# Medicaid Reform: A Rural Perspective

The National Rural Health Association (NRHA) is a 22,000 member nonprofit organization which is the leading advocate for improved health care for rural America. Formal organization policy is considered and adopted by the member-driven Rural Health Congress and Board of Trustees.

The potential impact of Medicaid reform on rural America requires that NRHA take an active and continuing leadership role at both the federal and state levels to advance the interests and health of rural communities and populations. NRHA must actively engage federal and state policymakers in the pursuit of Medicaid reform that protects rural people and advantages rural health.

This policy paper is informed by, is a companion to, and reaffirms the existing NRHA policy positions developed and approved in May 2007 (Exhibit A).[1] Additional policy positions are added as required by changed circumstances and new proposals for Medicaid reform. The policy statements reflect NRHA's core commitment that every individual in rural America must be assured of dependable access to high quality health care. They provide guidance to policymakers and NRHA staff on the pressing issue of Medicaid reform's potential impact on rural America.

## Medicaid: Rural Impact, The ACA, and Related Issues

Medicaid is the nation's single largest insurer. In fiscal year 2011, it covered an estimated 70 million children and adults – more than one-fifth of the U.S. population. Total state and federal program spending amounted to more than $430 billion that year, of which nearly 60% was federal. Federal expenditures alone were projected to surpass $3.3 trillion between 2010 and 2019.[2]

Medicaid reform is high on the agenda at both the Federal and State levels as governments seek to control the impact of rapid health care inflation on program costs. On average, states spend about 17.4% of their general revenue on Medicaid.[3] The growth of Medicaid costs is a key driver in state and federal deficits. This growth is caused by a multitude of factors including the demographic bubble of an aging population, the currently strained job market, and rapid growth in both unit costs and utilization per beneficiary.



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[1] Medicaid Reform: A Rural Perspective – May 2007. National Rural Health Association Web site. http://www.ruralhealthweb.org/index.cfm?objectid=3FF4D909-1185-6B66-881B175789C3DE48. Accessed September 16, 2012.

[2] Rosenbaum S, Westmoreland TM. The Supreme Court's surprising decision on the Medicaid expansion: How will the federal government and states proceed? *Health Affairs*. 2012;31(8): 1663-1672.

[3] The Fiscal Survey of the States: An Update of State Fiscal Conditions, Spring 2012. National Governors Association and National Association of State Budget Officers Web site. http://www.nasbo.org/sites/default/files/ Spring%202012%20Fiscal%20Survey_1.pdf. Accessed September 16, 2012.

Medicaid is an important part of health care funding for low-income Americans' primary, emergency and acute care, but is perhaps even more important in providing long-term care for a large share of the elderly and disabled. In many ways, Medicaid plays a bigger role in rural than in urban America. Nationally, Medicaid provides health insurance to a larger share of the population in rural areas (16.1 % of rural residents vs. 13.2% of urban residents). Further, Medicaid is a critical source of income for rural health care providers and contributes to rural economic development.[4,5,6,7] Because rural America is older and poorer than urban America, any reforms to Medicaid necessarily have the potential to more extensively impact rural beneficiaries, providers and communities. (See additional information in Exhibit B)

As this paper is written, Medicaid has become an even more critical focus for rural health policy due to the expansion of the program included in the Patient Protection and Affordable Care Act (ACA) and the June 2012 Supreme Court decision addressing that expansion.[8]

The ACA increases access to affordable health insurance by expanding eligibility for Medicaid benefits. Prior to the ACA, federal law mandated coverage for the following principal eligibility groups: pregnant women and children under age 6 with family incomes at or below 133% of the federal poverty level (FPL), children ages six through 18 with family incomes at or below 100% FPL, parents and caretaker relatives who meet the financial eligibility requirements of the former Aid to Families with Dependent Children program, and elderly and disabled people who qualify for Supplemental Security Income benefits based on low income and resources. Federal law prior to the ACA excluded nondisabled, non-pregnant adults without dependent children from Medicaid, unless states obtained waivers to cover them.

