THE IMPACT OF THE MEDICAID BUDGETARY CRISIS ON RURAL COMMUNITIES

Working Paper No. 77

WORKING PAPER SERIES

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THE IMPACT OF THE MEDICAID BUDGETARY CRISIS ON RURAL COMMUNITIES

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August 29, 2003

This paper is submitted to fulfill a task under a Cooperative Agreement with the
Federal Office of Rural Health Policy (HRSA) 6 U1C RH 00027-03

EXECUTIVE SUMMARY

Most states are struggling with severe budget shortfalls. Medicaid is the second largest expenditure in most states budgets, and, as program costs grow, absorbs an ever-greater share of states' general revenues. While almost every state planned to reduce Medicaid expenditures to address budget shortfalls in FY 2004, they face the conflicting pressure to retain essential program features that ensure that basic health care needs are met for the millions of program beneficiaries. Medicaid is currently the largest insurer in the country, and is the primary third-party payer for long-term care services. It is also an essential payment source for safety-net providers, such as federally qualified health centers, rural health clinics, community mental health agencies, hospitals and public health departments, that serve a disproportionate share of Medicaid and uninsured patients.

In this paper, a brief overview of the Medicaid program and options states have to reduce program costs are presented. Next, steps states have proposed or taken to reduce Medicaid costs, and the potential impact of these changes on rural areas are discussed. Finally, the potential impact on rural communities of federal proposals to redesign Medicaid is assessed.

The federal government sets basic Medicaid program rules, but gives states considerable flexibility within these broad federal parameters. States must agree to cover certain groups of individuals ("mandatory eligibles") and certain services ("mandatory services"). States have the latitude to cover additional groups of people ("optional eligibles") or services ("optional services"), and may charge certain groups of Medicaid recipients a nominal copayment for specific services. Absent a federal waiver of program rules, Medicaid programs must cover the same people and services throughout a given state ("statewideness requirement"); however, there are considerable differences in both the people covered and the services offered *across* states.

Approximately two-thirds of Medicaid expenditures are either for services to optional eligibles (44%) or for optional services to mandatory eligibles (21%). Thus, while it is often politically difficult to do so, states could substantially reduce costs by reducing the program to meet only the minimum requirements of the Medicaid statute. States also have considerable flexibility in setting provider payment rates and in designing the health care delivery system.

Most states have enacted changes to their Medicaid programs to cut prescription drug expenditures over the last two years. Changes in dispensing fees or reducing payments for prescription drugs may have a bigger impact on rural pharmacies than urban ones. There is evidence that rural pharmacists are more reliant on Medicaid as a source of revenue. Rural pharmacies are also more likely to be independent, suggesting greater financial vulnerability should they face declining Medicaid revenues. Finally, any cuts in prescription drug coverage for elderly and disabled Medicaid beneficiaries is likely to have a disproportionate impact on rural residents as rural beneficiaries are more reliant on

Medicaid as a source of third party coverage for their prescription drug coverage than their urban counterparts.

Over two-thirds of states are considering or have enacted reductions in provider reimbursement, many targeted at nursing homes and hospitals, although physicians and other providers have also had their reimbursement levels reduced or frozen. A reduction in Medicaid payments to providers (because of changes in eligibility, covered services or provider payment reductions), could have a disproportionate impact in rural communities. Because of the often fragile nature of the rural health care infrastructure, cuts in provider revenues, coupled with recent increases in costs for malpractice insurance, technology and other expenses, could force the closure or relocation of providers and could discourage new providers from practicing in rural areas. Given the transportation barriers rural residents already face, closures would cause critical provider access problems. Additionally, the impact of these losses could be particularly harmful to rural economies that rely on the health sector to bring outside money into the local community. As the health care industry is one of the major employers in many rural communities, cuts that adversely affect health care providers will have much broader economic implications in rural areas.

Many proposed benefit cuts target services most often used by older adults or people with disabilities. State reductions include restricted or eliminated vision services, chiropractic services, mental health services, hearing services and podiatry and personal care services. The availability of these services is likely to already be more limited in rural communities, and Medicaid cuts may further discourage providers from participating in Medicaid or locating in rural communities altogether—affecting access for all rural residents, not just those on Medicaid.

A number of states have already made program changes that restrict Medicaid eligibility. Targeted groups vary across states, and include parents, pregnant women, the blind and disabled, legal immigrants, those covered under the medically needy program, and young adults age 18 and 19. In addition, several other eligibility restrictions were proposed this year, including the elimination of coverage for women with breast and cervical cancer, and tightening income eligibility for nursing home residents. Several of these eligibility cuts could have differential impacts in rural areas, particularly those aimed at nursing home residents and low-income children.

Some states are making it more difficult for people to qualify, enroll or maintain their Medicaid enrollment. Strategies being employed include reinstatement of policies to count resources (assets) in determining Medicaid eligibility, the elimination of presumptive eligibility for pregnant women or children, and elimination of the 12-month continuous eligibility provided to children. Procedural changes that would require recipients to visit the Medicaid agency more frequently or would require more on-site interviews could potentially have a disproportionately adverse effect on rural beneficiaries, as they typically have greater transportation barriers. Also of concern are changes in resource rules that more strictly limit non-cash resources such as farmland or income producing property.

States have increased, or have plans to increase, the copayments charged to Medicaid recipients for services other than prescription drugs. Because of federal restrictions, states may only impose or raise copayments for adults for certain services. Raising the cost sharing requirements has an impact on both recipients and providers, and has been shown to reduce use of both necessary and unnecessary health services. Federal Medicaid rules prohibit participating providers from denying services to Medicaid enrollees who are unable to pay the copayment. Providers who serve a number of Medicaid patients who are unable to pay the required copayment are likely to view increased copayments as a provider-reimbursement cut, and may be discouraged from further participation in the Medicaid program.

The current administration has proposed a major overhaul of the Medicaid program, called the State Health Care Partnership Allotments. Under this new program, states would be given immediate fiscal relief in return for turning Medicaid and SCHIP into a single block grant, with the federal government paying fixed allotments each year. States are not required to participate in this initiative, but would not receive immediate fiscal relief unless they do so. The block grant proposal may be sufficient to cover the states' increasing Medicaid costs over the next ten years *if* their enrollment does not increase significantly and health care inflation is kept in check. States could keep any savings, providing a further incentive to hold down program costs. If states are unable to keep expenditures within the program cap, they could use new program flexibility to cut Medicaid expenditures. States would be required to provide a core set of services to the currently mandatory eligible individuals, but would be given unprecedented flexibility in program design. While the proposal is not described in great detail, it appears that states could eliminate coverage for some or all of the optional eligibles, change the covered benefits for some or all of the optional eligible groups, impose higher cost-sharing amounts, cap enrollment; and/or eliminate the statewideness requirement.

