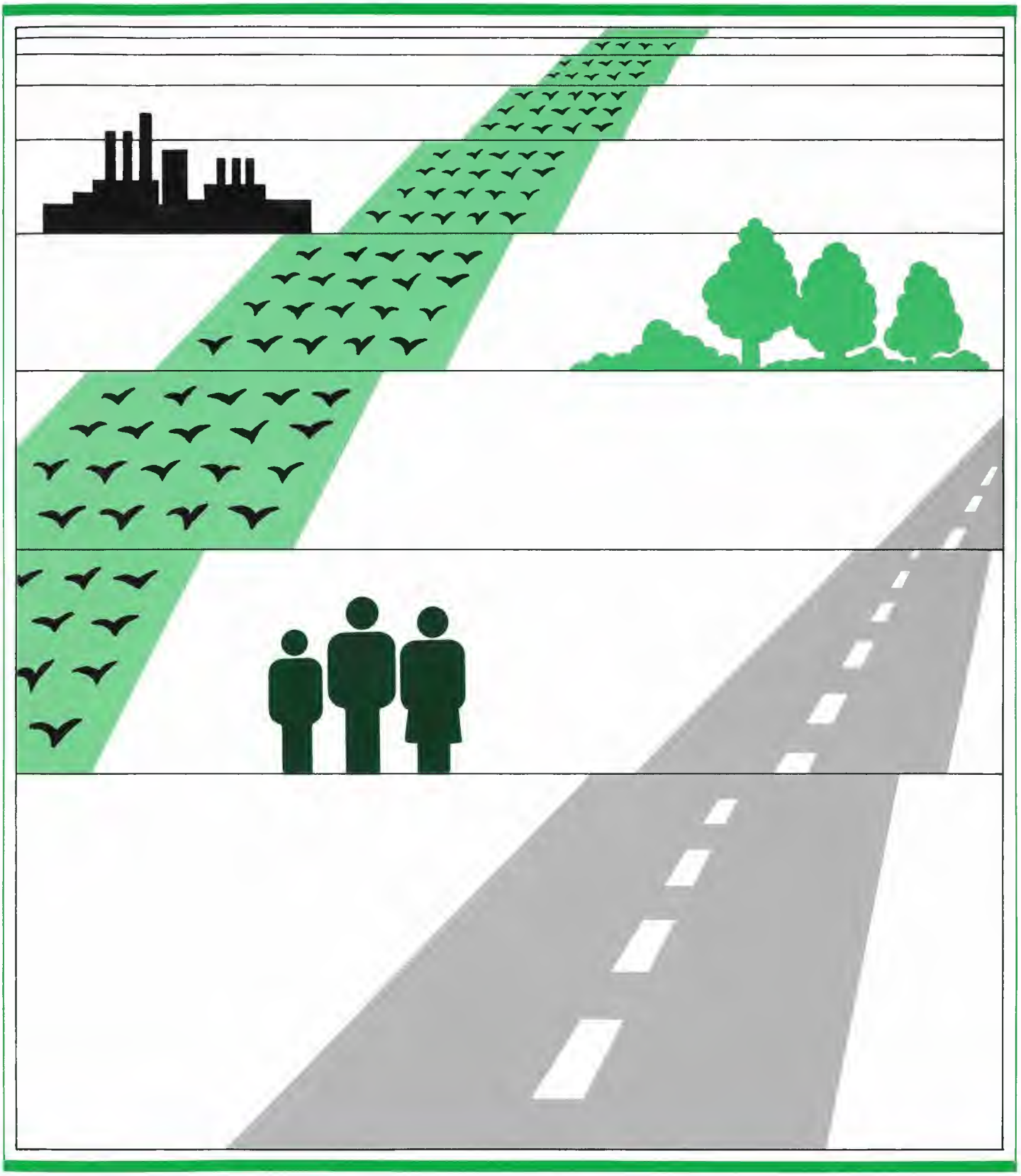
LIMITED ACCESS
Health Care for the Rural Poor



Center on Budget and Policy Priorities

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Health Care for the Rural Poor

Laura Summer

Center on Budget and Policy Priorities

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About the Author

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Preface

That rural residents can face difficulty in obtaining health care services may not seem particularly surprising, since people living in the country must often travel long distances to reach a doctor or hospital. Yet while geographic barriers do limit access to health care for some rural residents, access to health care is also limited by economic factors for many rural people, especially those who have low incomes.

