DUAL CLASSIFICATION: HOW URBAN HOSPITALS ARE CAPITALIZING ON MEDICARE RECLASSIFICATION POLICIES

ISSUE BRIEF

Magnolia market access
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EXECUTIVE SUMMARY

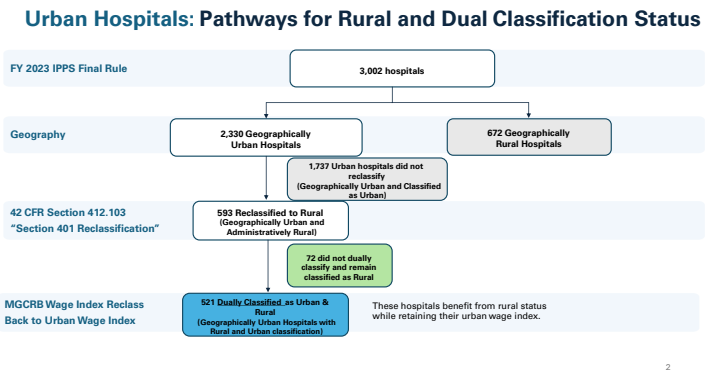
After decades of incremental legislative and regulatory changes and legal challenges, current CMS policies enable urban hospitals to reclassify as administratively rural for all purposes and then back to urban just for wage index purposes – known as "dual classification". This practice enriches already profitable urban hospitals by allowing them to access Medicare benefits and funding intended to support and protect rural hospitals. The trend in dual classification is occurring to the detriment of the rural health system.

- **The use of dual classification is rapidly expanding.** The number of geographically urban but administratively rural hospitals has grown twelvefold, while the number of true geographically rural hospitals has declined by more than 20% since 2013.
- **Dually classified hospitals are significantly larger.** Their median size in 2023 was 285 beds, compared with 155 for urban hospitals and 49 for rural hospitals.
- **Federal funds are being redirected.** Dollars intended to support rural hospitals and infrastructure are increasingly flowing to geographically urban hospitals, strengthening their financial position but potentially weakening the rural safety net.

What is Hospital Dual Classification?

Hospital dual classification refers to when a hospital is considered to be both a rural and urban provider for different Medicare payment purposes. A growing number of geographically urban hospitals located in major metropolitan areas have pursued this two-step reclassification strategy for billing and payment purposes under laws and Center for Medicare and Medicaid Services (CMS) regulations.

- Hospitals are first categorized as **urban or rural** based on their **geographic location.**
- **Step 1:** Geographically urban hospitals elect to be treated as **administratively rural** for Medicare payment purposes pursuant to 42 CFR §412.103, granting them access to certain benefits available to rural hospitals.
- **Step 2:** Hospitals then seek **geographic reclassification** back to a higher **urban** wage area under the Medicare Geographic Classification Review Board Process (MGCRB), resulting in higher payments for services to which the wage index applies.



The reclassification process originated with §401 of the Medicare, Medicaid, and the SCHIP Balanced Budget Refinement Act of 1999. Implemented through 42 CFR §412.103 (the "urban-to-rural" or "§401" redesignation allowed geographically urban hospitals to elect rural status for Medicare purposes. CMS' implementing regulations initially took a restrictive view of this authority, and through 42 CFR §412.230(a)(5)(iii) barred hospitals that had elected rural status under §412.103 from also seeking a geographic reclassification to a higher wage-index area via the Medicare Geographic Classification Review Board (MGCRB), effectively forcing geographically urban hospitals to choose between rural benefits and

