NATIONAL GRANGE

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1616 H St. NW, Suite 300, Washington, DC 20006

Rural America is Paying the Price for Medicare Loophole

by Christine E. Hamp, President of the National Grange.

For generations, rural hospitals have been more than just places to receive medical care. They are community lifelines that provide jobs and make the difference between life and death when emergencies strike miles from the nearest city. Yet today, these essential institutions are being quietly undercut by a Medicare loophole that diverts resources meant for rural communities to large urban hospitals.

At the National Grange, we advocate for the people who feed, fuel, and sustain this country. That means speaking out when policies meant to protect rural America are instead being used to weaken it.

The issue is hospital reclassification, and its consequences are painfully real for rural patients.

Under current Medicare rules, hospitals are classified as either geographically rural or urban. Rural hospitals receive special payment protections because they serve smaller, older, and often poorer populations, and because operating in rural areas is more expensive and less efficient by nature. These protections exist to preserve access to care where market forces alone cannot.

But over time, regulatory changes and court decisions have opened the door for geographically urban hospitals to reclassify themselves as "administratively rural." For example, any big-city hospital with more than 275 beds can become administratively rural and then be designated a Rural Referral Center – even if not a single rural patient is referred to them! Once they do that, they gain access to rural-only Medicare benefits. Then, in a second step, those same hospitals are allowed to reclassify to urban status for wage calculations, securing higher payments typically reserved for metropolitan facilities. This two-step maneuver is known as "dual classification."

In plain terms, some of the nation's largest, wealthiest hospitals are claiming the benefits of being both rural and urban even when the communities they serve don't match that description.

The growth of this practice has been dramatic. A new analysis from Magnolia Market Access shows that in just five years, the number of hospitals using dual classification ballooned from 168 in 2018 to 593 in 2023.

These are not small-town hospitals struggling to keep their doors open. The median dual-classified hospital has nearly six times as many beds as a true rural hospital and dual classified hospitals have far stronger balance sheets. In fact, these hospitals hold significantly more financial reserves per bed than either rural or standard urban hospitals. Yet they are drawing from the same pool of Medicare dollars that Congress intended to support rural care. Reclassification to rural status allows hospitals to reap benefits such as additional graduate medical education slots and more generous Medicare funding.

Meanwhile, real rural hospitals are disappearing. More than 130 rural hospitals closed between 2010 and 2021. When a rural hospital shuts down, the damage ripples outward: clinics close, mental health services disappear, jobs vanish, and patients are forced to travel farther for care. Rural Americans already face higher rates of chronic disease and lower access to providers. Losing local care only deepens those disparities.

Every dollar redirected to a dual-classified urban hospital is a dollar not available to prevent the next rural closure.

This is not about punishing urban hospitals or denying fair reimbursement. But as it stands, bad actors are eroding the rural safety net. We must align Medicare policy with reality and ensure that rural benefits go to hospitals that are truly rural in all ways.

Policymakers can make this happen. First, Medicare should tie rural payment enhancements to geographic rurality, ensuring that hospitals located in metropolitan areas cannot access rural-only benefits simply through administrative maneuvers. Second, Congress and the Centers for Medicare & Medicaid Services (CMS) should close the dual-classification loophole, restoring the original intent of rural protections. Finally, any savings from these reforms should be reinvested directly into truly rural providers to strengthen workforce recruitment, emergency services, and long-term sustainability.

Rural Americans cannot reclassify their communities when it becomes convenient. Farmers cannot move their fields closer to hospitals. Families cannot relocate overnight when care disappears. Public policy should reflect that reality.

The National Grange believes in fairness, stewardship, and strong rural communities. Protecting rural hospitals is not a partisan issue — it is a promise to the people of rural America. It is time to keep that promise and ensure Medicare dollars support the hospitals and patients they were meant to serve.