In addition to the implication of potential reductions in eligibles or services previously discussed, changing the Medicaid program into a block-grant has separate rural implications. If the statewideness requirements are waived, states could potentially design their programs to vary in different parts of the state. While this might allow states to adjust the program to meet unique needs in particular communities, experience suggests that rural areas may be the losers in this experiment. Rural communities ability to compete for block grant funding is another concern as many rural communities lack the expertise and experience in grant writing.

As states consider options to reduce Medicaid expenditures, they should explicitly examine the effect of strategies on rural communities, and consider the role Medicaid plays in covering rural beneficiaries and supporting the rural health infrastructure. Medicaid cuts, which may be more easily absorbed in larger urban places, can have more serious consequences in rural communities. The loss of patient revenues and an increase in the numbers of uninsured could potentially wreck havoc on an already fragile rural health infrastructure. When developing cost-containment strategies, states should consider ways to protect essential community providers (for example, CAHs or other critical providers in health professional shortage areas) or those that serve a

disproportionate share of Medicaid patients. Although any cut backs in the Medicaid program will have negative consequences for low-income individuals and providers everywhere, state policy-makers must make a concerted effort to insure that rural places do not shoulder more than their share of the burden.

INTRODUCTION

Most states are struggling with severe budget shortfalls (1). The number has risen steadily over the past three years from 19 states in FY 2001 to 43 states in FY 2002 (2), to 49 states in FY 2003. The projected FY 2004 shortfalls total more than $78 billion, and while not as severe as the FY 2003 shortfalls of approximately $200 billion, have been more difficult to address (3). In FY 2003, many states closed their budget shortfalls by dipping into reserves or taking one-time savings, however, once exhausted, these options were not available to address ongoing budgetary shortfalls (4). As a result, many states have been forced to make programmatic cuts and/or raise revenues. Although the current budget crises has been caused primarily by lower-than-expected revenues, rapidly growing Medicaid expenditures have added to the states' budget woes.

In 2002, Medicaid funded health and long-term care services for more than 47 million people (5). The program is financed by federal, state, and in some states, local contributions, with the federal government paying between 50-77% of program costs. Despite the large federal role in Medicaid financing, it is still the second largest expenditure in most states budgets, after education, and constitutes 15% of state general fund spending or more than 20% of total state expenditures (6). As program costs grow, Medicaid expenditures are absorbing ever-greater shares of the state's general revenues (6).

Medicaid spending was expected to increase 9% in FY 2003, although states only appropriated 4.8% to accommodate program growth. This led to many mid-year adjustments to Medicaid programs (1). States reported that they expect a 7.7% growth in Medicaid expenditures in FY 2004. Almost two-thirds of the increase in Medicaid expenditures between 2002 and 2004 is due to an increase in the per capita costs of health services for existing beneficiaries, rather than increases in enrollment, similar to increases in health care costs experienced in the commercial market (7). The per capita increases are being driven by rising prescription drug costs, advances in medical technology, and reduced managed care savings. More than four-fifths (82%) of the growth in expenditures is attributable to the costs of caring for the aged and disabled.

Almost every state planned to reduce Medicaid expenditures to address the budget shortfalls in FY 2004 (1). States have considered and enacted different options, some of which may have differential effects in rural areas. Nationally, people living in rural areas were more likely to receive Medicaid in 2002 than were people in urban areas (14.7% versus 11.2% respectively) (8). This may be due to the fact that rural residents are more likely to live in poverty: 14.7% of rural residents lived in poverty compared to 11.8% of urban residents (9;10). Eligibility cuts that adversely affect the elderly, people with disabilities or children may have a disproportionate rural impact, since national data suggest that these individuals living in rural areas are more likely to be covered by Medicaid than similar people living in urban communities. Provider or service cuts that discourage providers from participating in Medicaid can also disproportionately affect rural communities as there are generally fewer providers in rural communities.

This paper starts with a brief overview of the Medicaid program as well as options states have to reduce program costs. Next, some of the steps states have proposed or taken to reduce Medicaid costs, and the potential impact of these changes on rural areas are discussed. The final section assesses the potential impact on rural communities of federal proposals to redesign Medicaid.

MEDICAID BACKGROUND

Medicaid was enacted in 1965 to provide health insurance coverage to certain low-income individuals and families. States are not required to participate in the Medicaid program, but all states have chosen to do so. The federal government sets basic program rules, but gives states considerable flexibility in designing the program within these broad federal parameters. The federal government also shares the program costs, currently paying between 50-77% of the health care costs (called the Federal Medical Assistance Percentage or FMAP). This rate is based, in large part, on the states' per capita income such that poorer states receive a higher FMAP rate. States can receive an enhanced FMAP rate for coverage of children through their State Children's Health Insurance Program (SCHIP) and for coverage of women diagnosed with breast or cervical cancer. Higher FMAP rates are also available for coverage of family planning services, and for some administrative expenses, although most administrative costs are split 50/50 between the federal and state government. States may finance the non-federal share of Medicaid costs completely, or may require local (e.g. county) governments to share in the costs. Seventeen states required a local contribution in 1996 for the costs of some or all services provided to recipients (11).

As a requirement of participation in the Medicaid program, states must agree to cover certain groups of individuals ("mandatory eligibles") and certain services ("mandatory services"). States have the latitude to cover additional groups of people ("optional eligibles") or services ("optional services"),[1] and may charge certain groups of Medicaid recipients a nominal copayment for specific services. Absent a federal waiver of program rules, the state's Medicaid program must cover the same people and services throughout the state ("statewideness requirement"); however, there are considerable differences in both the people covered and the services offered *across* states. States are responsible for setting provider payment rates, but must operate within certain federally defined upper and lower payment limits. For example, states may not pay institutional providers, such as hospitals and nursing facilities, any more than Medicare would pay for these services ("upper payment limit"), but they must pay at least enough to "attract providers so that

[1] Children are entitled to broader Medicaid coverage. Medicaid-eligible children under age 21 must receive well-child preventive services, called Early and Periodic Screening, Diagnosis and Treatment (EPSDT). States must provide needed services to children diagnosed through an EPSDT screening, regardless of whether the state normally covers the needed service as part of its regular Medicaid program (as long as the service is federally allowable). For example, a state that does not normally cover dental services, must nonetheless pay for required dental services for Medicaid eligible children, if the need for dental care was identified as part of an EPSDT screen. Thus, states have far less flexibility in cutting services to eligible children than they do for eligible adults.

services are available to the Medicaid population at least to the extent they are available to the general population in the geographic area."[2] (12) States also have discretion in determining the delivery system for their Medicaid programs, albeit with fewer options than are available in the commercial market. For example, states can pay providers on a fee-for-service basis, or can contract with managed care organizations to provide services. A more complete description of the Medicaid program, including mandatory and optional eligibles and services is provided in Appendix A.

STATE ACTIONS TO REDUCE PROGRAM EXPENDITURES AND RURAL IMPLICATIONS

Approximately two-thirds of Medicaid expenditures are either for services to optional eligibles (44%) or for optional services to mandatory eligibles (21%) (13). Thus, while it is often politically difficult to do so, states could substantially reduce program costs if the program was reduced to meet only the minimum requirements of the Medicaid statute. States also have considerable flexibility in setting provider payment rates and in designing the health care delivery system, options they have used in the past to slow or reduce program growth. Further, states have undertaken administrative reforms, such as trying to increase fraud and abuse oversight, as a means of reducing program expenditures.

