

The Current and Future Role and Impact of Medicaid in Rural Health

*Prepared by the
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Overview

Medicaid is the nation's largest public insurance program and is a crucial source of health insurance coverage and provider payments for rural people, providers, and communities. The program fills gaps in health insurance coverage for rural people, particularly low-income families and children, and elderly and disabled Medicare beneficiaries. For example, in 2010, over 42% of low-income rural children relied on the Medicaid and the Children's Health Insurance Program (CHIP) as their source of coverage.¹ The Medicaid program is also a critical source of health care financing for the rural health system, including hospitals, doctors, and providers of long-term services and supports, and contributes significantly to local, rural economies by supporting health care and related employment.

Under the Patient Protection and Affordable Care Act of 2010, (ACA) the importance of Medicaid in the rural health system will grow significantly. Expanding Medicaid eligibility is a key element of the ACA's strategy for achieving near-universal coverage, with over half of the expected gains in health insurance coverage coming from the Medicaid expansion. In addition, significant Medicaid financing and delivery system reform initiatives, including the Health Homes, Dual Eligible Coordinated Care, and other demonstrations, could have significant implications for rural providers and the rural health system.

This brief outlines and describes the current Medicaid program and its importance to rural America. It also discusses rural implications of program expansion, including whether and how states choose to implement changes.

The Current Medicaid Program

The federal government and the states share the cost of the Medicaid program. States design their Medicaid programs within federally defined boundaries relating to eligibility, benefits, and administration. While federal law specifies certain categories of eligibility and benefits of mandatory coverage, well over half of Medicaid spending is for optional services and populations selected by the states.² States may also obtain waivers from the US Department of Health and Human Services to expand eligibility and coverage beyond that authorized by federal Medicaid law.

On average, states spend about 17% of their general funds on Medicaid, making it the second largest item in states' budgets.³ Overall, though, the federal government pays more than half the costs for Medicaid, about 57%;⁴ poorer states receive a higher federal match (the Federal Medical Assistance Percentage, FMAP, is calculated based on state per capita income relative to US per capita income).

Historically, Medicaid has covered fewer than half of low-income Americans. People in poverty must also fit within federally prescribed categories of eligibility, which, absent a federal waiver, limit Medicaid eligibility to those who are children, parents or caretaker relatives, permanently

and totally disabled, or elderly. One of the most sweeping changes in the ACA is a provision, effective 2014, which will extend Medicaid eligibility to all individuals and non-elderly adults with incomes up to 138% (includes a 5% income disregard) of the federal poverty line (\$23,050 for a family of four in 2012).⁵ If fully implemented, this provision will provide new insurance coverage through Medicaid to approximately 17 million uninsured Americans including 3.7 million rural persons.⁶

Medicaid: An Important Source of Insurance Coverage in Rural America

Medicaid is a crucial safety net program for rural people (Figure 1), serving three critical roles. First, it is a health insurance program for low-income households, including workers and their children who do not have access to private insurance. The percentage of persons in poverty was higher in 2011 outside of metropolitan areas (17.0%) as compared to metropolitan areas (14.6%).⁷ Rural workers have less access to employer-sponsored insurance: rural employers are less likely to offer health insurance, and rates of employer-sponsored insurance are lower in rural areas, 51.1% as compared to 56.1% in urban areas.⁸ As a consequence, rates of uninsurance have been historically higher in rural than in urban areas, especially in smaller, more remote rural areas.⁹ However, the expansion of coverage for children under Medicaid and the Children's Health Insurance Program has narrowed differences in rural-urban coverage.¹⁰

Second, Medicaid helps fill gaps in Medicare for low-income elderly and disabled people, covering one in six Medicare recipients (the so-called "dual eligibles").⁹ Rates of disability are 80% higher in rural areas—almost 8% of rural residents receive Social Security benefits compared to just over 4% of

Figure 1. The Rural Impact of Medicaid

Medicaid is currently a crucial safety net program for **rural persons**:

- The program is a critical source of insurance coverage, with 18% of rural persons enrolled in Medicaid in 2010 compared to 15.5% of urban persons.⁸
- CHIP has dramatically improved insurance coverage rates and stabilized coverage for rural children.
 - Before CHIP, stability of public coverage among low-income children did not differ by rural vs. urban residence. After CHIP was implemented, those in rural areas were 18% less likely than their urban counterparts to become uninsured.¹¹
 - In 1996-1997, 19% of rural children were uninsured compared to 16% of urban children. By 2003-2007, the rates were 12% for rural children and 14% for urban children.¹¹
 - During 2003-2007, 37% of rural children received CHIP/Medicaid benefits compared to only 27% of urban children. As of 2009, 40% of rural children were covered by CHIP/Medicaid, compared to 32% of urban children.¹²
- A recent study indicates a reduction in mortality rates in states that have expanded Medicaid.¹³
- As the single largest source of payment for long-term services and supports, Medicaid provides essential access to these services for the rural disabled and elders. While rural residents make up approximately a quarter of the Medicare population, 31% of Medicare's dual-eligible population lives in rural America.¹⁴

urban residents,¹⁵ meaning that more rural residents must rely on public rather than private insurance.