The ACA expands the Medicaid program's mandatory coverage groups by requiring participating states to cover nearly all people under age 65 with household incomes at or below 133% FPL ($14,856 per year for individual and $30,657 per year for a family of four in 2012) beginning in January 2014. There is a special deduction from income equal to 5% of the poverty level raising the effective eligibility level to 138% of FPL. Many states currently do not cover adults without dependent children at all and cover

[4] *State Profiles of Medicaid and CHIP in Rural and Urban Areas*, (2009). North Carolina Rural Health Research and Policy Analysis Center Web site. http://www.shepscenter.unc.edu/medicaidprofiles/. Accessed September 16, 2012.
[5] John Bailey. Medicaid and Rural America. Center for Rural Affairs Web site (Health Care Series, No. 15, February 2012). http://files.cfra.org/pdf/Medicaid.pdf. Accessed September 16, 2012.
[6] State Health Facts. Kaiser Family Foundation Web site. http://www.statehealthfacts.org. Accessed September 16, 2012.
[7] The Economic Impact of SoonerCare on Oklahoma's Economy (January 2011). National Center for Rural Health Works, Oklahoma State University. Oklahoma Hospital Association Web site. http://www.okoha.com/AM/Template.cfm?Section=Medicaid1&Template=/CM/ContentDisplay.cfm&ContentID=16963. Accessed September 16, 2012.
[8] National Federation of Independent Business v. Sibelius, 132 S. CT. 2566(2012).

parents only at much lower income levels than the ACA's Medicaid expansion minimum.[9]

According to the Congressional Budget Office, a nonpartisan agency advising Congress, the ACA's Medicaid expansion as written would cover an estimated 17 million uninsured, low-income Americans.[10]

In its ACA decision, the Supreme Court held that the Medicaid expansion was unconstitutionally coercive because states did not have adequate notice to voluntarily consent and the Secretary of Health and Human Services could withhold all existing Medicaid funds for state noncompliance. The court remedied the constitutional violation by finding that Congress may not make the state's existing Medicaid funds contingent upon the state's compliance with the ACA Medicaid expansion. If a state chooses not to expand Medicaid coverage as described by the ACA, the DHHS Secretary may withhold the funding offered for the expansion, but may not withhold a state's existing Medicaid funding. The court's decision leaves the Medicaid expansion provision of the ACA intact and instead restricts the Secretary's enforcement authority.[11]

The court's decision leaves in place all other provisions of the ACA related to the Medicaid program, such as the temporary increase in primary care provider payments, the new options to expand home and community-based services, the gradual reductions in Disproportionate Share Hospital (DSH) payments, and the requirement that states maintain the eligibility standards in place as of March 23, 2010, until the Secretary certifies health insurance exchange readiness.[12]

While the ACA Medicaid expansion remains in place, the practical effect of the court's decision makes the Medicaid expansion optional for the states. This result creates a number of issues and uncertainties regarding the impact and implementation of the Medicaid expansion in rural communities. For example, no less than 12 states have indicated that they either will not implement or are leaning toward opting out of the Medicaid expansion. Included in these states are heavily rural states with adult uninsurance rates above the national average, such as Texas, Nevada, Florida, South Carolina, Mississippi, and Louisiana.[13] Additionally, a number of states are seeking, or have indicated they will seek, approval of waivers or plan modifications to restrict Medicaid eligibility to lower levels than established in the ACA.

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[9] A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion. Kaiser Commission on Medicaid and the Uninsured Web site. http://www.kff.org/healthreform/8347.cfm. Policy Brief #8347, August 2012. Accessed September 16, 2012.

[10] Estimates of Insurance Coverage Provisions of the Affordable Care Act Updates for the Recent Supreme Court Decision. Congressional Budget Office Web site. http://www.cbo.gov/sites/default/files/cbofiles/attachments/ 43472-07-24-2012-CoverageEstimates.pdf. July 2012. Accessed September 16, 2012.

[11] National Federation of Independent Business v. Sibelius, 132 S. CT. 2566(2012).