Smith and his colleagues surveyed Medicaid officials in 50 states and the District of Columbia to determine what actions states had taken to reduce Medicaid costs in FY 2002 and to find out what additional plans states had to contain Medicaid expenditures in FY 2003 (1). Preliminary results from an updated survey showing states plans in FY 2004 are also available (14). States most often reported actions to reduce pharmaceutical costs and to freeze or reduce provider payments (Table 1). Approximately half of the states were contemplating benefit or eligibility reductions.

[2] 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.204. Provider groups and Medicaid recipients have been able to successfully challenge the adequacy of state Medicaid payments on this basis. (71). In addition, states must pay enhanced payments to certain providers, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)(12;35). States are also required to "take into account the situation of hospitals that serve a disproportionate number of low-income people with special needs" (12). This is known as the disproportionate share hospital (DSH) provision and gives states the flexibility to provide additional payments to hospitals that serve a disproportionate share of uninsured and Medicaid patients. However, DSH payments may not exceed the actual costs to the hospitals to serve Medicaid and uninsured patients on an inpatient and outpatient basis (less any amount the hospital receives in its regular Medicaid payments).

Table 1
Implemented or Planned Medicaid Cost Containment Strategies in FY 2002 and FY 2003

Cost Containment Actions	Implemented in FY 2002 *(Number of states & DC)*	New Plans at Some Time in FY 2003 *(Number of states & DC)*	Plans for FY 2004 *(Number of states & DC)*
Pharmacy related actions	32	45	43
Payment provider rate freezes or decreases	22	37	45
Benefit reductions	9	25	20
Eligibility reductions	8	27	18
Implementation or increase in non-pharmacy copays	4	17	21
Expansion of managed care	10	12	NA
Implementation of disease or case management	11	24	NA
Enhanced fraud and abuse	16	21	NA
Long-term care reform	7	19	NA
Any cost containment effort	45	50	NA

Source: Smith, V., Gifford, K., Ramesh, R., and Wachino, V. Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003. Kaiser Commission on Medicaid and the Uninsured. 2003 Jan.; Kaiser Commission on Medicaid and the Uninsured. Preliminary results from upcoming 50 state survey report on state budgets and Medicaid. The Henry J. Kaiser Family Foundation. 2003 Aug.

While it is unknown at this time how many of these proposed cost containment efforts were implemented, it is important for policy makers to consider the potential rural implications of these initiatives. Each of these cost containment strategies is discussed in greater detail below:

Reducing Pharmaceutical Costs

Most states have enacted changes to their Medicaid programs to cut prescription drug expenditures over the last two years (15). Changes have included the following:

- 28 states have implemented or changed Preferred Drug Lists (PDLs)
- 34 have added or made changes to prior authorization rules
- 26 have increased the copay for recipients
- 18 have established or made changes to their supplemental drug rebate program

- 21 have placed restrictions on brand name drugs or forced recipients to substitute generic drugs
- 9 have limited the number of allowable prescriptions per month

Changes in the prescription drug dispensing fee or reducing the payment for prescription drugs may adversely impact all pharmacists, but may have a bigger impact on rural pharmacies. There is some evidence to suggest that rural pharmacists are more reliant on Medicaid as a source of revenues, with less ability to cost-shift to other payers when Medicaid revenues are reduced. For example, a current study of pharmacists and pharmacies in rural areas found that nationally, 16.0% of retail prescriptions are covered by Medicaid in rural areas, compared to 10.5% in urban areas (16). Rural pharmacies are also more likely to be independent, and thus less likely to be part of corporate chains (17). This suggests fewer cash reserves to absorb decreased revenue from Medicaid prescriptions, which could make rural pharmacies more vulnerable to closure. This theory is supported by several researchers who have suggested that decreased prescription drug profitability may threaten access to rural pharmacists in the future (18-20).

Any cuts in prescription drug coverage for elderly and disabled Medicaid beneficiaries is likely to have a disproportionate impact on rural residents. Rural Medicare beneficiaries are more reliant on Medicaid as a source of third party coverage for their prescription drug coverage than their counterparts: 13.1% of prescription medicine expenditures for rural Medicare beneficiaries are paid by Medicaid, 29.8% by private insurance, and 47.6% are paid out-of-pocket (21). In contrast, 11.5% of prescription expenditures for urban Medicare beneficiaries are covered by Medicaid, 35.7% by private insurance, and 37.8% out-of-pocket.

Imposing new or higher pharmacy copayments can also negatively affect rural Medicaid beneficiaries. Although it is a condition of participation in Medicaid that a provider may not deny services to Medicaid beneficiaries due to their inability to pay a required copayment, a survey of pharmacists in three states suggested that some pharmacists refuse to waive the copayments (22). This may be more of a problem for rural residents, as a greater percentage of rural residents live in poverty than do urban residents (9;10).

Provider Payment Rate Decreases

Thirty-seven states reported that they were considering or had enacted reductions in provider reimbursement (1). Many of these reductions were targeted at nursing homes and hospitals, although physicians and other providers have also had their reimbursement levels reduced or frozen. The reduction in Medicaid reimbursement rates, coupled with recent increases in professional liability insurance, may lead some providers to drop coverage or to limit their willingness to accept Medicaid patients. This is an especially acute threat in rural areas where private insurance is less prevalent and providers have less opportunity to cost-shift to recover losses from public insurance.

Nursing homes: Nursing facilities are among the few health care resources that are more readily available in rural areas than urban. Nationally, there are 51.9 certified beds per 1,000 people age 65 or older in urban areas, compared to 66.7 in non-metro counties (23). A greater proportion of the rural elderly are admitted to nursing homes than the urban elderly (6% compared to 5.1%) (24). This is due, in part, to the fact that there are fewer home and community based services available in rural areas. Further, rural nursing patients are more likely to rely on Medicaid as their primary payer source: 68.7% of nursing home residents in isolated communities, 70.7% of residents in small rural towns, 67.9% of residents in large towns, and 66.7% of residents in urban areas rely on Medicaid as their primary payer for nursing facility services (25).

