

RUPRI Rural Health Panel

Keith J. Mueller, Ph.D. (Panel Chair)

Andrew F. Coburn, Ph.D.

A. Clinton MacKinney, M.D., M.S.

Timothy D. McBride, Ph.D.

Rebecca T. Slifkin, Ph.D.

Mary Wakefield, Ph.D., R.N.

Providing decision makers with timely, objective, and expert analysis of the implications of policy for rural health

Medicaid and Its Importance to Rural Health

Issue Brief



Rural Policy Research Institute
Charles W. Fluharty, Director
214 Middlebush Hall
University of Missouri
Columbia, MO 65211
(573) 882-0316 (phone)
(573) 884-5310 (fax)
www.rupri.org/ruralhealth

In recent years, many proposals to reform Medicaid have been outlined by states and organizations such as the National Governors Association, the National Conference of State Legislatures, and, most recently, the National Commission on Medicaid. In rural America any change in Medicaid policy will have implications for people, providers, and places. Medicaid is a critical source of insurance coverage in rural America, filling gaps in both Medicare coverage and the availability and accessibility of private insurance that are more pronounced in rural than in urban areas. Health care providers, especially those who serve disproportionately large percentages of Medicaid eligibles, rely on Medicaid payments to cover at least the marginal costs of treating those patients. Federal and state Medicaid dollars also contribute to rural community development by generating health care jobs (and other economic activity) and providing health coverage for many low-wage workers.

Medicaid serves more people than any other U.S. health program, providing health insurance for the low-income population that fall within specific eligibility categories. Medicaid is a partnership between the federal government and the states, which share the cost of the program. States design and administer Medicaid within federally defined boundaries relating to eligibility and benefits, but well over half of Medicaid

spending is for optional services and populations selected by the states.¹ In addition, states may obtain federal waivers to operate their Medicaid programs

outside of federal guidelines. On average, states spend about 17% of their general funds on Medicaid, making it the second largest item in states' budgets.²

Insufficient attention has been paid to the role of the Medicaid program and the impact of reform proposals in rural America. History suggests that many reform initiatives are likely to play out differently in rural and urban communities. For

	People	Money
Medicaid	52 million	\$305 billion
Medicare	42 million	\$297 billion

Source: Kaiser Commission on Medicaid and the Uninsured.

This analysis was funded under a cooperative agreement with the Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, grant number U18RH03719. The conclusions and opinions expressed in this brief are the authors' alone; no endorsement by ORHP is intended or should be inferred. The Rural Health Panel receives continuing support from RUPRI, the result of a Congressional Special Grant, administered through the Cooperative State Research, Education, and Extension Service, U.S. Department of Agriculture.

example, the recent experience of state Medicaid managed behavioral health care initiatives, in which rural mental health provider shortages and other problems significantly undermined the effectiveness of these programs, provides a good case in point.³ Also, while traditional Medicaid “statewideness” requirements ensure that eligibility and benefits are the same in all areas of a state, through waivers states can design programs that vary across geographic areas. The ability for states to waive the statewideness requirements creates flexibility when reforming programs that could benefit rural areas, but also removes the protection that this requirement guarantees.

People: In Rural America, Medicaid Is a More Important Source of Insurance Coverage Than Elsewhere in the Country

Medicaid is a safety net for certain low-income individuals who otherwise would be uninsured, and serves to close coverage gaps for low-income Medicare beneficiaries (“dual eligibles”). Rural residents, both those under 65 years of age and the elderly, are more likely to be enrolled in Medicaid:

- In 2002, 14.7% of rural residents were enrolled in Medicaid compared to only 11.2% of urban residents.⁴
- Among individuals under 65 years of age, 15.3% of rural residents, but only 11.2% of urban residents, report that Medicaid is their primary source of health insurance.⁵
- Among the elderly, 10.1% received Medicaid benefits compared to 8.2% of urban elderly.⁶