[12] A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion. Kaiser Commission on Medicaid and the Uninsured Web site. http://www.kff.org/healthreform/8347.cfm. Policy Brief #8347, August 2012. Accessed September 16, 2012.

[13] State Health Facts. Kaiser Family Foundation Web site. http://www.statehealthfacts.org. Accessed September 16, 2012.

The Congressional Budget Office estimates that 6 million fewer people will be covered by Medicaid due to states deciding not to implement the Medicaid expansion. The CBO further estimates that only about 3 million of these will receive subsidies through the exchanges and about 3 million will remain uninsured. [14] While the number of rural Americans included in these figures is currently difficult to determine, the net rural coverage expansion under the ACA (total of health insurance exchange plans and Medicaid expansion) has been estimated at 5 million individuals.[15] A significant portion of these are likely to remain uninsured if states opt out of the Medicaid expansion. If the financial impact on the rural health care delivery system of providing care for this remaining number of uninsured is coupled with reductions in Disproportionate Share Hospital payments resulting from implementation of the ACA, the negative impact on rural providers and consumers would be substantial.

Given uncertainties of both the path of Medicaid reform in the wake of the Supreme Court decision and the continuing federal and state budget issues related to Medicaid, it is impossible to envision and address every potential for future concern in rural communities – a fact demonstrated by the multitude of questions already addressed to the Department of Health and Human Services following the Supreme Court decision.[16] It is, however, possible to articulate a set of principles to guide Medicaid policy development and program implementation that will support access, equity, and quality for rural Medicaid beneficiaries and rural communities.

The following are a set of general policy principles and areas of further research and focus to improve future policy-making and health care results from Medicaid, especially in rural America.

**Principles of Medicaid Reform:**

Any Medicaid reform, whether implemented at the Federal or state level, must give special consideration to rural America. This includes implementation of the reforms and expansion included in the Affordable Care Act. Negative rural impacts should be minimized and mitigated to assure that rural Americans receive equitable access to Medicaid coverage and benefits.

When Medicaid reform is considered and implemented and when reform proposals are evaluated at either the federal or state level, the following principles should be applied:

1. Medicaid reform, however designed and implemented, must not harm patient health or population health. Proposals to reform Medicaid must be evaluated based on

[14] Estimates of Insurance Coverage Provisions of the Affordable Care Act Updates for the Recent Supreme Court Decision. Congressional Budget Office Web site. http://www.cbo.gov/sites/default/files/cbofiles/attachments/ 43472-07-24-2012-CoverageEstimates.pdf. July 2012. Accessed September 16, 2012.

[15] Modernizing Rural Health Care: Coverage, Quality and Innovation. United Health Center for Health Reform and Modernization Web site. http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper6.pdf Working Paper 6, July 2011. Accessed September 16, 2012.

[16] NAMD's SCOTUS Questions. National Association of Medicaid Directors Web site. http://medicaiddirectors.org/sites/medicaiddirectors.org/files/public/namd_submitted_questions_120703.pdf. July 3, 2012.; Letter to President Barack Obama. Republican Governors Public Policy Committee Web site. http://rgppc.com/medicaid-and-exchange-letter-2/. July 10, 2012. Accessed September 16, 2012.

their likely impact on patient and population health, specifically including the health of rural patients and populations.

2. Medicaid reform must be effectively integrated with other insurance and health system reforms to assure that all rural residents have access to affordable health insurance coverage and high quality health care.[17]

3. Medicaid reform, however designed and implemented, must assure that rural beneficiaries are treated equitably as compared to non-rural beneficiaries in eligibility, coverage, benefits and quality of care.

4. Medicaid reform (including reimbursement strategies) must support the development and maintenance of a network of essential rural providers, including primary medical, oral, and behavioral health providers, emergency care providers, transportation providers, and long-term care providers, to assure effective and continued local access by beneficiaries. (Refer to NRHA definition of Primary Care and Rural Primary Care for additional information.)

