Center in late 2017, the downsizing of Westlake Regional Hospital after becoming TJ Health Columbia in 2016, and the conversion of Crittenden Community Hospital from an inpatient acute care hospital to a rural emergency hospital in 2024 (Mountain Top Media 2017; Boswell 2016; The Crittenden Press 2024). Among these, only TJ Health Columbia shows a positive operating margin in our cost data in recent years; the other two have continued to struggle with negative margins.

According to the Sheps Center interactive map, Kentucky had 3 hospital closures roughly 10 years ago: Nicholas County Hospital in 2014, Parkway Regional Hospital in 2015, and New Horizons Medical Center in 2016. While these three hospitals closed largely before the period for which we examine cost reports, and New Horizons and Nicholas County were non-OPPS critical access hospitals, they nevertheless illustrate how prolonged struggle can end in closure. On its path to closure, the *Louisville Courier-Journal* reported that Nicholas County Hospital bled money and reduced its total hospital beds from 24 to 12 (Ungar 2014). The loss of services was pronounced for residents of the nursing home, which had been attached to the hospital and was a source of care for residents (Ungar 2014). Ahead of closing, Parkway Regional was reported to be ceasing its emergency and inpatient care (West Kentucky Star 2014). After New Horizons closed, it was acquired by St. Elizabeth Healthcare in 2016; however, in mid-2017, St. Elizabeth discontinued emergency services due to low patient volumes (Haines 2017).

Hospital-Physician Integration

A less obvious implication of the continued expansion of site-neutral payments is how they might affect rural physician decisions about private practice versus working for hospitals. To explore possible impacts in this area, it is useful to understand what the literature has to say about physicians integrating with hospitals and the distribution of physicians across urban and rural areas.

Hospital-physician integration has emerged as a possible consequence of the difference in payments between OPPS and PFS over the last ten years. The likelihood that beneficiaries wind up in an HOPD rather than a physician's office, where they face higher bills, is increased as hospitals absorb more independent physician practices. A report from the American Medical Association suggests that the share of physicians in private practice declined from around 60 percent in 2012 to around 42 percent in 2024 (Kane 2025). This is not solely attributable to differences in Medicare reimbursement but demonstrates an increasing concentration of physicians in healthcare and hospital systems. The argument for hospitals' integration with physicians is that the gap in compensation levels creates an incentive for HOPDs to absorb their competition. Vertical integration with physicians increases operating margins if the net gain in revenue from new patients outweighs the physicians' cost, and the higher price for services may allow physicians to earn a higher income from the hospital with fewer administrative duties.

There is some empirical literature that supports this proposition. Devlin and McCormack (2023) find that increased Medicare reimbursements for independent physicians in four "frontier" states under the Patient Protection and Affordable Care Act (ACA) of 2010 led to reduced vertical integration between hospitals and physicians participating in Medicare and may have increased the quantity of services physicians provided. Dranove and Ody (2019) find that

increased Medicare reimbursements for hospital-employed physicians relative to other physicians increase vertical integration. Post et al. (2021) find an association between higher relative Medicare reimbursement and integration among primary care and medical specialties, but not surgery. Post (2021) finds that an increase in a primary care physician's value to hospitals via increased Medicare payments is associated with an increased likelihood of hospital integration. However, such associations do not necessarily hold for all specialties. Hu et al. (2024) find little evidence of an association between the ratio of HOPD reimbursement values to office-based physician values and integration for oncologists, and their imprecise results suggest an opposite sign to that of Post et al. (2021).

Other studies have also noted shifts in the location of services for Medicare beneficiaries —from offices to HOPDs— that are suggestive of greater integration (Kapoor et al. 2025; Song et al. 2015; Masoudi et al. 2019). One study notes increased expenditures for Medicare beneficiaries after physicians integrate (Capps et al. 2018). Post et al. (2024), however, find little evidence of differences in Medicare spending on inpatient and outpatient cardiology services provided by integrated and non-integrated physicians. Beyond the potential spread of higher costs from integration, one study suggests that integrated physicians see fewer Medicare patients after integration (Post et al. 2025).