A substantial portion of the rural population is poor. A substantial proportion also lacks health insurance. Poverty rates are higher — and insurance rates are lower — in rural than urban areas. Many rural residents simply cannot afford health care.

This report synthesizes data from a number of sources to examine the availability of health care services for rural residents. The report focuses on the accessibility of those services to the rural low income population. The initial chapters review health status measures and health care service use in rural areas. The data presented here show that when health status is taken into account, rural residents — and particularly the rural poor — make use of health care services to a lesser extent than their urban counterparts do.

The remainder of the report examines factors that prevent some rural residents from receiving needed care. A limited supply of health care providers and inadequate insurance coverage are two factors discussed. The report also examines federal programs that are designed to improve access to health care for the low income population but that do not function as well in rural areas as in urban locations. The report concludes with recommendations to improve access to health care for the rural low income population.

This report is one in a series of Center publications examining the conditions facing low income families and individuals in rural America. Other reports in the series include a demographic overview (*Poverty in Rural America: A National Overview*, April 1989), two reports on the rural working poor (*Laboring for Less: Working but Poor in Rural America*, October 1989, and *Fulfilling Work's Promise: Policies to Increase Incomes of the Rural Working Poor*, February 1990), a report on housing conditions faced by the poor (*The Other Housing Crisis: Sheltering the Poor in Rural America*, December 1989), and a report on income distribution (*The Rural Disadvantage: Growing Income Disparities Between Rural and Urban Areas*, April 1990).

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The author claims sole responsibility for the contents of the report.

Executive Summary

Many rural residents face difficulty in obtaining health care. Access to health care for these residents may be limited by economic as well as geographic barriers and by a shortage of medical providers in rural areas.

These problems are most acute for those rural inhabitants who have low incomes. A substantial fraction of the rural population is poor, with the poverty rate for rural areas exceeding that for urban areas. In addition, when compared with the urban population, a larger proportion of rural residents in general — and of the rural poor in particular — lack health insurance coverage.*

The Health Status of Rural Residents

In general, rural residents are not as healthy as residents of urban areas. While the differences between the metro and nonmetro populations are not great for most measures of health status, the nonmetro population consistently fares worse on these measures than the metro population does. Within the rural population, the health status of low income residents is inferior to that of residents with higher incomes. Poor rural residents are also more likely to be in poor health than are their poor urban counterparts.

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*In this report, the terms "urban," "metropolitan," and "metro" are used interchangeably to describe those areas designated by the Census Bureau as metropolitan statistical areas. The terms "rural," "nonmetropolitan," and "nonmetro" are used interchangeably to describe areas the Census Bureau designates as outside metropolitan statistical areas.

One indication health problems are somewhat greater in rural areas comes from the National Health Interview Survey, conducted annually by the National Center for Health Statistics at the U.S. Department of Health and Human Services. In this survey, people are asked to assess their health status as excellent, very good, good, fair, or poor. The survey results show that a larger proportion of the nonmetro population than of the metro population reports itself to be in fair or poor health.

- For the years 1985 through 1987, fair or poor health was reported by 12.6 percent of nonmetro residents, but by 9.3 percent of metro residents.

- This difference holds across race and age lines with higher proportions of blacks, whites, and elderly people reporting themselves to be in fair or poor health in nonmetro than in metro areas.

- This disparity shows up among low income people, as well. Some 18.8 percent of nonmetro respondents with incomes below $20,000 rated their health as fair or poor, compared with 16.2 percent of metro residents in this income bracket.

- These differences in health assessments between metro and nonmetro residents are accompanied by a second, sharper set of differences: those between low income nonmetro residents and the rest of the nonmetro population. While 18.8 percent of nonmetro residents with incomes below $20,000 rated their health as fair or poor, just 5.7 percent of nonmetro residents at income levels above $20,000 did.

Data on the incidence of medical conditions provide a more objective measure of the health status of rural and urban residents. The incidence of acute conditions — short-term illnesses — is similar in metro and nonmetro areas. But the rate of "restricted activity days" associated with acute conditions — days on which a person must restrict ordinary activities — is greater among nonmetro residents. In addition, nonmetro residents are more likely than metro residents to be affected by chronic conditions — long-term illnesses — and also are more likely to incur injuries.