5. Medicaid managed care program implementation must include network adequacy standards[18] that assure participation by essential rural providers and reimbursement levels that both adequately reflect the costs incurred by these providers and offer the financial incentives necessary to assure access to care in rural communities.[19]

6. Medicaid reform must support programs promoting better coordination and integration of care that will improve rural patient outcomes and satisfaction, at the same time as increasing efficiency and decreasing costs.

7. Medicaid reform implementation must take into account the fact that Medicaid is disproportionately important to rural economies, not just for Medicaid beneficiaries but to maintain a viable health care system that serves and contributes to the entire rural community.

8. Medicaid funding reform initiatives, particularly those addressing the allocation of funding responsibility between federal and state governments, must recognize the limited ability of many states to generate state revenue to support Medicaid programs. Funding reform initiatives must:

[17] Sommers BD, Baicker K, Epstein AM, Mortality and access to care among adults after state Medicaid expansions. *N Engl J Med*. 2012; 367:1025-1034.
[18] Standards that describe the criteria by which purchasers of coverage can assess whether or not a health insurance plan or managed care organization maintains a provider network that includes essential community providers, a sufficient number of providers, and an appropriate level of provider expertise to assure that plan members or beneficiaries will have adequate access to all required services.
[19] Decker SL. In 2011 nearly one-third of physicians said they would not accept Medicaid patients. *Health Affairs*. 2012; 31(8): 1673-1679.

a. safeguard existing federal and state-level funding mechanisms that allow states to maintain effective coverage and access to care under Medicaid ; and

b. encourage development and implementation of innovative federal and state-level funding mechanisms that can reduce the burden on state budgets without reducing Medicaid coverage and access to care.[20,21]

9. Evaluation of Medicaid reform proposals, including evaluation of requests for waivers or changes by state Medicaid programs, must include a Rural Impact Study that identifies anticipated impacts on rural areas and contains specific proposals for mitigation of any disproportionate negative impact on rural beneficiaries, health care providers, or health care delivery systems.

10. In implementing Medicaid reform, including approving state plans and waivers, the federal government must not abdicate its moral, legal, and financial responsibilities to rural, Medicaid eligible populations and to support the development of sustainable rural health systems. [22]

11. Medicaid programs at the federal and state levels should participate in and use the results of targeted research that further documents and defines rural-specific potential impacts of reform proposals and identifies models of care delivery and provider payment that will promote sustainable rural health care delivery systems and improved outcomes for rural beneficiaries.

NRHA advocates evidence-based, thoughtful Medicaid reform that protects what's good about rural health care; assures equitable treatment of rural beneficiaries, providers, and communities; and saves money by focusing reform on promoting increasing coordination of care and sustaining rural health care delivery systems.

**Statement of NRHA Policy**

1. NRHA reaffirms the policy positions adopted in the May 2007 Issue Paper, Medicaid Reform: A Rural Perspective, and adopts the Principles of Medicaid Reform to guide its evaluation of reform proposals and its responses to such proposals.
2. State Rural Health Associations, and other stakeholders and advocates for Medicaid reform, are urged to adopt and use the Principles of Medicaid Reform in evaluating

[20]Park E, Solomon J. Proposal to Establish Federal Medicaid "Blended Rate" Would Shift Significant Costs to States. Center on Budget and Policy Priorities Web site. http://www.cbpp.org/files/6-24-11health.pdf. June 24, 2011. Accessed September 16, 2012.
[21] Health Care Provider and Industry Taxes/Fees. National Conference of State Legislatures Web site. www.ncsl.org/default.aspx?tabid=14359. July 2012. Accessed September 16, 2012.
[22] Kenen J. Health Policy Brief: Medicaid Reform. , *Health Affairs* Web site. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_60.pdf. January 12, 2012. Accessed September 16, 2012.

and responding to federal and state-level Medicaid reform proposals.

3. Medicaid stakeholder and advocacy organizations are encouraged to include and address rural concerns in their considerations of and activities related to Medicaid reform at federal and state levels.