Finally, Medicaid is the nation's major source of payment for long-term care, covering 7 of 10 nursing home residents.¹⁶ It is estimated that the number of rural elderly is expected to grow from 7.26 million in 2012 to 11.11 million by 2029.¹⁷

Medicaid's Financial Support for Providers in Rural America

Because Medicaid covers so many rural residents, it is an essential source of financial support for rural providers. Without Medicaid, many rural providers would be faced with trying to serve communities in which the number of charity care patients outnumbered those with insurance, a financially impossible scenario that would further weaken the rural health care delivery system and lead to a further loss of rural providers. Almost one-third of rural physicians derive 25% or more of their patient revenues from Medicaid, compared to only 19.9% in urban areas.¹⁸ For rural hospitals, 14% of the gross revenues in 2009 came from Medicaid¹⁹ (Figure 2).

Medicaid is the largest single payer for long-term services and support, (LTSS) including institutional services (i.e. skilled and intermediate care facility services), residential care, and home care (e.g. home health

and home and community-based services). With rural areas disproportionately affected by the growth of the elder population (more than 15% of rural residents are older than age 65 compared to about 13% of the US population as a whole),²² the availability and accessibility of LTSS in rural areas is largely dependent on Medicaid policy.

In addition, Medicaid is a critical source of financial support for rural primary care providers who are the primary source of mental health care in many rural communities. State Medicaid programs cover mental health services that are often not available under other sources of health insurance. Without the Medicaid program as a major source of financing, the problems of mental health service availability and accessibility in rural America would be even more acute. Community mental health centers serving rural populations have become more reliant on Medicaid financing as federal block grant funding has declined.²³

Figure 2. The Importance of Medicaid Today to Rural Providers

In part because of the higher rates of coverage of rural persons, Medicaid is a particularly important source of payment for **rural providers**:

- Almost one-third of rural physicians derive 25% or more of their patient revenues from Medicaid, as compared to 19.9% in urban areas.¹⁸
- Physicians in rural areas are more likely to serve Medicaid beneficiaries than are their urban counterparts.
- Medicaid financed 40% of the \$177.6 billion spent nationally on long-term care in 2010.²⁰
- Medicaid is the primary source of funding for publicly provided mental health services, financing nearly half of the provided mental health services in rural areas.²¹

Medicaid's Contribution to Local Economies

Although Medicaid's benefits to rural people and providers are clear, the program's contribution to rural communities is often overlooked (Figure 3). From an economic point of view, federal Medicaid matching dollars that flow into state economies generate economic activity. A report by the Kaiser Commission on Medicaid and the Uninsured found, based on 29 studies in 23 states, that Medicaid spending generates jobs, income, and state tax revenues. They found these specific examples of economic impacts:

- In Oklahoma in fiscal year 2006, business spending of \$8 billion and 99,036 jobs
- In Missouri in 2004, \$5.82 billion in economic activity and 79,892 jobs²⁴

Figure 3. The Importance of Medicaid to Rural Communities

An important benefit of the Medicaid program is its contribution to **rural community** well-being through a stronger health care system and a more stable local economy. Medicaid contributes to rural communities in four important ways:

- by providing opportunity for access to health care services, in turn influencing health status, productivity, and quality of life of citizens;
- by providing patient revenue, Medicaid helps retain health professionals;
- by supporting the social services infrastructure; and
- by contributing to the economy through revenue and job creation.

Impending Decisions and Their Impact on Medicaid in the Future

The future impact of Medicaid will be a function of policy decisions that are made at both the federal and state level, as well as future demographic shifts facing rural America. Federal policymakers will be making key decisions about the FMAP, minimum benefit requirements for mandatory eligibles, program changes for dual eligibles, and long-term care programs. State policymakers will be making key decisions about whether or not to participate in the ACA's Medicaid expansion for adults, the extent to which they contract with managed care firms for the Medicaid population (including dual eligibles), and the extent to which they will establish relationships with accountable care organizations within the Medicaid program. These decisions will have profound impacts on the Medicaid program of the future. In addition, rural America, like the rest of America is facing a huge explosion of growth in the growth of the elderly population, which will have implications for the Medicaid program.