Several characteristics of rural residents lead to high numbers of Medicaid beneficiaries in each of the three groups just identified. There are higher rates of poverty in rural areas: 14.7% of rural residents live in poverty compared to 11.8% in urban areas.⁶ The percent of rural residents who have employer-sponsored insurance (55.1%) is also lower than for urban residents (60.8%).⁷ And finally, rural areas generally have a higher proportion of older persons in their total population (20%) than do urban areas (15%).⁸

There are four major groups of individuals who are particularly reliant upon the Medicaid program to cover their health care costs. These include:

- Low-income disabled. Over 8 million low-income disabled are covered by Medicaid. Beneficiaries with disabilities only represent 16% of Medicaid enrollees (2003), but they account for 43% of expenditures.² Rural residents are more likely to be disabled—while 6.4% of residents of small MSAs and 8.0% of residents of nonmetropolitan areas reported limitation in work activity due to health problems, only 4.5% of residents of large MSAs report the same.⁵
 - Low-income elderly. The role of Medicaid for the low-income elderly, almost all of whom are dually eligible for Medicaid and Medicare, is to cover services not included under Medicare, most importantly nursing facility services. While elderly beneficiaries represent only 9% of Medicaid enrollees (2003), they account for 26% of Medicaid expenditures, largely as a result of long-term care expenditures, which represent 36% of Medicaid spending.² Because the percentage of the population that is elderly is higher in rural areas, and because there is more reliance on care in nursing facilities due to lack of community-based alternatives, any change in the benefits provided to the dually eligible could have a disproportionate rural impact.⁹
 - Children. Due to rural poverty, a disproportionate percentage of rural children are Medicaid eligible. In the most remote rural counties, 27% of children are covered by Medicaid.¹⁰
 - Pregnant women. Over one-third of all births are paid for by Medicaid.²
-

Providers: In Rural America, Medicaid Is an Essential Revenue Source

Since Medicaid is the source of health insurance coverage for many rural residents, it is therefore an important source of revenue for many rural providers. Although in many states Medicaid may not be perceived of as an adequate payor, Medicaid payments are still important to rural providers. Without Medicaid coverage many patients would be uninsured, leaving providers with less revenue because uninsured low-income patients will be unable to pay even the Medicaid rate. Rates of private coverage are lower in rural areas, also increasing the importance of Medicaid payment.

Physicians in rural areas are more likely to serve Medicaid beneficiaries than are their urban counterparts. Almost 20% of rural physician patient revenue is accounted for by Medicaid, compared to only 15% for physicians located in urban areas.¹¹ Reimbursement for services provided in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) is dictated by the federal Medicaid statute, so although these providers are disproportionately located in rural areas (RHCs must be located in nonurbanized areas, and 51% of FQHCs are in rural areas), they have some protection from changes in reimbursement. They would be affected, however, if changes in eligibility requirements decreased the number of their patients covered by Medicaid.

Medicaid is a particularly important source of payment for providers of long-term care. In 2003, Medicaid financed 40% of the \$151 billion spent nationally on long-term care.¹² Nursing facility beds are more plentiful in rural areas, and a higher percentage of rural elderly are admitted to these facilities.⁹ In the absence of Medicaid coverage, the persons covered by that program would either opt not to use long-term care services, or they would do so but in most instances would not be able to pay even the Medicaid rates for services received (exceptions would be persons retaining assets that, had coverage been available, they might have divested in order to qualify for Medicaid).

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. Medicaid is the primary source of funding for publicly provided mental health services, accounting for 44% of spending.² Community Mental Health Centers serving rural populations have become more reliant on Medicaid financing as federal block grant funding has declined. Finally, as mentioned earlier, Medicaid is a critical source of revenue for rural primary care providers who are the primary source of mental health service in many rural communities.¹³ Without Medicaid revenue, those providers would be treating persons with limited or no means to pay, thereby reducing total revenue and contributing to potential loss of services.

Communities: In Rural America, Medicaid Helps Secure Providers and Generate Economic Activity

The purpose of Medicaid is to remove a barrier to access by providing payment to providers for services delivered to Medicaid beneficiaries. An important additional benefit of Medicaid is its contribution to community well-being through a stronger health care system and a more stable local economy. Medicaid contributes to rural economic development in four important ways: (1) by providing opportunity for access to health care services, which in turn influences health status and therefore productivity and quality of life of citizens; (2) by providing patient revenue that helps retain the presence of health professionals; (3) by supporting the social services infrastructure; and (4) by contributing to the economy through revenue and jobs it generates.