Evidence on potential spillover effects on the privately insured is less clear and sparse, but suggests some undesirable effects may exist. Godwin et al. (2021) do not find an association between vertical integration and higher facility fees for privately insured patients, but do find some associations between integration and higher prices among cardiology, primary care, and orthopedic specialties. Maughan et al. (2025) and Sen et al. (2022) suggest that private insurers also pay higher rates at HOPDs than at ambulatory surgical centers.

The federal government's current policy position is trending toward expanding site-neutral payments, which compensate providers at the lower rate of the PFS for more services regardless of setting. However, as a policy prescription, it is unclear if this will have a fully desirable effect. The American Medical Association (AMA) suggests that, once adjusted for inflation in practice costs, Medicare's compensation for physicians has declined by approximately one-third from 2001 to 2025 (AMA 2025a). In another document, the AMA documents changes in the PFS' conversion factor —the base amount used in PFS payment calculations— from 1992-2025. From its peak of $38.26 in 2001, the conversion factor declined by 15.5% to $32.35 in 2025 (AMA 2025b).[10]

If HOPDs face higher facility costs to provide required standby services, then enforcing payment parity at the lower of the two rates will likely generate a decrease in the quantity supplied of these services (Clemens and Gottlieb 2014). Independent physicians could potentially integrate into a system that has a better payer mix or relocate to a more affluent area more easily. Hospitals cannot move or be acquired quite as easily, leaving cost reductions via service and staffing cuts as more likely options. The effects of such reductions may be felt more keenly in rural areas, where physicians' and hospitals' payer mixes tend to skew more toward Medicaid and Medicare (AMA 2024).

Post et al. (2021) suggest that vertical integration is more likely in rural areas. If this is driven by independent practice becoming less viable due to declining reimbursement in real

[10] At first, this may appear somewhat misleading, as PFS payments are a function of more than just the conversion factor. However, after the statutory adjustments under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and subsequent budget neutrality adjustments by the CMS, the conversion factor reflects changes to weights for elements such as relative work units (RVUs). This is noted by the CMS in 2017. "The overall update to payments under the PFS based on the finalized CY 2018 rates …reflects the … update established under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, …the misvalued code target recapture amount, required under the Achieving a Better Life Experience (ABLE) Act of 2014. After applying these adjustments, and the budget neutrality adjustment to account for changes in RVUs,… the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89" (CMS 2017).

terms, then reducing HOPD reimbursements in rural areas may not simply reduce integration. Urban physicians may see their choices as fairly binary when faced with reduced Medicare reimbursements. They can integrate or practice privately, whichever remains most appealing. Rural physicians, however, may more strongly consider the third option of relocating. Moving from a rural practice location to a more urban area likely means a physician will have a patient mix less reliant on Medicare, and the physician can reduce the impact from reimbursement decreases with privately insured patients.

If faced with poor reimbursement options regardless of whether practicing independently or within an HOPD, the rural supply of physicians may shrink, worsening concerns over shortages. For example, Cornelius et al. (2024) suggest that only about three percent of oncologists treating Medicare patients practice in rural locations. The American Hospital Association (AHA) suggests that Medicare cancer patients receiving care in HOPDs tend to come from low-income and rural areas compared to those receiving care in physician offices (AHA 2025). This suggests that oncologists in rural areas may be disproportionately integrated, and reimbursement reductions for cancer drug administration services may incentivize them to leave rural areas rather than practice independently.