The Use of Health Care Services in Rural and Urban Areas

Although their health appears to be poorer, rural residents — and particularly poor people in rural areas — generally use health care services to a lesser extent than do their urban counterparts.

When health status is taken into account, nonmetro residents are less likely than metro residents to receive routine care from physicians. In the years 1985 through 1987, nonmetro residents in fair or poor health had fewer annual contacts with physicians than did metro residents in fair or poor health.

Similarly, while pregnant women in nonmetro and metro areas are equally likely to have medical conditions that could affect their pregnancies adversely, a larger proportion of women in nonmetro areas receive inadequate prenatal care. Pregnant women who live in rural areas are more likely than those in urban areas to begin prenatal care late in pregnancy and to make fewer than the recommended number of prenatal visits. Rural residents are also less apt than urban residents to receive adequate pediatric care. Children in fair or poor health see physicians less frequently in rural than in urban areas.

Rural residents in need of primary care services are less likely to receive them than are residents of urban areas. On the other hand, hospitalization rates among individuals in fair or poor health are similar in metro and nonmetro areas, and hospitalization rates among *all* individuals are actually higher in nonmetro areas. It may be that in the absence of primary care providers, rural residents must depend on hospitals to a greater extent than urban residents do.

Barriers to Health Care Services for Rural Residents

For rural residents, particularly those who live in sparsely populated areas, geographic barriers to receiving health care services are significant. Often the population base in rural areas is simply not large enough to support the type of medical facilities and practitioners available to residents of more densely populated areas. In an emergency, the lack of proximity to care can be life threatening. For routine services, the need to travel great distances can be a deterrent to seeking care.

Rural residents with limited resources have more difficulty contending with the limited supply of health care providers. They are more likely to be discouraged by the amount of time required to travel for care, particularly if it results in a loss of income from hours lost at work. Also, transportation may be difficult to arrange. Public transportation is generally not available, and private transportation is often not affordable for low income households.

The Scarcity of Physicians in Rural Areas

One factor limiting access to health care services is the scarcity of physicians in rural areas.

- In 1988, some 111 nonmetro counties in the United States had no physician at all. No metro county lacked a physician.

- That same year there were 97 practicing physicians per 100,000 people in nonmetro counties, compared with 225 per 100,000 people in metro counties.

Primary care physicians — those in general practice, family practice, general internal medicine, general pediatrics and obstetrics and gynecology — provide the majority of care in rural areas. Nevertheless, the supply of physicians participating in each of the primary care specialties is much more limited in rural than urban areas.

The shortage of obstetrical care providers is a particular problem. In 1988, there were 1,473 counties — all of them nonmetropolitan — that lacked even a single obstetrician. This represents almost two-thirds of all nonmetro counties. In addition, 22 states, including all of the 10 most rural states, had large regions with no practicing obstetrician in 1988. This shortage of obstetricians is eased to some extent by the availability of other physicians, such as family practitioners, who provide obstetrical care. Even when other providers are taken into account, however, obstetrical care is less available to women in rural than in urban areas. This problem is likely to worsen in the future, since the number of physicians providing obstetrical care is declining. Escalating malpractice insurance rates, low reimbursement rates from public and private insurers, and an increasing proportion of patients who cannot pay for maternity care are contributing to a continuing drop in the number of maternity care providers.

In 1988, there were also 1,488 nonmetro counties with no pediatrician. The number of pediatricians for every 100,000 women of childbearing age was more than three times higher in metro than in nonmetro areas.

The Vulnerability of Rural Hospitals

For most rural residents, access to hospital care is not as limited as access to ambulatory health care. There are indications, however, the financial viability of some rural hospitals is being threatened. Hospital closings can have a significant impact not only on access to hospital care in rural areas, but also on

the availability of primary care services. Communities without hospitals have a harder time attracting and retaining health care professionals.

From 1981 through 1988, some 398 community hospitals closed. About half — 48 percent — were located in rural areas. The percentage decline in the number of nonmetro hospitals during that period — 7.8 percent — far excluded the 2.1 percent decline in the number of metro hospitals.

Financial Barriers to Receiving Health Care

Many rural residents face significant financial barriers to receiving health care. Poverty rates are higher in rural than urban areas. Some 15.7 percent of the nonmetro population had incomes below the poverty level in 1989, compared with 12 percent of the population in metro areas.