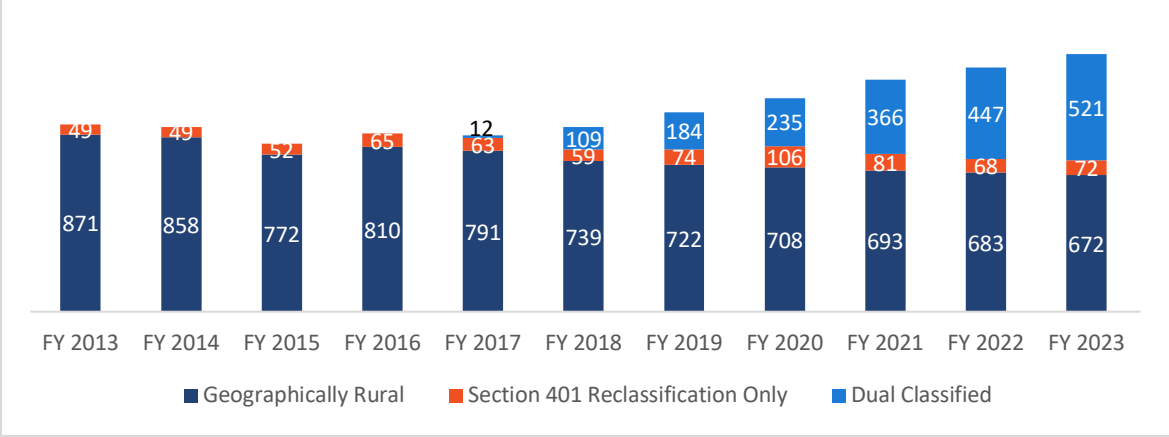
wage-index relief. Between 2015 and 2016, federal appellate courts in the Second and Third Circuits invalidated this "no-stacking" rule, holding that §401 requires CMS to treat a §401-reclassified hospital as located in the state's rural area for all purposes under §1886(d) of the Social Security Act, including MGCRB reclassification, and that CMS could not categorically prohibit dual classification of those hospitals to urban. Following another court ruling in 2020, CMS further clarified in a May 2021 interim final rule that hospitals that reclassify to rural pursuant to 42 CFR §412.103 are considered located in the state's rural area, including having met all regulatory criteria a hospital must meet to be approved for geographic reclassification to another wage index area, starting with FY 2023 applications. This sequence of court rulings and regulatory changes established a consistent, clear pathway for urban-rural-urban dual classification.

These changes allow dually classified hospitals to access benefits intended for rural facilities while also receiving the higher urban wage index. Reclassification to rural status confers several advantages, including the ability to qualify as a Rural Referral Center (RRC) or Sole Community Hospital (SCH), both of which trigger higher CMS reimbursement than the standard Inpatient Prospective Payment System (IPPS)[i], generating additional federal funding through both direct and indirect graduate medical education (GME) payments, as well as enhanced payment add-ons under the Outpatient Prospective Payment System (OPPS).[ii] RRCs and SCHs also have a lower threshold for 340B covered entity (CE) eligibility. The number of "rural" hospitals was also considered in applications for the newly created Rural Transformation Fund, potentially siphoning the dollars meant to improve health care delivery for rural Americans, who, unlike hospitals, are unable to reclassify when convenient.

How Has Dual Classification Grown, and Who Benefits from It?

Dual classification has grown sharply since the policy took effect; in 2017, 75 of the 866 hospitals classified as rural were reclassified or dual classified, and 791 were geographically rural. By 2023, a total of 1,265 hospitals held rural status, but only 672 were true geographically rural hospitals - more than 45% were reclassified or dually classified geographically urban hospitals (Figure 1). Most dually classified hospitals are considered nonprofits, and the top 20 by revenue are all major teaching hospitals with net patient revenues ranging from $2.9B to more than $9B, indicating that larger, highly resourced systems are strategically leveraging this policy to increase reimbursement.[iii]

Figure 1. Administratively Rural Hospitals Classification (2013-2023)