These incentives, however, are not restricted to oncologists alone. Fraze et al. (2022) suggest that rural primary care practices have two to four times more attributed Medicare beneficiaries than urban practices, despite having fewer clinicians per practice. This suggests a disproportionate impact of site-neutral payments among rural physicians and reduced options for Medicare beneficiaries if their primary physician moves to an urban area. If the trend of lowering HOPD reimbursements while maintaining the same or declining PFS reimbursement is maintained, then this could leave Kentucky's rural Medicare beneficiaries with lower access to

care. Beneficiaries with Medicare FFS will face lower coinsurance payments with site-neutral payments, but this does not account for patients' unmeasured cost increases if reimbursement reductions result in fewer rural hospitals, fewer rural hospital services, or fewer physicians practicing in rural areas.

Increasing the Physician Fee Schedule

In previous sections, we discussed the impact of expanded site-neutral payments and OPPS payment reductions on Kentucky hospitals and their HOPDs. We noted that rural hospitals were going to be the most negatively affected, with outright decreases in their expected OPPS payment amounts. This added financial strain could result in reduced access for Kentucky's rural Medicare beneficiaries and rural residents in general through potential closures of hospitals, closures of HOPDs, or closure of certain outpatient service lines. We further pointed out that replacing prior OPPS-level reimbursements with PFS-level reimbursements may result in a declining rural physician supply.

To at least partially alleviate this risk, Congress and the CMS could consider increasing PFS reimbursements. As noted, inflation-adjusted PFS reimbursements have been declining. With reimbursement declines, Medicare patients become less attractive to health care providers, particularly providers in rural areas, whose patient mixes skew toward the publicly insured. The gap between the government's payment ceiling for outpatient services (OPPS) and the floor (PFS) can be sizeable. Post et al. (2021) suggest higher Medicare payments of 74 and 224 percent, depending on physician specialty, had services reimbursed by non-integrated physicians under the PFS been reimbursed under the OPPS. Devlin and McCormack's (2023) results indicate that a one percent increase in Medicare office-based reimbursement for physicians reduces the probability of integration by 1.55 percentage points. Based on these findings, if the

government intends to expand site-neutral payments, it could be more beneficial to have the reimbursements of the PFS and OPPS mutually converge rather than simply lower HOPD reimbursements.

With that said, an across-the-board increase in the PFS would not fully compensate hospitals for the losses from site neutral payments unless overall Medicare expenditures increased substantially. Full compensation could only occur if the PFS were to be increased to the HOPD payment rates, in which case the only change would be increased fees at freestanding facilities. This would undercut the motivation for site-neutral payments, which is to *reduce* Medicare costs.

V. Conclusion

Expansions of site-neutral payments and other changes in OPPS payments for 2026 could further strain Kentucky's already struggling rural hospitals. OPPS payments to urban and rural Kentucky hospitals are expected to decrease by 0.3 and 0.1 percent due to expanded site-neutral payments for certain drug services. This and other payment adjustments are expected to reduce Kentucky's urban hospitals' OPPS payment increase for 2026 from the purported 2.6 percent national increase to 0.8 percent. Kentucky's rural hospitals, however, are expected to see a net 0.6 percent decrease in OPPS payments, ensuring a net reduction in hospital revenue. Across the state, we estimate total annual losses from site-neutral payments of $1,419,000 for Kentucky's rural hospitals and $7,420,000 for urban hospitals. When combined with other adjustments by CMS, the predicted reduction in revenue for Kentucky's rural hospitals comes to $4,967,000.

These numbers imply predicted per-hospital losses from site-neutral payments of $36,000 per rural hospital and $239,000 per urban hospital. Revenue lost per rural hospital from all OPPS payment changes is estimated to be $127,000. While these per-hospital losses may sound

modest, many Kentucky hospitals – particularly in rural areas – operate on negative or razor-thin margins, making them vulnerable to even modest financial setbacks. Moreover, the impacts can be expected to scale accordingly if site-neutral payments are expanded further.

These losses should be weighed against the benefits of savings to Medicare when evaluating the net welfare effects of CMS' OPPS payment adjustments. Persistent operating losses tend to lead to reductions in uncompensated care and, if they are deep enough, closures of departments or even entire hospitals. Moreover, if HOPDs are paid the PFS rate, rural physicians, who tend to see more Medicare patients, may be incentivized to relocate to urban areas. All of these scenarios point towards reduced access to health care, particularly in the most vulnerable parts of Kentucky.