**Exhibit A – Medicaid Policy Paper – 2007 Recommendations**

Improving Dialogue and Fostering Collaboration

- The challenges to rural health cannot be adequately addressed without more focused discussions of the impact of Medicaid. These discussions should be pursued, with the support of other organizations sharing NRHA interests, in the context of how Medicaid should be an influential partner (not just a payer) in advancing rural health. They should address how state and federal Medicaid programs can use their leverage as major payers to help build rural systems of care that will better meet the needs of the nation's rural population. "Partnership" discussions need to become more positive and to transcend many historic experiences.

- Any changes in federal or state Medicaid policies should require a rural impact assessment. Requests by states for waivers of "state-wideness" should identify anticipated impacts on rural areas. Waivers should not be granted if anticipated state changes negatively and disproportionately affect rural populations.

Equity and Access

- There should be equity of Medicaid benefits across medical, oral health, and behavioral health benefits. Particular attention needs to be given to the disparities in health that affect rural populations and often Medicaid beneficiaries most specifically.

- Federal policies should continue to support advances in telemedicine as a tool to expand access and ensure adequate reimbursement for telemedicine services.

- In order to promote improvements in rural transportation for Medicaid beneficiaries, CMS should assess whether states are adequately addressing the requirements of the Medicaid program to provide non-emergency medical transportation benefits.

Eligibility and Enrollment

- Since rural recipients are more likely to rely on Medicaid as their source of insurance coverage, any changes in eligibility or in the application and recertification procedures which lead to reduced numbers of eligibles can have a disproportionate adverse impact in rural communities. Conversely, changes to expand eligibility or simplify the application process could positively affect rural communities. The federal and state governments should analyze the impact of eligibility changes on rural communities prior to implementation.

- Given the size and poverty level of the rural elderly and disabled populations, coordination of benefits and enrollment into available programs for dual-eligible beneficiaries should be given greater priority.

- Rural Medicaid recipients must be treated equitably by managed care and consumer-choice programs.

Adequate Reimbursement for Providers

- Provider payments in rural areas must be adequate to assure Medicaid beneficiaries of financial access to services as well as to support recruitment and retention of providers.

- Protections should be implemented for rural providers, requiring state Medicaid plans to set payment rates that would reimburse the allowable cost appropriate to "economically and efficiently operated" rural providers, as defined by the states subject to approval by the Centers for Medicare and Medicaid Services. This approach should require that providers receiving such cost-based reimbursement receive no less when participating in managed Medicaid programs.

- This approach should also recognize that Medicaid programs should in some cases reimburse at a higher rate for services in rural areas than in non-rural settings to support the recruitment, operation, and retention of providers.

Improving the Utilization of Resources and Integration of Services

- Medicaid reimbursement should support chronic disease management and case management programs for Medicaid beneficiaries that improve quality and continuity of care while achieving cost savings. Issues that may be unique to rural populations need more focused assessment. Case management can be particularly beneficial to rural beneficiaries who may need additional assistance identifying providers and in obtaining medically necessary transportation.

- Adequate Medicaid access provided at sustainable state and federal costs will require reductions in waste, redundancies, and inadequate community level collaboration.

- To ensure improvements in rural systems of care for children, coordination should be improved between Medicaid and the State Children's Health Insurance Program (SCHIP).

- Expanded multi-organizational collaboration should be encouraged, if not required, to advance the development of sustainable, integrated community health strategies for Medicaid populations.

- Additional support is needed for public health and other initiatives that will foster the expansion of preventive services to rural Medicaid populations. Reimbursement structures need to adequately compensate providers for these services and

collaboration between public health entities and providers needs to be fostered.

Workforce Development

- Support should continue for J-1, Conrad 30, and National Health Service Corps providers serving rural communities. These physicians should be required to treat Medicaid patients.

- Given the profound challenges of recruiting to rural communities, the definition of eligible providers should be expanded to cover all types of primary care, mental health, and oral health providers (not just physicians) and to include general surgery (an increasing critical shortage category).