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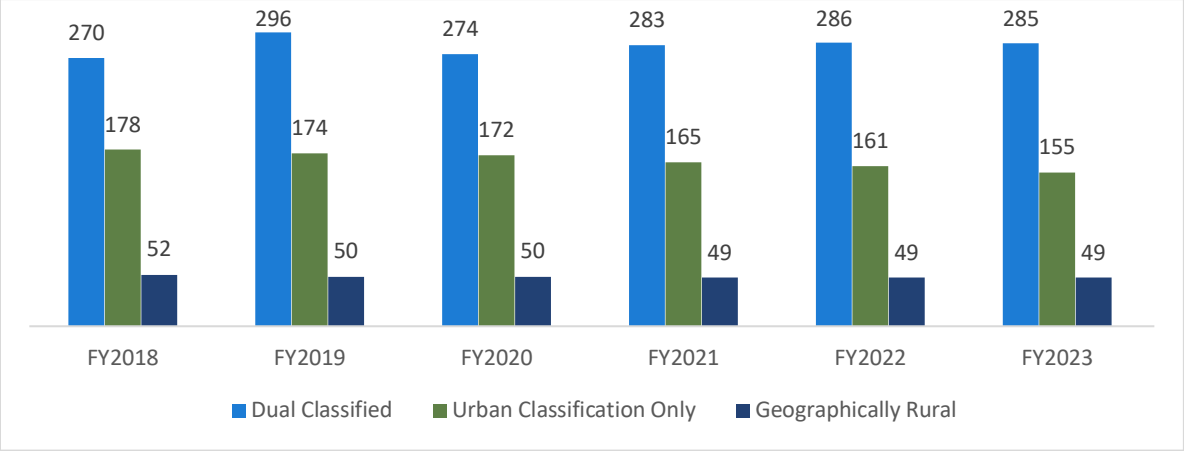
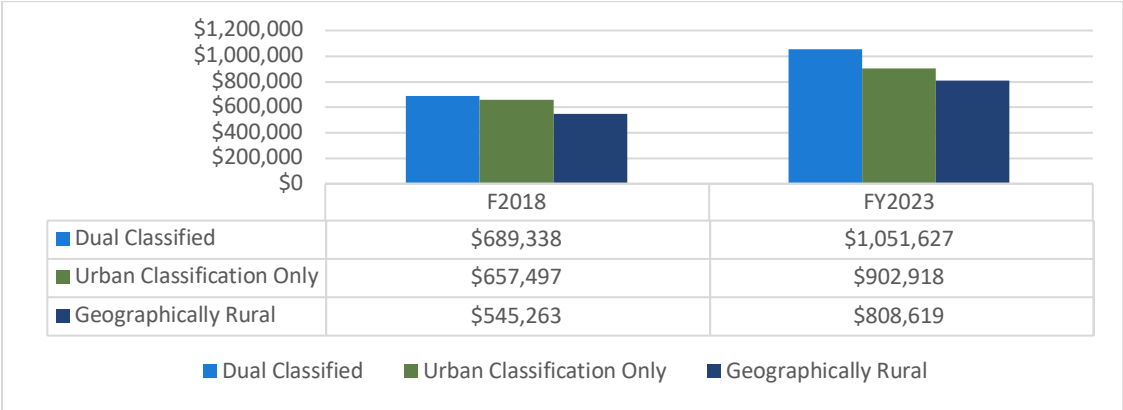
Dually classified hospitals are substantially larger than their urban and rural peers. In 2023, the median size of dually classified hospitals was 285 beds, compared with 155 for urban hospitals and 49 for rural hospitals (Figure 2). More than 162,000 urban beds were dually classified in 2023, representing 61% of all beds in administratively rural hospitals nationwide.[iv] In other words, there are significantly more geographically urban beds receiving rural benefits than there are rural beds receiving them.

Figure 2. Median Hospital Bed Size, by Hospital Classification (FY 2018-2023)



By receiving dual classification, hospitals can "have their cake and eat it too" -- benefiting from a higher urban wage index and the ability to qualify as a Rural Referral Center or Sole Community Hospital under a lower 340B threshold. 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. To assess the general financial health of hospitals and compare dually classified hospitals with other hospitals, we examined the metric general fund balance per bed. This measure assesses each hospital's total assets net of total liabilities, calculated on a per-bed basis to control for size. Our analysis shows that dually classified hospitals have higher general fund balances, and those balances increase at a greater rate compared to urban only or true rural hospitals (Figure 3). In 2023, dually classified hospitals reported $1.1M in general funds per bed compared to urban ($0.9M) and rural ($0.8M) hospitals. When applied to the bed count, this translates to an estimated general fund balance of approximately $299.7 million for dually classified hospitals, compared with $139.9 million for hospitals classified as urban only and $39.6 million for geographically rural hospitals.

Figure 3. Median General Fund Balance (per Bed), By Hospital Classification (FY 2018-2023)



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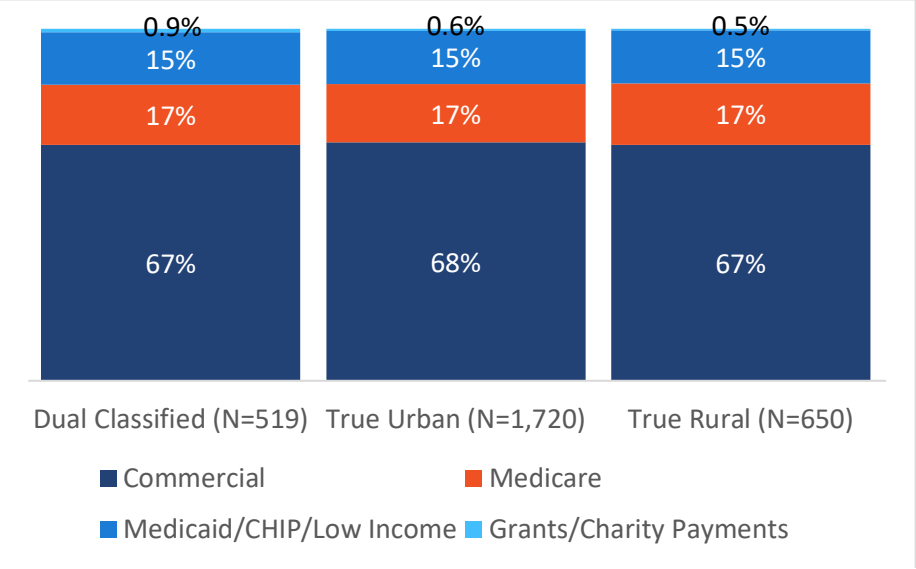
Although dually classified hospitals report higher general fund balances per bed, they are not treating a greater share of low-income, charity, or Medicaid patients despite their larger size, stronger financial position, access to the 340B program as a RRC or CAH, and other policy advantages. In 2023, dual-classified, urban, and rural hospitals provided care to similar percentages of commercial (67-68%), Medicare (17%), Medicaid/low-income (15%), and grant/charity care (0.5-0.9%) patients.[a]