- *Hospitals*: Overall, rural hospitals admit fewer Medicaid patients than do urban hospitals. Medicaid accounted for 9.7% of the acute care discharges of rural hospitals, compared to 11.3% of discharges in urban hospitals. Further, data from Medicare cost reports indicate that the larger the hospital, the greater the proportion of Medicaid discharges to total discharges: hospitals with up to 25 beds have the smallest proportion of total discharges attributable to Medicaid (6.0%), compared to 10.1% in hospitals with 26-100 beds, 11.7% in hospitals with 101-300 beds, and 11.9% in hospitals with 300 beds or more. Despite the fact that small rural hospitals are less likely to serve Medicaid patients, Medicaid reimbursement cuts are a significant threat to them because they are much more financially fragile than urban hospitals. Small rural hospitals, particularly those with less than 25 beds, have the lowest total margins, and most are operating in the red (Table 2). Because of their precarious financial standing, any Medicaid reimbursement reductions to these small rural hospitals could be particularly devastating. Additionally, payment cuts to rural hospitals could significantly impact the overall rural economy, as hospitals are often a major employer in rural communities. (26;27)

Table 2
Total Margins (Median Hospital Margins)

	Rural	Urban
≤ 25 beds	-0.6%	0.6%
26 – 100 beds	1.9%	3.0%
101 – 300 beds	3.4%	1.9%
> 300 beds	4.0%	3.1%

Source: Centers for Medicare and Medicaid Services. Hospital Cost Report Information System. FY 1999.

State Medicaid reimbursement policies could also adversely impact Critical Access Hospitals. As of July 15, 2003, there were 714 rural CAHs (which represent 23% of all rural hospitals). Under federal Medicare rules, CAHs receive cost-based reimbursement for Medicare inpatient and outpatient services. Although states are not required to pay cost-based reimbursement for Medicaid inpatient services, 17 pay CAHs an enhanced reimbursement rate; in several of these states the reimbursement methodologies could potentially pay CAHs more than cost (28). Further, 13 states

have special reimbursement policies for outpatient services provided by CAHs. Since there is no federal requirement that states pay enhanced rates for either inpatient or outpatient Medicaid services, states could eliminate the enhanced reimbursement as a cost-cutting strategy. By definition, CAHs are the smallest of the small rural hospitals (less than 15 acute care beds) and tend to have low or negative financial margins; thus, while Medicaid payments are not a large percentage of most CAHs' revenues, they are nonetheless important to the financial well-being of these institutions.

- *Physicians:* It is unclear whether provider payment cuts will have a differential impact on rural providers, and in turn, recipients' ability to access rural providers. Surely, providers will object to reductions or freezes in Medicaid reimbursement rates; however, it is not known whether reductions will cause providers to stop participating in the Medicaid program or shrink their Medicaid panels to limit their loss. Historically, rural providers have been more likely to participate in Medicaid, and they have been less likely to restrict access (29;30). Further, the net income of rural family physicians or general practitioners is comparable or slightly higher than urban family physicians; although pediatricians and internists earn somewhat less than their urban counterparts (Table 3). These factors suggest that, to some degree, provider payment reductions may not affect physician services in rural areas.

Table 3
Mean Physician Net Income, 2000*

	General/Family Physicians	Pediatric Physicians	General Internal Medicine
Nonmetro	$151,200	$130,900	$143,000
Metro less than 1 million people	$141,700	$146,300	$167,900
Metro more than or equal to 1 million people	$142,100	$134,700	$166,600

Source: Physician Socioeconomic Statistics, 2003 Edition. Chicago, IL. Center for Health Policy Research, American Medical Association
*After expenses but before taxes.

However, *any* reduction in participation among rural physicians could be devastating for rural recipients, as there are already proportionately fewer physicians in rural areas than in urban areas (aside from family physicians and general practitioners) (Table 4). Rural areas are also more likely to be designated as Health Professional Shortage Areas (HPSAs), indicating that there are fewer primary care providers in rural communities to absorb the loss of physicians than in urban areas: 91% of the whole county Health Professional Shortage Areas (HPSAs), and 65% of the part county HPSAs are in non-metro counties (9). Payment reductions that affect the

number of participating specialists could have a particularly devastating impact on rural communities; as there are only about one-third as many specialists per population in rural versus urban communities.

Table 4
Physician Ratios per 1,000 Population

	Primary Care				
	General/ Family Physicians	Pediatricians	Internal Medicine	Total Primary Care	Specialists
Nonmetro	.3409	.2338	.1318	.5897	.4059
Metro	.3039	.5765	.2760	.8443	1.1114

Note: Primary care includes general practitioners, family physicians, pediatricians, and general internists (both MDs and ODs). Source: US DHHS, Area Resource File, 2002; US Department of Commerce, Census 2000, 2002.

Additionally, Medicaid cuts which discourage doctors from practicing in rural areas or cause doctors to leave rural areas can also have a major impact on the rural economy. One study by Doekson found that three full-time physicians in a rural Oklahoma town generated 27 jobs, directly and indirectly in the local community. Thus, Medicaid reimbursement cuts to physicians can have widespread negative effects on the local rural economy beyond the loss of a single provider. (31;32).

- *Dentists*. Dentists have historically been reluctant to participate in the Medicaid program (33). A 1996 Office of Inspector General Report noted that 80% of the states reported that low dental usage among Medicaid recipients was due to the shortage of dentists willing to accept Medicaid (34). These shortages were worse in rural areas, which is partially a reflection of the overall lack of dentists in rural areas. There are .6466 dentists per 1,000 people in nonmetro areas, compared to 1.0465 in urban areas, (10) and rural areas are more likely to be designated as dental health professional shortage areas: 94% of the whole county dental HPSA and 67% of the partial county dental HPSAs are in rural counties (9). One of the primary explanations for the low dental participation in Medicaid is inadequate dental reimbursement (34). Thus, any reduction in Medicaid rates to dentists has the potential to make it more difficult to find dentists willing to treat Medicaid recipients and compound an existing rural dental access problem.

- *Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).* Unlike other health care providers, states have much less discretion in reducing payments to FQHCs and RHCs. Under the federal Medicaid statute, FQHCs and RHCs services are federally mandated services and must be paid on a prospective

payment system. The federal Benefits Improvement and Protection Act of 2000 (BIPA) set forth guidelines under which states must pay FQHCs and RHCs a per visit payment that is calculated using a base rate (the average of the center's 1999 and 2000 "reasonable costs"), inflated using the Medicare Economic Index for primary care[3] (35). The amount a center receives must be adjusted in the event of an increase or decrease in the scope of services provided by the FQHC or RHC. States can establish an alternative reimbursement system, provided that the centers agree to the new payment and the new payment is no less than the amount the center would have been paid under PPS.

While federal law sets minimum payment thresholds, some states have frozen and/or reduced FQHC/RHC payment rates (36). Such reductions may have an immediate and direct impact on rural areas. By definition, rural health clinics must be located in rural areas[4], and 51% of FQHCs are located in rural areas (37;38). These providers have less ability to cost shift to private payers, as they typically see more Medicaid, Medicare and uninsured and fewer privately insured patients (Table 5). Without adequate reimbursement, access to primary care and other health services provided by these important safety-net institutions may suffer.