- Given the need for more rural providers to ensure adequate Medicaid access, training programs for physicians, dentists, advanced practice nurses, registered dental hygienists, and pharmacists should be expanded. There should be particular attention to advocating for additional federal funding for educational programs that commit to expanding rural training in settings that provide care to Medicaid recipients and the uninsured, and that demonstrate success in achieving additional rural placements in proportion to funding.

- Support should be enhanced for Area Health Education Center (AHEC) programs specific to addressing the needs of rural populations, with focused attention on the needs of providers in caring for Medicaid beneficiaries.

Long-Term Strategies

- As a long-term strategy, NRHA could advocate for CMS to expand the Medicare benefit package to include long-term care and freeing the states to concentrate on the medical, dental, and behavioral health needs of Medicaid recipients.

A Suggested Research Agenda

- The importance of Medicaid to rural communities' economies and to sustaining rural development needs to be better understood, as do the relationships between rural spending, direct and indirect impacts on rural communities, states budgets, and federal matching payments. More specific research should be encouraged.

- Further research is required related to models of care most suitable for delivering more cost effective integrated packages of services to Medicaid beneficiaries, e.g., through CAHs, FQHCs, and school-based health programs in rural areas.

- Additional study is needed to clarify barriers to rural Medicaid enrollment, including the implications for new citizenship documentation requirements.

- Federal and state provisions related to the transfer of assets should be carefully monitored to see if there is a differential impact on rural areas (e.g., on farm families).

- Expanded research should be supported for chronic disease management and case management for Medicaid beneficiaries.

- There should be an assessment of the appropriateness of Medicaid reimbursement at a higher rate for services in rural areas than in non-rural settings in order to support the recruitment, operation, and retention of providers.

**Exhibit B - Defining Rural Characteristics and Unique Considerations for Rural Medicaid**

*Developed by Elizabeth Zimmerman, BSN, MPH, RN*

Rural residents tend to be sicker, poorer, older, are more likely to report "fair" to "poor" health statuses and are less insured than the non-rural population.[i] The limited number of rural doctors exacerbates such health disparities: more than 19 percent of Americans live in rural communities, where only 11.4 percent of physicians practice in rural areas.[ii] The rural population has disproportionate health needs, which are exacerbated by comorbidities associated with considerable access barriers in rural communities, e.g., oral health care, behavioral health and substance abuse services. When combined with a higher percentage of Medicaid eligibles in rural communities, these circumstances make the Medicaid program critically important to rural residents.

Important characteristics of rural populations that highlight the disproportionate reliance on Medicaid include the following:[iii]

**Medicaid rural enrollment**

- For all Americans, the second largest provider of health care coverage are public programs like SCHIP, Medicare and Medicaid, with rural population's rate for participation in publicly funded programs is 4 percent higher than the urban population.[iv]
- More than 16 percent of rural individuals report enrollment in Medicaid compared to 13.2 percent of urban residents.[v]
- Among rural residents less than 65 years of age, close to 16 percent of this population rely on public insurance compared to 11 percent of their urban counterparts.[vi]
- Approximately 35 percent of rural children have Medicaid coverage compared to 27.6 percent of urban children.[vii]
- As population and geographical density decreases within rural areas, rural families are more likely to be covered by public sources of insurance (e.g., Medicaid, SCHIP) than urban families.[viii]

**Rural elderly**

- In 2010, more than 15 percent of the rural population was 65 years old and older, in comparison to the 12.4 percent national rate.[ix] This comprises 7.5 million rural elderly with a growing subpopulation at a more dramatic rate than with the urban elder population.[x]
- Among the elderly residents in rural areas, 23 percent receive Medicaid benefits compared to 20 percent of the urban elderly.[xi]

- Twenty percent of the American elder population has at least two chronic diseases, with a disproportionate number of the elderly being in rural areas.[xii]

**Rural poverty**

- The poverty rate for nonmetropolitan areas rose from 13.4 percent in 2000 to 16.9 percent in 2009, the highest since 1992.[xiii]

Without Medicaid, there would be a larger percentage of the rural population without any health insurance coverage.