Also, a substantial proportion of the rural population has no health insurance. Some 16.9 percent of all nonelderly nonmetro residents had no health insurance coverage in 1988, compared with 15.4 percent of nonelderly metro residents. In addition, during a 28-month period ending in May 1987, some 32 percent of nonmetro residents — nearly one in every three — lacked insurance for at least one month.

Insurance coverage rates are particularly low for the poor, women of childbearing age, and single-parent families. For all these groups, nonmetro residents have lower coverage rates than do metro residents. For example, 37.1 percent of the nonelderly poor in nonmetro areas lacked coverage in 1988, compared with 34.3 percent of those in metro areas.

A number of factors are associated with low health insurance coverage rates in rural areas. The poor are more likely to be uninsured than those with higher incomes, and a higher proportion of the nonmetro than of the metro population is poor. Also, health insurance coverage is closely related to employment, but a smaller proportion of nonmetro than of metro employees receive coverage through their jobs.

The differences are especially large among small businesses. A 1989 survey found that 46 percent of small businesses in rural areas do not sponsor health insurance for their employees, a figure far above the 28 percent of small businesses in urban areas that decline to provide coverage. In addition, 40 percent of all rural agricultural workers and their families had no coverage in 1988.

Another factor accounting for lower health insurance coverage rates in rural areas is the variability in Medicaid eligibility rules from state to state. Medicaid

eligibility rules tend to be more restrictive in rural than in urban states. As a result, low income residents in rural areas are not as well served by Medicaid as their urban counterparts.

- In 1988, 38.7 percent of the nonmetro poor had Medicaid coverage.
- Some 44.8 percent of poor residents in metro areas had such coverage.

The Role of Federal Programs in Providing Access to Care in Rural Areas

National Health Service Corps

The National Health Service Corps was established in 1972 to address problems stemming from the uneven geographic distribution of health care providers in the United States and the resulting inadequate access to health care services for many population groups. The Corps recruits physicians and other health professionals to serve in areas with a shortage of health professionals. These areas are known as health professional shortage areas, or HPSAs. The National Health Service Corps is particularly important to rural areas. Of 1,956 health professional shortage areas in 1990, some 70 percent were in rural areas.

Over the years, the NHSC has placed thousands of health care practitioners in needy communities. These practitioners agree to serve in health professional shortage areas in exchange for financial assistance with their educational expenses. Unfortunately, however, the effectiveness of the Corps has diminished sharply over the past decade, as funding for the program has been reduced. Funding peaked in fiscal year 1980 with an NHSC appropriation of $153.6 million. By contrast, the appropriation for fiscal year 1990 was only $50.7 million. This represented a decline of 77 percent, after adjusting for inflation.

As a result of these reductions, the field strength of the Corps has declined. At its peak, the Corps had 3,300 health care professionals in service. By 1989, only 1,944 professionals remained — fewer than half what the Department of Health and Human Services estimated was needed to provide service in health professional shortage areas. Many HPSAs now lack health care providers.

In October 1990, legislation was enacted to reauthorize the NHSC through the year 2000 and to begin rebuilding the Corps. The legislation includes provisions designed to increase the number of health care providers in health professional shortage areas. A scholarship program that had attracted medical students to the Corps, but was terminated in 1987, is reinstated, and a student

loan program is made more attractive. Other provisions are aimed at increasing the proportion of providers who will remain in HPSAs after their term in the Corps ends.

This legislation should help revitalize the National Health Service Corps — *if* funds are available to implement the initiatives and to recruit a sufficient number of health care providers. The fiscal year 1991 appropriation of $91.7 million for the Corps represents an increase of $41 million over the fiscal year 1990 appropriation. However, after inflation is taken into account, the appropriation for fiscal year 1991 is still 64 percent lower than funding was a decade earlier. In addition, the Bush Administration's funding request for fiscal year 1992 — $96.1 million — does little more than maintain the fiscal year 1991 level, after adjustment for inflation.

The number of providers delivering health care services will eventually increase, as students now entering the scholarship program graduate and enter in the Corps. The Corps, however, will be able, in the immediate future, to supply only a modest fraction of the health care providers needed in underserved areas. The current scarce supply of NHSC providers continues to leave many rural communities without health care professionals.