Table 5
Source of Insurance Coverage
(US Population, Community Health Centers, Rural Health Centers)

	2001 US Insurance Coverage (2001)	Community Health Center Patients (2001)	Rural Health Centers (Patient Visits, 2000)
Private insurance	70.9%	5%	28.4%
Medicare	13.5%	7%	30%
Medicaid	11.2%	35%	25%
Other public	3.4%	4%	
Uninsured	14.6%	39%	14.6%
Other			3.9%

Source: 2001 US insurance data from: U.S. Census Bureau. (39); Community health center data from: Rosenbaum S, Shin P. (37); Rural health clinic data from: Gale JA, Coburn AF. (40)

- *Public health:* NACCHO reports that public health departments in rural areas are more likely to directly provide adult immunization, case management, child health services, chronic disease control screening, family planning and maternal health, home health care, and STD and tuberculosis testing and treatment. Rural public

[3] States have some discretion in determining the "reasonable costs" included in calculating the base rate.
[4] A small percentage (1.5%) of Rural Health Centers are located in areas classified as urban core. Although RHCs are usually required to operate in non-urbanized areas, in a few instances areas have been reclassified as urban since the center opened. (40)

health departments are also more reliant on service revenue (25%), including Medicaid, as a source of income than are urban public health departments (14%) (41). Cuts in Medicaid revenues could thereby threaten the financial stability of rural health departments and force them to eliminate much needed services, as many health departments use Medicaid funding to support other public health functions (42;43).

Non-pharmaceutical Benefit Reductions

Sixteen states have either cut adult dental services altogether or reduced benefits (15). Dental care utilization is worse for rural elders than for urban elders (44), possibly due, in part, to the fact that there are fewer dentists practicing in rural areas. Eliminating dental coverage for adults, or reducing the covered services may further discourage dentists from participating in Medicaid.

Many proposed benefit cuts target services most often used by older adults or people with disabilities. State reductions include restricted or eliminated vision services (11 states), chiropractic services (9 states), and mental health services (6 states) (15). States have also chosen to either restrict or cut treatment for hearing services (45;46) and podiatry and personal care services(15;47). The availability of these services is likely to already be more limited in rural communities. For example, there are fewer community-based, in-home service options in rural areas than urban (24). While national data are not available to show the geographic availability of podiatrists, audiologists, physical, occupational and speech therapists, there are some state level data. For example, there are approximately half as many physical therapists practicing in rural areas of North Carolina as in urban communities: 2.42 per 10,000 population in rural vs. 4.37 in urban (48). Speech therapists are about 40% less likely to be located in rural areas in North Carolina (2.5 speech therapists per 10,000 population in non-metro compared to 4.3 in metro)(49). Cuts in Medicaid coverage for these services may further discourage providers from participating in Medicaid or locating in rural communities altogether—affecting access for all rural residents, not just those on Medicaid.

Eligibility Reductions

As of July 21, 2003, sixteen states had made program changes that restricted Medicaid eligibility during the past two years (15). Some states have made income requirements for parents, pregnant women and the blind and disabled more restrictive. Others have completely eliminated certain optional eligibility groups, such as legal immigrants, those covered under the medically needy program, and young adults age 18 and 19. States have also reduced income eligibility thresholds for the State Children's Health Insurance Program (SCHIP) and capped SCHIP enrollment, cut presumptive eligibility for children, eliminated 12-month continuous eligibility for children and reduced transitional benefits from 24 to 12 months (15;50). In addition to the proposals that were enacted, several other eligibility restrictions were proposed this year, including the elimination of coverage for women with breast and cervical cancer, and tightening income eligibility for

nursing home residents. Several of these eligibility cuts could have differential impacts in rural areas, as described below:

- *Older adults*: Older adults (age 65 or older) constitute 10.2% of program recipients, but use 27.3% of program expenditures (12). States have great latitude in reducing program expenditures by cutting program coverage to the elderly, as 56% of older adults qualify for Medicaid through one of the optional eligibility categories (13). In fact, some states have proposed such cuts, which could have a disproportionate impact in rural communities, since there are proportionately more rural elderly receiving Medicaid (10.1%) than urban elderly (8.2%) (8). Rural elderly are also more likely to live in poverty (12.4%) compared to urban elderly (9.1%) (10).

- *People with disabilities:* More than one-fifth (22%) of the people with disabilities who are receiving Medicaid qualify through optional eligibility groups (13). Most disabled individuals qualify for Medicaid through the receipt of SSI payments, and a greater proportion of the rural population receives SSI on the basis of disability (blind or disabled) than in urban areas: 27.5 people per 1,000 people under age 65), than there are in urban areas (20.7 per 1,000) (10). While states cannot limit coverage for the SSI population in most states,[5] states do have some flexibility in reducing or eliminating coverage for individuals who currently qualify for Medicaid on the basis of disability but who are not receiving SSI cash assistance (optional eligibles). We lack the data to determine whether there are disproportionately more people receiving Medicaid in rural areas on the basis of one of the optional eligibility categories for people with disabilities. Thus, it is unclear whether reducing Medicaid coverage for people with disabilities is likely to have a disproportionately adverse effect on rural beneficiaries.

- *Breast and cervical cancer:* Cancer screening among women is less common in rural areas than in metropolitan areas (51;52). This may explain, at least in part, why rural women are more likely to be diagnosed with breast or cervical cancer at a later stage than urban women (53-55). The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA), signed into law in October 2000, gave states an enhanced FMAP for cancer treatment services of women screened through the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). By 2002, 42 states had chosen to include the BCCPTA as part of their optional Medicaid services (56). Although it is not yet known whether the BCCPTA has helped reduce urban-rural cancer detection disparities, it is likely that some rural providers have increased screening services for Medicaid and indigent women since the cost of treatment is covered if cancer is detected.

Medicaid coverage for breast and cervical cancer treatment may be even more critical in rural areas, where late stage cancer is more commonly detected, than in urban areas.

[5] Most states provide Medicaid automatically to individuals receiving SSI. However, 11 states have chosen a more restrictive eligibility option for the elderly and disabled. Under this option (called 209(b)), states can restrict Medicaid coverage to those individuals who've been eligible under state rules in effect in January, 1972 for the aged, blind and disabled.

Thus, elimination of this optional Medical eligibility group (women diagnosed with breast or cervical cancer) could lead to worse outcomes for women living in rural areas.

Children: Approximately 20% of all Medicaid enrolled children are covered through an optional eligibility group (13). According to the US Census, rural and urban areas have approximately the same proportion of children in their population (25.3% versus 25.7% respectively); however, children in rural areas are more likely to be covered by Medicaid (10). Nationally, Medicaid covers about one in four children, however, one in three rural children are Medicaid recipients (5). This difference is likely due to the fact that rural children are more likely to live in poverty (19.4%) compared to urban children (15.9%) (10). Thus, any changes that eliminated low-income children from Medicaid or SCHIP could disproportionately affect children living in rural communities.

Procedural Barriers

Several states are changing their eligibility determination process to make it more difficult for people to qualify, enroll or maintain their Medicaid enrollment. Some of the strategies being employed include reinstatement of policies to count resources (assets) in determining Medicaid eligibility, the elimination of presumptive eligibility for pregnant women or children, and elimination of the 12-month continuous eligibility provided to children (1;50). Procedural changes that would require Medicaid recipients to visit the Medicaid agency more frequently or would require more on-site interviews could potentially have a disproportionately adverse effect on rural beneficiaries, as rural residents typically have greater transportation barriers (57). Changes in resource rules that more strictly limit non-cash resources (such as farmland or income producing property) are also likely to restrict Medicaid eligibility for proportionately more rural residents than urban residents.