Some additional points to consider with health insurance coverage within rural communities are included in the following:

**Rural uninsurance**

- A person's health insurance status is a strong determinant of an individual's utilization of health care services: an uninsured person is two times less likely to seek health care treatment than an insured person.[xiv]
- As proximity to urban areas and population density decreases, the rate of uninsured rural population increases.[xv]
- The nonmetropolitan population is more likely to be uninsured than the metropolitan population (20 percent to 17 percent, respectively).[xvi]
- Frontier communities have an even higher average (23 percent) rate of uninsurance.[xvii]

**Employer-sponsored insurance**

- Approximately 61 percent of the rural non-elder population have employer-sponsored insurance, lower than for the urban non-elder population (72 percent).[xviii]
- The higher proportion of rural small businesses and lower-wage employment are two predictors explaining why employed rural Americans receive less employer-sponsored insurance coverage than urban workers.[xix]
- Rural workers pay higher costs for similar health insurance plans than urban workers.[xx]
- Rural families are more likely to not have a full-time employed and/or to have a self-employed family member, increasing the likelihood of being uninsured.[xxi]
- Rural families have lower family incomes than urban families (57 percent of uninsured rural residents have income below 200 percent of the FPL versus 50 percent for urban residents).[xxii]

In Addition:

- Rural workers are 50 percent more likely to have Medicaid coverage than workers in urban counties, but this is not enough to compensate for their lower private coverage.
- Families in rural areas more likely to have a child living in the house, which increases Medicaid eligibility.[xxiii]

- With increased costs of medical care and a highly unequal number of older and disabled persons within the rural population, negative changes in public insurance programs (e.g., Medicaid and SCHIP) may disproportionately affect high-poverty rural areas.[xxiv]
- Any cuts in Medicaid benefits will affect rural Medicaid beneficiaries and exacerbate health disparities, as having health insurance and having access to care are directly linked.[xxv]

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[i] Artnak, KE, McGraw, RM, Stanley, VF. Health care accessibility for chronic illness management and end-of-life care: A view from rural America, *The Journal of Law Medicine and Ethics*. 2011;39(2):140-155.

[ii] Office of Rural Health Policy (ORHP). Office of Rural Health Policy Rural Guide to Federal Health Professions Funding. Health Resources and Services Administration (HRSA) Web site. http://www.hrsa.gov/ruralhealth/pdf/ruralhealthprofessionsguidance.pdf. May 2012. Accessed September 17, 2012.

[iii] Medicaid: A Primer. Kaiser Commission on Medicaid and the Uninsured Web site. http://www.kff.org/medicaid/7334.cfm. June 2010. Accessed September 17, 2012.

[iv] Jones, CA, Parker, TS, Ahearn, M, Mishra, AK, Variyam, JN. Health status and health care access of farm and rural populations. United States Department of Agriculture Web site. http://www.ers.usda.gov/media/155453/eib57_1_.pdf. August 2009. Accessed September 17, 2012

[v] The Current Population Survey (CPS) 2008-2009 data may provide an estimate of rural population enrollment in Medicaid that is lower because some consumers may not realize that their state-specific program or managed care organizations may be named differently but is actually still Medicaid. These consumers may answer "no" to questions regarding Medicaid coverage. State Profiles of Medicaid and CHIP in Rural and Urban Areas – User's Guide. North Carolina Rural Health Research and Policy Analysis Center Web site. http://www.shepscenter.unc.edu/medicaidprofiles/. Accessed September 16, 2012.

[vi] Blankenau, J, Bailey, JM, Hudson, J. The causes and consequences of the rural uninsured and underinsured. Center for Rural Affairs Web site (Health Care Series, No. 3, April 2009). http://files.cfra.org/pdf/Causes-and-Consequences-of-Rural-Uninsured.pdf Accessed September 17, 2012.

[vii] State Profiles of Medicaid and CHIP in Rural and Urban Areas – User's Guide. North Carolina Rural Health Research and Policy Analysis Center Web site. http://www.shepscenter.unc.edu/medicaidprofiles/. Accessed September 16, 2012.