References

- ¹ Staley M, Bean J, Ulrich J, (2011). Rates of Public Health Insurance Coverage for Children Rise as Rates of Private Coverage Decline. Durham, NH: Carsey Institute, University of New Hampshire.
- ² Kaiser Commission on Medicaid and the Uninsured. (July 2001). Medicaid “Mandatory” and “Optional” Eligibility and Benefits (Publication No. 2258). Washington, DC: The Henry J. Kaiser Family Foundation.
- ³ The Fiscal Survey of States. (Spring 2012). Washington, DC: National Association of State Budget Officers. Accessed at: www.nasbo.org.
- ⁴ Angeles J, Broaddus M. (March 28, 2012). Federal government will pick up nearly all costs of health reform’s Medicaid expansion. Washington, DC: Center on Budget and Policy Priorities.
- ⁵ United States Department of Health and Human Services. (February 2012). Computations for the 2012 Annual Update of the HHS Poverty Guidelines for the 48 Contiguous States and the District of Columbia. Accessed at: <http://aspe.hhs.gov/poverty/12computations.shtml>.
- ⁶ Based on analysis presented in McBride, T. (December 22, 2009). Impact of the Patient Protection and Affordable Care Act on Covered Persons as Amended. Health Panel Brief. Rural Policy Research Institute for Rural Health Policy Analysis and Washington University in St. Louis, and additional unpublished simulations.
- ⁷ US Census Bureau. (2012). Income, Poverty and Health Insurance Coverage in the United States, 2011. Current Population Reports. P60-243.
- ⁸ Current Population Survey. (March 2011). Annual Social and Economic Supplement.
- ⁹ Lenardson J, Ziller E, Coburn A, Anderson N. (June 2009). Profile of Rural Health Insurance Coverage: A Chartbook. Portland, ME: Rural Health Research and Policy Centers & University of Southern Maine.
- ¹⁰ Ziller E, Coburn A. (February 2009). Rural Coverage Gaps Decline Following Public Health Insurance Expansions. Portland, ME: Maine Rural Health Research Center: University of Southern Maine.
- ¹¹ Ziller E. (2012). Rural Children More Likely to Have and Retain Public Coverage After CHIP (Policy Brief). Portland, ME: Maine Rural Health Research Center. University of Southern Maine, forthcoming.
- ¹² King J, Holmes G. (May 2011). Recent Changes in Health Insurance Coverage in Rural and Urban Areas. Chapel Hill, NC: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research.
- ¹³ Sommers BD, Baicker K, Epstein AM. (July 25, 2012). Mortality and Access to Care Among Adults after State Medicaid Expansions. New England Journal of Medicine. (10.1056/NEJMsa1202099). Accessed at: <http://www.nejm.org/doi/full/10.1056/NEJMsa1202099#t=articleTop>.
- ¹⁴ Medicare Payment Advisory Commission. (June 2011). A Data Book: Health Care Spending and the Medicare Program. Washington, DC: Medicare Payment Advisory Commission.

¹⁵ Bishop B, Gallardo R. (November 29, 2011). The Geography of Disability. Daily Yonder. Accessed at: <http://www.dailyyonder.com/geography-disability/2011/11/29/3619>.

¹⁶ Kaiser Commission on Medicaid and the Uninsured. (March 2011). Medicaid Matters: Understanding Medicaid's Role in Our Health Care System. Washington, DC: The Henry J. Kaiser Family Foundation. Accessed at: <http://www.kff.org/medicaid/8165.cfm>.

¹⁷ Calculations were derived from the 2012 Community Population Survey-based estimate of rural aged 65 and older for 2012. Annual mortality rates were incorporated by age/sex cohort for 2029 calculations.

¹⁸ Calculations based on the 2008 Health Tracking Physician Survey from the Center for Studying Health Systems Change.

¹⁹ Avalere Health Analysis of American Hospital Association Annual Survey data. (2009). The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform [presentation]. American Hospital Association and Avalere.

²⁰ Kaiser Commission on Medicaid and the Uninsured. (March 2011). Medicaid and Long-Term Care Services and Supports. Washington, DC: The Henry J. Kaiser Family Foundation.

²¹ Kaiser Commission on Medicaid and the Uninsured. (July 2005). Medicaid: A Primer (Publication No. 7334). Washington, DC: The Henry J. Kaiser Family Foundation.

²² United Health Group. (2011). Analysis of the Health Resources and Services Administration (HRSA) Area Resource File (2007 data) and U.S. Census Bureau data (2009 data).

²³ Lambert D, Agger M. (December 1994). Access of Rural Medicaid Beneficiaries to Mental Health Services, Working paper # 4. Portland, ME: Maine Rural Health Research Center.

²⁴ Kaiser Commission on Medicaid and the Uninsured. (January 2009). The Role of Medicaid in State Economies: A Look at the Research. Washington, DC: The Henry J. Kaiser Family Foundation.

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