Implementation of Non-Pharmacy Beneficiary Copayments

Seventeen states have increased, or have plans to increase, the copayments charged to Medicaid recipients for services other than prescription drugs. Absent a waiver, states are prohibited from imposing any cost-sharing on certain Medicaid recipients including children under age 18, pregnant women for any pregnancy-related services, terminally ill hospice patients, or residents in institutional settings such as ICF/MR or nursing facilities. States are also prohibited from imposing cost-sharing for certain services, including emergency services or family planning.[6] Because of these federal restrictions, states may only impose or raise copayments for the adult population (including parents of children, the elderly and people with disabilities) for certain services. When cost-sharing is allowable, it must be limited to nominal amounts.[7]

[6] 42 U.S.C. § 1396o(a)(10); 42 C.F.R. § 447.53 (12).

[7] Copayments are limited to between $0.50 to $3.00 depending on the service;, deductibles can be no more than $2 per family per month; and coinsurance is limited to 5% of the payment the agency makes for the service. States can impose higher copayments on the non-emergency use of the emergency room, if the

Raising the cost sharing requirements has an impact on both recipients and providers. Increasing a Medicaid recipient's copayments has been shown to reduce use of both necessary and unnecessary health services because of an inability to pay, and leads to adverse health outcomes (58). Further, copayments effectively reduce the state's payment to providers in many cases. Federal Medicaid rules prohibit participating providers from denying services to Medicaid enrollees who are unable to pay the copayment. Providers who serve a number of Medicaid patients who are unable to pay the required copayment are likely to view increased copayments as a provider-reimbursement cut, and may be discouraged from further participation in the Medicaid program.

Expansion of Managed Care and/or Implementation of Disease or Case Management

Twelve states are considering expanding managed care as a means of controlling costs. While this was a very popular cost-containment mechanism in the early and mid-1990s, states have not found it as helpful in containing costs in recent years. Primary care case management (PCCM) continues to be the most prevalent form of managed care in rural areas. States have found it difficult to attract fully capitated managed care companies into rural areas, and health plan withdrawals have caused some states to reassess their reliance on fully capitated health plans for their Medicaid populations (59). Relying on fully capitated health plans as a source of significant savings may be unrealistic, especially for rural areas.

Several states have explored enhanced primary care case management programs, including case management and/or disease management, as a means of improving care while reducing program costs (60). While more challenging to operate in rural areas because enrollees are more geographically disperse, a case study of three states with such programs found that case management was beneficial to rural enrollees. Case managers helped link recipient to other available services in the community, and helped serve as "physician extenders" by providing more intensive patient education, monitoring the patient's condition and providing follow-up, particularly beneficial to small rural practitioners with fewer staff.

FEDERAL INITIATIVES

Increases in the FMAP Rates

Congress recently enacted a state fiscal relief package intended to help ease states budgetary pressures (7). As part of the Jobs and Growth Tax Relief Reconciliation Act of

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state can show that the recipient has alternate available and accessible sources of non-emergency outpatient services (12).

2003, Congress appropriated $10 billion to increase the share of Medicaid expenses paid by the federal government. Under the new legislation, the Federal Medical Assistance Rate (FMAP) will be increased for the time period from April 1, 2003 through June 30, 2004 under the following conditions:

1) *Hold harmless provisions*. Federal FMAP rates are recalculated each year, and may be increased or decreased depending on a state's economic conditions during three years prior to the calculations.[8] Because of the three-year calculation, states could experience a reduction in the federal match rate (leading to higher state costs) during a recession. This could happen, for example, if the state had experienced economic growth in the two-three year time period prior. The state fiscal relief package will ensure that the federal FMAP rate does not decline between April 1, 2003-June 30, 2004. From April-September 2003 (FFY 2003), the FMAP rate will be the higher of the regular FMAP rate for FFY 2002 or its regular FMAP rate for FFY 2003 (7). From October 2003-June 2004 (FFY 2004), the state's FMAP rate will be the higher of the regular FMAP rate for either FFY 2003 or FFY 2004.

2) *Increase in FMAP rate by 2.95 percentage points*. States' FMAP rates are scheduled to increase by 2.95 percentage points from April 1, 2003-June 30, 2004. To qualify for these additional federal funds, states must maintain Medicaid eligibility that was in effect in its state plan on September 2, 2003 (maintenance of effort requirement). States that restrict Medicaid eligibility will not qualify for additional FMAP amounts unless they revert to the eligibility rules in effect September 2, 2003. This additional 2.95 percentage points in the FMAP applies to the regular Medicaid services, but not to the state's administrative costs, disproportionate share hospital (DSH) payments, or any payment for which the state already receives enhanced FMAP rate (such as family planning or SCHIP).

Because of the maintenance of effort requirement, states will presumably be discouraged from reducing Medicaid eligibility after September 1, 2003. However, the maintenance of effort requirement does not preclude states from reducing provider payments, cutting or limiting optional services, or imposing additional cost-sharing amounts. Further, the state fiscal relief provisions only apply through June 30, 2004. Thus, states are likely to continue efforts to reduce Medicaid expenditures despite the temporary assistance.

Block Grant

The Bush Administration has proposed a major overhaul of the Medicaid program, called the State Health Care Partnership Allotments (61). Under this new program, states would be given immediate fiscal relief in return for turning Medicaid and SCHIP into a single block grant, with the federal government paying fixed allotments each year—federal spending would no longer be based on the number of eligibles or cost of services (62).

[8] The FMAP rate is recalculated annually based on the state and national per capita income from the prior three-year period (12).

Participating states would receive two federal allotments, one for acute care and one for long-term care. The amount of the state's initial allotment would be based on its Medicaid spending in FY 2002, with an inflation factor that is higher in earlier years than in later years. This fiscal relief is in addition to the funds allocated under the Jobs and Growth Tax Relief Reconciliation Act of 2003. States are not required to participate in this initiative, but would not receive immediate fiscal relief unless they do so.

Under the proposal, states would be given an additional $12.7 billion over the first seven years, with $3.25 billion (25.6%) of the funds coming in the first year (FY 2004) (63). These funds are effectively a loan to the states that would be repaid by reductions in the federal allotments in the eighth through tenth years. Every year, states would be required to contribute at least the same amount they spent on Medicaid and SCHIP in 2002 ("maintenance of effort" requirement), inflated each year by the medical CPI.