Community and Migrant Health Centers

Community health centers provide primary health care services in areas designated as "medically underserved" by the Department of Health and Human Services. The Migrant Health Centers program funds facilities much like community health centers that serve migrant and seasonal agricultural workers and their families. Many health centers receive funding from both the Community and Migrant Health Centers programs.

While the health services provided by community and migrant health centers are available to anyone in the area a center covers, the centers primarily serve patients with limited resources. In 1989, almost half of community and migrant health center patients — 49 percent in rural centers and 48 percent in urban centers — were uninsured. Most other patients had insurance through a government program.

Community and migrant health centers are a particularly important source of health care services for low income rural residents. In 1989, some 60 percent of the community health centers were located in rural areas. Almost all funding for the migrant health center program supports centers located in rural areas. Nevertheless, due to funding constraints, many rural areas lack access to a community or migrant health center. Three of the 10 most rural states —

Montana, North Dakota, and Wyoming — have just one or two centers in the entire state.

In addition, in areas that have a center, the need for health care services often outstrips the ability of the center to provide them. A survey of community health centers in 1987 found long waiting lists of individuals seeking care. The waiting lists averaged between 15 percent and 28 percent of patient enrollment.

Adding to the centers' problems are rapidly rising health care costs. Many centers must devote increasing portions of their budgets to recruiting physicians, offering more competitive salaries, and paying the escalating cost of medical malpractice insurance premiums. Some centers must also pay for needed capital improvements. Other centers have been affected by the reductions in the ranks of the National Health Service Corps; in 1990, more than two-fifths of all physicians at community health centers were members of the Corps. In addition, the centers face an increased patient load. Between 1984 and 1988, the number of patient visits at rural community health centers rose from 9.3 million to 11 million. Finally, the centers are burdened financially by a patient population increasingly unable to pay for health care.

Despite these financial burdens, federal funding for community health centers has remained virtually unchanged since 1981, after adjusting for inflation. If the adjustment is made using inflation in medical care costs, rather than inflation in the economy as a whole, funding is found to have declined significantly. During the same period, funds for migrant health centers have fallen 21 percent, after adjusting for inflation. The Bush administration's fiscal year 1992 budget request includes no additional funding for Community and Migrant Health Center programs. With inflation, program funding will actually decline about four percent in fiscal year 1992.

Community and migrant health centers should benefit financially from federal legislative changes. These changes will increase the level of reimbursement the centers receive for providing services to Medicaid and Medicare beneficiaries. These increased reimbursements should enable some centers to reduce waiting lists and to provide care for a larger number of individuals who lack health insurance coverage. Some centers may also be in a position to expand the range of health care services they offer. Nevertheless, if new health centers are to be established in a substantial number of medically underserved areas, the Medicaid and Medicare changes will be insufficient. Significant increases in appropriations for the Community and Migrant Health Center programs will also be needed.

The Medicaid Program

Both federal and state funds finance Medicaid, a health insurance program that pays for medical services for low income families with children and low income people who are elderly or have disabilities. States administer the program, and within federal guidelines, they make many of the key decisions on where to set income eligibility limits, which groups to cover, and which services to pay for.

Medicaid eligibility rules are generally more stringent in rural than urban states. Consequently, the proportion of low income people eligible for Medicaid is lower in nonmetro than in metro areas.

State Variations in Medicaid Eligibility for Families with Children

Federal law requires all states to provide Medicaid benefits to pregnant women, infants, and children under age six with family incomes below 133 percent of the federal poverty line. However, states have the option of going beyond these mandates and providing Medicaid benefits to pregnant women and infants with family incomes up to 185 percent of the poverty line.

- As of July 1990, four of the 10 most rural states had income limits for pregnant women and infants greater than 133 percent of the poverty line. By contrast, eight of the 10 most urban states did.

- None of the frontier states sets income eligibility limits for pregnant women and infants above 133 percent of the poverty line.

As of July 1, 1991, states will also be required to extend coverage to poor children age six and older who were born after September 30, 1983. This requirement will phase in Medicaid coverage over the next 12 years for poor children from the ages of six through 18. By October 1, 2002 — when this requirement will be fully phased in — virtually all poor children less than 19 years of age will be eligible for Medicaid.