[viii] Lenardson, J, Ziller, E, Coburn, A, Anderson, N. Research & policy brief: Health insurance profile indicates need to expand coverage in rural areas. University of Southern Maine, Muskie School of Public Service Web site. http://muskie.usm.maine.edu/Publications/rural/pb/Rural-Health-Insurance-Profile.pdf. July, 2009. Accessed September 17, 2012.

[ix] Okrent, D. Rural Health and Health Reform Brief. Alliance for Health Reform Web site. http://www.allhealth.org/publications/Uninsured/Rural_Health_and_Health_Reform_94.pdf. January 2010. Accessed September 17, 2012.
[x] The 2010 Report to the Secretary: Rural Health and Human Services Issues. National Advisory Committee on Rural Health and Human Services Web site. http://www.hrsa.gov/advisorycommittees/rural/ 2010secretaryreport.pdf. May 2010. Accessed September 17, 2012.
[xi] Blankenau, Bailey, & Hudson, 2009.
[xii] Artnak, McGraw, & Stanley, 2011.
[xiii] In 2009, an estimated 8.1 million people lived in poverty in nonmetropolitan communities, continuing a 30-year trend that the rate of poverty is higher in nonmetropolitan than metropolitan areas. USDA, Economic Research Service Web site. http://webarchives.cdlib.org/sw1rf5mh0k/http://ers.usda.gov/Briefing/ IncomePovertyWelfare/. Also see Miller, K. Why definitions matter: Rural definitions and state poverty rankings. Rural Policy Research Institute (RUPRI)Web site. http://www.rupri.org/Forms/ Poverty%20and%20Definition%20of%20Rural.pdf. March 2010. Accessed September 17, 2012.
[xiv] Sherrill, WW, Crew, L, Mayo, RM, Mayo, WF, Rogers, BL, Haynes, DF. Educational and health services innovation to improve care for rural Hispanic communities in the US. *Education for Health*. 2005;18(3):356-367.
[xv] Lenardson, et al., 2009.
[xvi] Bolin, J., Gamm, L. Access to quality health services in rural areas—insurance: A literature review. Rural Healthy People Web site. http://www.srph.tamhsc.edu/centers/rhp2010/03Volume2access-insurance.pdf. 2003. Accessed September 17, 2012.
[xvii] Alliance for Health Reform, 2010.
[xviii] Blankenau, Bailey, & Hudson, 2009.
[xix] Ibid.
[xx] Coburn, AF, MacKinney, AC. McBride, TD, Slifkin, RT, Ziller, E. Assuring health coverage for rural people through health reform. Rural Policy Research Institute (RUPRI) Web site. http://www.rupri.org/Forms/Health_ReformBrief_Oct09.pdf. October 2009. Accessed September 17, 2012.
[xxi] Ziller, E, Coburn, A. Research & policy brief: Rural coverage gaps decline following public health insurance expansions. University of Southern Maine, Muskie School of Public Service Web site. http://muskie.usm.maine.edu/Publications/rural/pb/Rural-Public-Health-Insurance.pdf. July, 2009. Accessed September 17, 2012.
[xxii] The nonmetropolitan earnings per job is 67 percent of earnings per metropolitan job, with an additional slow 8 to 10 percent rural population growth in comparison to 14 percent urban population growth. Jones, CA, Parker, TS, Ahearn, M, Mishra, AK, Variyam, JN. August 2009.
[xxiii] U.S. Census, American Community Survey, Table GCT1103 (1 and 3-Year Estimates), 2010.
[xxiv] Rural America At-a-Glance, 2011 Edition. United Department of Agriculture Web site. http://www.ers.usda.gov/media/123318/eib85.pdf. September 2011.
[xxv] Perlino, CM. Medicaid, Prevention and Public Health: Invest Today for a Healthier Tomorrow. American Public Health Association (APHA) Web site. http://www.apha.org/NR/rdonlyres/675F96CD-7701-4049-89BD-D96625A6A3BE/0/MedicaidReport.pdf. 2005. Accessed September 17, 2012.

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