

How Urban Hospitals Tap Rural Benefits - and Why It Matters



Many urban hospitals are exploiting Medicare’s rules by first reclassifying themselves as “administratively rural” to access benefits meant for true rural providers, then using the Geographic Classification Review Board process to reclassify back to urban status for wage index purposes. This dual classification—treated as rural for some payments and urban for others—allows large, well-resourced metropolitan hospitals to maximize reimbursement while diverting critical support away from the rural hospitals that rely on it.



Hospital dual reclassification accelerated significantly - **from 168 hospitals in 2018 to 593 in 2023** - following a patchwork of court decisions and CMS policy changes allowing geographically urban hospitals to reclassify as rural, and then dually classify as urban for purposes of the wage index.

Median bed size for dually classified hospitals is more than 5 times that of rural hospitals in 2023: **285 to 49**. The larger size of these dually classified hospitals means that there are now significantly more geographically urban beds receiving rural benefits than rural beds receiving them.

Dually classified hospitals exhibit **greater financial strength** than either hospitals that are truly rural or only classified as urban, as measured by their general fund balance.

2017:

75 of 866 hospitals with rural status were dually classified, while **791** were true geographically rural hospitals



2023:

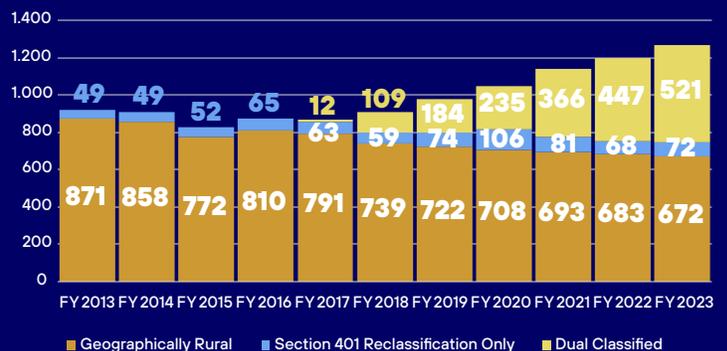
593 of 1,265 were dually classified, while **672** were true geographically rural hospitals



Most dually classified hospitals are nonprofits, and the top 20 by revenue are major teaching hospitals with net patient revenues from **\$2.9B to over \$9B**, showing that large, well-funded systems are strategically using this policy to boost reimbursement.

ADMINISTRATIVELY RURAL HOSPITALS CLASSIFICATION (2013-2023)

By receiving dual classification, hospitals are benefiting from a higher urban wage index, additional graduate medical education slots, more generous Medicare funding and potentially expanded eligibility for the 340B program. Because there is no requirement for these hospitals to provide additional rural patient services, there is no visibility into how these additional dollars impact patient care.



CLOSING THE DUAL-CLASSIFICATION LOOPHOLE WOULD REDIRECT RESOURCES TO TRULY RURAL PROVIDERS. TYING RURAL PAYMENT BENEFITS TO ACTUAL GEOGRAPHIC RURALITY WOULD BETTER MATCH POLICY TO NEED, PROTECT ACCESS, AND STRENGTHEN RURAL HEALTH CARE LONG-TERM.