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Figure 1. Operating Margins for Kentucky's OPPS Rural Hospitals in Cost Report Data

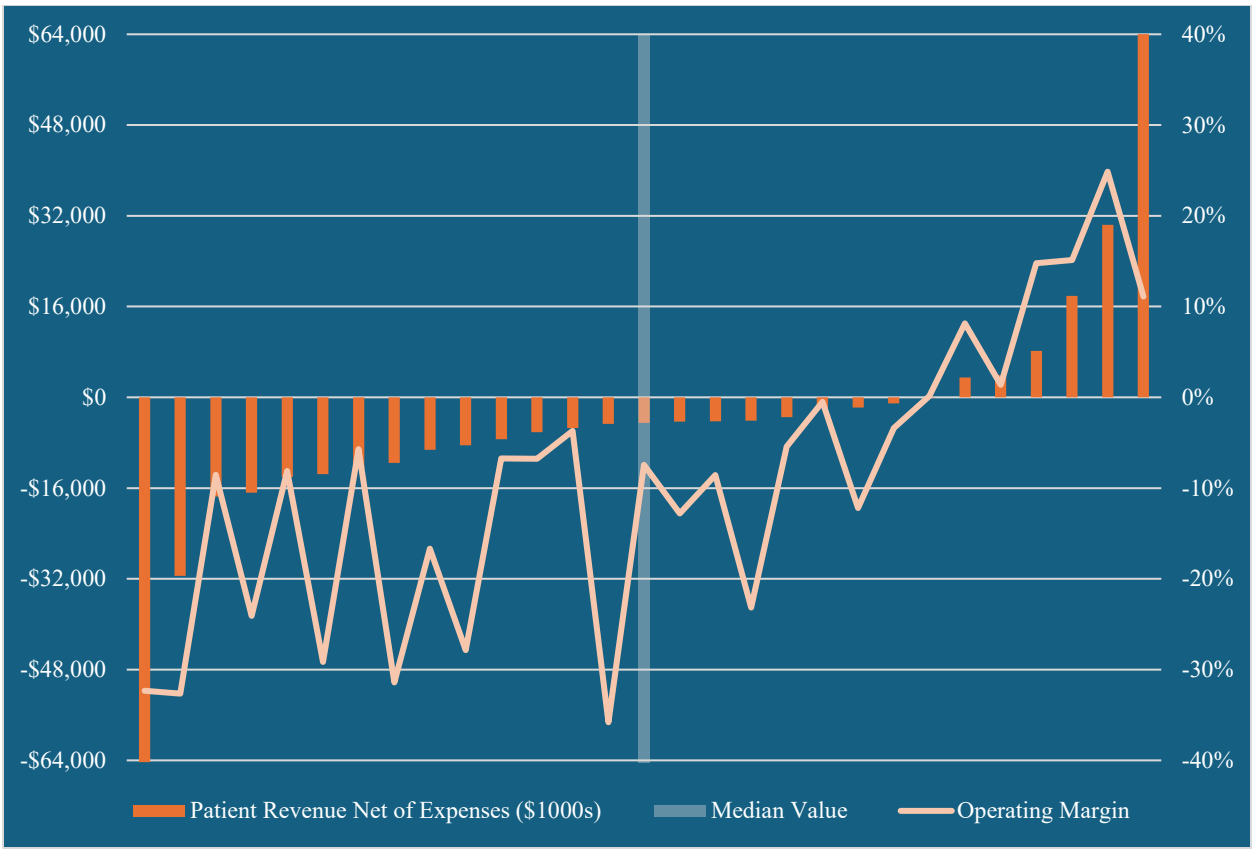

Figure 2. Operating Margins for Kentucky's OPPS Urban Hospitals in Cost Report Data