The block grant proposal may be sufficient to cover the states' increasing Medicaid costs over the next ten years *if* their enrollment does not increase significantly and health care inflation is kept in check. States could keep any savings, providing a further incentive to hold down program costs. If states are unable to keep expenditures within the program cap, they could use new program flexibility to cut Medicaid expenditures. States would be required to provide a core set of services to the currently mandatory eligible individuals, but would be given unprecedented flexibility in program design. While the proposal is not described in great detail, it appears that states could: eliminate coverage for some or all of the optional eligibles (currently one-third of the people covered by Medicaid); change the covered benefits for some or all of the optional eligible groups; impose higher cost-sharing amounts; cap enrollment; and/or eliminate the statewideness requirement.

This proposal has significant implications for rural areas. Not only will the potential reductions in eligibles or services have the same implications discussed previously; but changing the Medicaid program into a block-grant has separate rural implications. The primary potential rural concerns include: waiving the statewideness requirements, rural communities ability to compete for block grant funding, the impact of a future economic downturn, and the potential loss of federal funds.

- *Waiving the statewideness requirements*: In the absence of a waiver, states currently are required to operate their Medicaid program consistently throughout the state, with uniform eligibility rules and identical covered services. Without this requirement, states could potentially design their programs to vary in different parts of the state. While this might allow states to adjust the program to meet unique needs in particular communities, experience suggests that rural areas may be the losers in this experiment. For example, when states were given flexibility in designing their home and community based waiver programs, some states excluded rural areas from programs that offer alternatives to institutionalization (64;65).

- *Rural ability to compete for funds in block grant*: Although the design of the proposed block grant program is currently very vague, if implemented as a

competitive process of applying for funds, rural areas could be at a significant disadvantage. Many rural communities lack the expertise and experience in grant writing that would be needed to compete with urban areas for block grant money, so a competitive process could reduce the total funds going to rural areas in proportion to the populations in need (66;67). However, block grants can be designed to set-aside specific funds for rural areas, so that rural areas are not competing against urban ones. The design of a Medicaid block grant program is critical, as it would determine whether rural areas would continue to receive the same amount of federal funds as they had under the entitlement program or would potentially lose funding if they were forced to compete against either urban centers or other rural areas for discretionary funds.

- *Implications of a future economic downturn*: Historically, Medicaid has operated as a safety-net during economic downturns, covering more people as they lose their jobs and/or health insurance. Because the current program is an entitlement, federal contributions increase when program expenditures grow. If the program is turned into a block grant, federal funds will remain constant, regardless of changes in the number of people covered by the program, or expenditures per beneficiary. If the country experiences another recession, states suffering from an economic downturn will be hard pressed to finance coverage of newly uninsured individuals without additional federal funds. Without sufficient funding, states may impose waiting lists or other mechanisms to limit new eligibles. If the recession were to affect rural and farm economies more quickly and substantially than it did urban areas, as in the recent recession, such strategies could have a disproportionate impact on rural communities (68).

- *Impact of the potential loss of federal funds*. Federal Medicaid payments account for more than 40% of all grant funds transferred from the federal government to states (12). These funds are then transferred to local communities through provider payments. Medicaid dollars contribute to the overall viability of the rural health infrastructure, which in turn helps support the rural economy. Hospitals, for example, are often one of the largest employers in the community. Taking into consideration the entire contribution of the health care industry to a local economy, a study of nine Oklahoma counties found nine percent of the community residents working directly in the health sector. Including secondary employment in sectors supplying goods and services to support the health care industry, the health sector accounted for 14 percent of community employment (32). A reduction in federal funds to the rural healthcare industry could have long-lasting and far-reaching effects on already precarious rural economies.

CONCLUSIONS

States are facing conflicting pressures to reduce Medicaid expenditures while retaining essential program features to ensure that the basic health care needs are met for the millions of people covered by the program. The important role that Medicaid plays in

providing health insurance to millions of low- and moderate-income individuals who would otherwise be uninsured and unable to afford necessary services has long been recognized. Medicaid is currently the largest insurer in the country, covering more people than Medicare (69), and the Medicaid program is the primary third-party payer for long-term care services. It is also an essential payment source for safety-net providers, including federally qualified health centers, rural health clinics, community mental health agencies, public health departments and hospitals that serve a disproportionate share of Medicaid and uninsured patients.

What is not often considered is the role that Medicaid plays in covering rural beneficiaries and supporting the rural health infrastructure. Rural residents are more likely to be in poverty, and are more likely to fall into certain "categories" of individuals eligible for Medicaid (i.e., elderly, people with disabilities, and children). Not surprisingly, rural residents are more likely to be covered by public health insurance, and less likely to have private employer-based coverage (57).

Medicaid, while not always the primary payor source for rural providers, is nonetheless an important source of revenue. State or federal actions that reduce Medicaid payments to rural providers (because of changes in eligibility, covered services or provider payment reductions), could have a disproportionate impact in rural communities. Because of the fragile nature of the rural health care infrastructure in many communities, cuts in provider revenues, coupled with recent increases in costs for malpractice insurance, technology and other expenses could force the closure or relocation of providers and could discourage new providers from practicing in rural areas. Given the transportation barriers rural residents already face, closures would cause critical provider access problems. Additionally, the impact of these losses could be particularly harmful to rural economies that rely on the health sector to bring outside money into the local community. As the health care industry is one of the major employers in many rural communities, cuts that adversely affect health care providers will have much broader economic implications in rural areas.

States that are considering options to reduce Medicaid expenditures should explicitly examine the effect of these proposals on rural communities. Medicaid cuts, which may be more easily absorbed in larger urban places, can have more serious consequences in rural communities. The loss of patient revenues and an increase in the numbers of uninsured could potentially wreck havoc on an already fragile rural health infrastructure. When developing cost-containment strategies, states should consider ways to protect essential community providers (for example, CAHs or other critical providers in health professional shortage areas) or those that serve a disproportionate share of Medicaid patients. Although any cut-backs in the Medicaid program will have negative consequences for low-income individuals and providers everywhere, state policy-makers must make a concerted effort to insure that rural places do not shoulder more than their share of the burden.

APPENDIX A

States participating in the Medicaid program must agree to cover certain groups of individuals ("mandatory eligibles") and certain services ("mandatory services"). States have the flexibility of covering additional eligibles ("optional eligibles") or services ("optional services"), and may charge certain Medicaid eligibles a nominal copayment for certain services.

Eligibles

Typically, individuals or families must meet three eligibility requirements in order to qualify for Medicaid: categorical, income and resources:

1) *Categorical eligibility*: the individual or family must fit a covered eligibility group, including pregnant women, children, families with dependent children, people with disabilities or older adults (age 65 or older). Absent a federal waiver of program rules, states may not provide Medicaid to people that do not fall within an allowable category of eligible individuals, regardless of how poor the person is. Thus, most states are precluded from covering adults without children if they are not elderly or disabled.

2) *Income limits*: states must cover individuals that fall below federally prescribed income thresholds, but have some flexibility to expand coverage to include categorically qualified persons above the minimum federal income limits.

3) *Resource limits*: states must generally limit coverage to individuals with countable resources below a specified amount. Resources include money in the bank, real property, cars, and certain other assets. States have considerable flexibility in setting the resource limits, and need not impose them for pregnant women or children.