Medicaid payments contribute to the incomes of providers located in rural areas that have difficulty attracting and retaining health professionals. The marginal payment from Medicaid can help make primary care practices viable in sparsely populated areas that would otherwise be financially unable to support the presence of a provider, due to disproportionately high levels of uninsured.

Medicaid payments to providers in rural communities contribute directly to the community's financial base, leading to additional employment in health care and associated occupations (e.g., suppliers, retailers serving the health care employees) and more local spending (from workers, patients, and families while care is being provided). Of importance to states interested in supporting local rural economic development, federal Medicaid matching dollars that flow into state economies generate economic activity, including the creation of jobs and additional income and state tax revenues. According to one study, total state Medicaid spending generated nearly 3 million new jobs and over \$100 billion in wages in fiscal year 2001.¹⁴ Specific state examples include the following:

- In Missouri, every \$1 million in state Medicaid spending generates \$1.57 million in federal matching funds, resulting in \$3.06 million in business activity, 42.3 jobs, and \$1.49 million in wages.¹⁵
- In Alaska, the total employment and income created as a result of the Medicaid program's health care services expenditures during fiscal year 2001 was 8,717 jobs and \$334.1 million in income.¹⁶

-
1. 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.
 2. Kaiser Commission on Medicaid and the Uninsured. (July 2005). *Medicaid: A primer* (Publication No. 7334). Washington, DC: The Henry J. Kaiser Family Foundation.
 3. Willging, C., Waitzkin, H., & Wagner, W. (2005). Medicaid managed care for mental health services in a rural state. *Journal of Health Care for the Poor and Underserved*, 16(3), 497-514.
 4. Silberman, P., Rudolf, M., D'Alpe, C., Randolph, R., Slifkin, R. (2003). *The impact of the Medicaid budgetary crisis on rural communities* (Working Paper No. 77). The University of North Carolina at Chapel Hill, North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research.
 5. National Center for Health Statistics. (2003). National Health Interview Survey, 2003.
 6. Silberman, P., Rudolf, M., Brogan, L., Poley, S., Slifkin, R. & Moore, C. (2005). *The impact of Medicaid cuts on rural communities* (Working Paper No. 82). The University of North Carolina at Chapel Hill, North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research.
 7. U.S. Bureau of Labor Statistics & U.S. Bureau of the Census. (2005). Current Population Survey, March 2005.
 8. Rogers, C. (2002). The older population in 21st century rural America. *Rural America*, 17(3), 2-10.
 9. Coburn, A. F., & Bolda, E. J. (1999). Rural elderly and long-term care. In T. C. Ricketts (Ed.), *Rural health in the United States* (pp. 179-189). New York: Oxford University Press.
 10. Kaiser Commission on Medicaid and the Uninsured. (April 2003). *The uninsured in rural America*. Washington, DC: The Henry J. Kaiser Family Foundation.
 11. Center for Studying Health System Change. (2000/2001). Community Tracking Survey - Physician Survey. Washington, DC: Center for Studying Health System Change.
 12. O'Brien, E. (November 2005). *Long-term care: Understanding Medicaid's role for the elderly and disabled*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, the Henry J. Kaiser Family Foundation.
 13. Gale, J. and Lambert, D. (2006). Mental healthcare in rural communities: The once and future role of primary care. *North Carolina Medical Journal*, 67(1), 66-70.
 14. Families USA. (January 2003). *Medicaid: Good medicine for state economies* (Publication no. 03-107) Washington, DC: Families USA Foundation.
 15. Missouri Foundation for Health. *Economic and health benefits of Missouri Medicaid* (Show Me Series: Report 5). St. Louis, MO: Ferber, J.
 16. Doeksen, G.A. & St. Clair, C. (March 2002). *Economic impact of the Medicaid program on Alaska's economy*. Oklahoma State University.
-