Figure 4. Payer Mix, by Hospital Classification (FY 2023)



What is the Impact on Rural Patients and How Can Policies Be Changed to Ensure Rural Hospitals Receive the Revenue They Need?

The U.S. rural health care system depends on a stable network of rural hospitals and related services. Yet this network is rapidly eroding. Between 2010 and 2021, 136 rural hospitals closed - including 19 closures in 2020 alone.[v] Rural hospitals have been further strained by states' failure to expand Medicaid, persistent workforce shortages, and the financial pressures of serving small, aging, and low-income populations. As a result, the 20% of Americans living in rural areas - and the 14% living in nonmetropolitan counties - face growing barriers to essential care.[vi,vii]

Hospital closures rarely occur in isolation. From 2012 to 2017, counties that lost a geographically rural hospital also experienced nearly a 10% decline in rural health clinics and more than a 6% decline in community mental health centers.[viii] Medicare fee-for-service beneficiaries in these areas have a higher prevalence of the ten most common chronic conditions than beneficiaries in areas without closures, underscoring how vulnerable these patients are when local care disappears.[ix]

While rural hospitals are struggling to survive, dually classified hospitals are capitalizing on a policy loophole to increase revenue. Despite generally being larger and better -resourced hospitals, dually classified hospitals still receive rural payment enhancements even though they have no requirements to

[a] Similar trends were found for all hospital and patient-types between 2018-2023; only 2023 was shown for brevity.

serve predominantly rural or low-income populations, and our study shows their payer mix is on average similar to other hospitals. As a result, federal funds intended to maintain the national rural health infrastructure are increasingly diverted to metropolitan systems with relatively strong balance sheets.

Every dollar shifted to dually classified hospitals is a dollar not available to shore up the rural safety net, weakening already fragile hospitals, hastening closures, and reducing access to care in the communities that need it most.[x] Closing the dual-classification loophole would free up resources that could be redirected back to truly rural providers. Linking rural payment benefits to geographic rurality would align policy with need, protect access, and support the long-term viability of rural health care.

Methodology

Acute care hospitals and urban/rural/dual classifications were identified using Healthcare Provider Cost Reporting Information System (HCRIS) Cost Report data[xi] (Form CMS-2552-10) and IPPS Impact Files[xii] for FY2013-FY2023. Hospital characteristics, including bed size, general funds, and payer mix, were identified from the National Academy for State Health Policy (NASHP) Hospital Cost Tool (HCT)[xiii].

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[i] Special treatment: referral centers, 42 C.F.R. Sect. 412.96 (1985).
[ii] Special treatment: Medicare dependent, small rural hospitals, 42 C.F.R. Sect. 412.108 (1990).
[iii] Urban Hospitals Increasingly Reclassified as Rural | Johns Hopkins | Bloomberg School of Public Health
[iv] Sharp Rise In Urban Hospitals With Rural Status In Medicare, 2017–23 | Health Affairs
[v] rural-hospital-closures-threaten-access-report.pdf
[vi] Ibid.
[vii] Rural Classifications - What is Rural? | Economic Research Service
[viii] GAO-21-93, RURAL HOSPITAL CLOSURES: Affected Residents Had Reduced Access to Health Care Services
[ix] Ibid.
[x] Rural-work-plan-FINAL.pdf
[xi] https://www.cms.gov/data-research/statistics-trends-and-reports/cost-reports
[xii] https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/historical-impact-files-fy-1994-through-present
[xiii] https://tool.nashp.org/