There are a number of different groups of people that states must cover (See Table 6), including: pregnant women and infants and children up to age five with incomes up to 133% of the federal poverty guidelines, children ages 6 through 18 with incomes up to 100% of the federal poverty guidelines, families with dependent children who would have met the Aid to Families with Dependent Children (AFDC) program rules in effect prior to the federal welfare reform changes in 1996, and elderly and disabled who receive Supplemental Security Income (13). [9] States *may* expand eligibility to include persons who meet categorical qualifications, but have higher incomes or more resources. In

[9] Eleven states did not provide Medicaid automatically to older adults and people with disabilities who receive SSI in 2001 (12). These states, known as 209(b) states (named after a different section of the Medicaid statute), limit coverage to the elderly and disabled who would have met the state's program rules for cash assistance that were in effect on January 1, 1972.

1998, 71% of all Medicaid recipients fell into a mandatory eligibility group and 29% fell into an optional group (13).

Table 6
Mandatory and Optional Eligibility Groups

Mandatory Eligibles	Optional Eligibles
• Children below federally prescribed income levels • Adults in families with children (e.g., adults that would have met the states AFDC eligibility requirements, transitional Medicaid) • Pregnant women ≤133% FPL • Disabled SSI beneficiaries • Certain working disabled • Elderly SSI beneficiaries • Medicare Buy-In groups (QMB, SLMB, QI-1, QI-2)	• Children above federal minimum income levels[10] • Adults in families with children (above prior AFDC limits) • Pregnant women >133% FPL • Women diagnosed with breast or cervical cancer • Disabled (above SSI income limits) • Disabled (under Home & Community Based waivers) • Certain working disabled (with income above the SSI income limits) • Elderly (with income above the SSI income limits, State supplement only recipients[11]) • Elderly nursing home residents (with incomes up to 300% SSI levels) • Medically needy

Source: Kaiser Commission on Medicaid and the Uninsured. Medicaid "Mandatory" and "Optional" Eligibility and Benefits. July 2001.

Income and resource eligibility rules are complex, and vary by eligibility category. Historically, states have had the flexibility to establish higher income and resource limits for pregnant women and children (See Table 7).

[10] States that participate in the State Children's Health Insurance Program (SCHIP) were required to maintain the Medicaid eligibility coverage for children that were in effect on June 1, 1997 (Title XXI, Sec. 2105). Thus, while states with higher income limits for children could reduce their Medicaid income eligibility limits and not violate the Medicaid statute, they may violate the SCHIP maintenance of efforts requirements, thereby jeopardizing federal SCHIP funds.

[11] Under federal law, states have the option of providing a state cash supplement to people who receive SSI payments, or to individuals who have income in excess of the SSI income eligibility threshold. In 1999, all but six states provided a state supplemental payment (12).

Table 7
Income and Resource Rules by Medicaid Eligibility Category

Major Medicaid Eligibility Groups:	Income		Resources
	Minimum Limits	Maximum Limits	
Children	*Ages 0-5:* 133% FPG	200% FPG [1, 2]	No resource limit required
	Ages 6-18: 100% FPG	200% FPG [1, 2]	No resource limit required
	Ages 19-20: AFDC income eligibility rules in effect in 1996	AFDC income eligibility rules [1, 2]	AFDC resource rules in effect in 1996 [1]
Pregnant women	133% FPG	185% FPG [1, 2]	No resource limit required
Family with dependent children	AFDC income eligibility rules in effect in 1996	AFDC income eligibility rules [1, 2]	AFDC resource rules in effect in 1996 [1]
People with disabilities	SSI income limits, currently ~74% FPG for individual [3]	100% FPG [1, 2]	SSI resource limits [1]
Working disabled	SSI income limits, currently ~74% FPG for individual	250% FPG	SSI resource limits [1]
Older adults (age 65 or older)	SSI income limits, currently ~74% FPG for individual [3]	100% FPG [1, 2]	SSI resource limits [1]
Medicare buy-in	135% FPG	175% FPG	Twice the SSI resource limits

[1] States can set more "liberal" income and resource rules, effectively eliminating any upper limits on income or resources.

[2] States that have medically needy programs can provide Medicaid coverage to individuals or families with incomes above the state threshold, if the person or family incurs medical bills that equals the difference between their countable income and the state's medically needy income limits. The individual or family is responsible for paying the medical bills equal to this difference (or "spend-down"); Medicaid covers medical bills in excess of the spend-down.

[3] States need not provide coverage automatically to all SSI recipients, as long as they cover the aged, blind or disabled who would have been eligible under state rules in effect in January, 1972 (called the 209(b) option).

Services

States *must* cover certain services, although they may set "reasonable" limits on the coverage, as long as the limits are sufficient to provide the care required by most people needing the care. For example, states must cover hospital services, but may place reasonable limits on the number of hospital inpatient days covered per admission. Similarly, states may put reasonable limits on the number of covered doctor or clinic

visits. States *may* also cover other services, such as prescription drugs, dental services, or therapy services, as long as these services are permitted to be covered under the Medicaid statute. The list of mandatory and optional services are listed in Table 8.

Table 8
Mandatory and Optional Services

Mandatory Services	Optional Services
• Hospitals (inpatient, outpatient) • Physician services Family planning services and supplies • Laboratory and x-ray services • Pediatric and family nurse practitioner services • Federally qualified health center services (community, migrant health centers) • Rural health clinic services • Nurse-midwife services • EPSDT services for children under 21 • Transportation • Nursing facility (NF) services for individuals aged 21 or older • Home health care for persons eligible for nursing facility services	• Prescribed drugs • Medical care or remedial care furnished by licensed practitioners under state law • Clinic services • Diagnostic, screening, preventive and rehabilitative services • Physical therapy and related services • Optometrist services and eyeglasses • Prosthetic devices • Dental services, dentures • Primary care case management services • TB related ambulatory services & drugs for qualifying persons • Intermediate care facilities for the mentally retarded (ICF/MRs) • Inpatient and nursing facility services for individuals 65 years or older in an institution for mental diseases (IMD) • Home health care services (for individuals who are not otherwise eligible for nursing facility services) • Case management services • Respiratory care for people dependent on ventilators • Personal care services • Private duty nursing services • Hospice care • Services provided under a PACE program • Home and community based care to certain persons

Source: Kaiser Commission on Medicaid and the Uninsured. Medicaid "Mandatory" and "Optional" Eligibility and Benefits. July 2001.

Children are entitled to broader coverage. States are required to provide Medicaid eligible children under age 21 with well-child preventive services, called Early and

Periodic Screening, Diagnosis and Treatment (EPSDT). States must also provide services deemed necessary through an EPSDT screening, regardless of whether the state normally covers the service as part of its regular Medicaid program (as long as the service is federally allowable). For example, a state that does not normally cover dental services must pay for required dental services for Medicaid eligible children, if the need for dental care was identified as part of an EPSDT screen. Thus, states have far less flexibility in cutting services to eligible children than they do for eligible adults.

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