For many members of low income families — including women who are not pregnant and (until October 1, 2002) some poor children age six and over — Medicaid eligibility remains based either on eligibility for AFDC or, in some states, on income limits for the Medically Needy component of the Medicaid program. This is an optional program that provides Medicaid coverage to some individuals who have high medical expenses.

State Definitions

In this report, states are ranked as urban or rural according to the proportion of the population in each state living in metro and nonmetro areas.

The 10 most rural states are: Idaho, Vermont, Montana, South Dakota, Wyoming, Mississippi, Maine, West Virginia, North Dakota, and Arkansas.

The 10 most urban states are: New Jersey, the District of Columbia, California, Maryland, Connecticut, Rhode Island, Florida, Massachusetts, New York, and Pennsylvania.

States in which approximately half or more of the counties are very sparsely populated are termed "frontier states." The nine frontier states are: Montana, Wyoming, North Dakota, Nevada, Utah, South Dakota, New Mexico, Colorado, and Idaho.

- In eight of the 10 most rural states, Medicaid income limits for families with children are below 50 percent of the poverty line. This is true in only one of the 10 most urban states.

- The median Medicaid income limit for a family of three is $373 per month in the 10 most rural states. It is $638 per month in the 10 most urban states, a difference that far exceeds any variation in the cost-of-living.

State Variations in Medicaid Eligibility Rules
For People Who are Elderly or Have Disabilities

Medicaid eligibility rules for the elderly and for people with disabilities also tend to be more restrictive in rural than in urban states. The Medicaid eligibility rules for these groups are tied closely to eligibility for the Supplemental Security Income program. In about half of the states, the federal SSI income limit effectively serves as the Medicaid income limit for people who are elderly or have disabilities. Most of the remaining states add a state supplemental SSI benefit to the federal SSI benefit. In these states, SSI income eligibility limits are raised when state supplemental benefits are provided. This usually leads to an increase in Medicaid income limits as well. Rural states are less likely than urban states to provide these SSI supplemental benefits. As a result, Medicaid income limits for SSI beneficiaries tend to be significantly lower in rural than in urban states.

States also have an option to extend Medicaid eligibility to elderly people and people with disabilities who are not on SSI but who still are poor. Essentially, states can cover elderly people and people with disabilities whose incomes fall between the state's SSI income limit and the poverty line. As of July

1989, some 13 states had adopted this option. Urban states make greater use of the option than rural states do.

Taking into account the various state options, the most urban states have considerably more generous Medicaid eligibility rules than the most rural states do. (Income eligibility limits for people with disabilities generally are the same or similar to those for the elderly.)

- In 1989, Medicaid income at eligibility limits for elderly individuals and couples were at the poverty line or higher in eight of the 10 most urban states.

- By contrast, in eight of the 10 most rural states, Medicaid income limits for elderly individuals and couples fell below the poverty line.

- In all nine frontier states, Medicaid income limits for elderly people were below the poverty line.

Facilitating Application and Enrollment

Some of those eligible for Medicaid benefits may not receive them because of a cumbersome application process. States have a number of options available to streamline the application process. However, many rural states fail to use these options.

One such option is known as "presumptive eligibility." This enables publicly funded health clinics to make temporary determinations of Medicaid eligibility at sites where pregnant women receive health care. The women must then apply for benefits at the Medicaid agency before the end of the following month. In states adopting this option, pregnant women receive immediate Medicaid coverage for prenatal care. In states without presumptive eligibility, pregnant women must go to the local welfare office to apply for Medicaid and then may have to wait up to 45 days for their application to be processed.

- As of July 1990, three of the 10 most rural states had elected the presumptive eligibility option. Six of the 10 most urban states had.

- Four of the nine frontier states had a presumptive eligibility program.

In a majority of states, poor elderly people and people with disabilities who receive SSI benefits are automatically enrolled in Medicaid. No separate Medicaid application is required. In six states, a separate application must be filed with the state Medicaid agency, even though all SSI recipients who apply will be granted

Medicaid coverage. Three of these states — Idaho, Nevada, and Utah — are frontier states. Filing a separate application is particularly burdensome for elderly applicants living in rural areas and frontier areas where the population is widely dispersed.

In all states, a new group of low income elderly people and people with disabilities is eligible for a limited form of Medicaid assistance. Known as Qualified Medicare Beneficiaries, these people have incomes below the poverty line but are not otherwise eligible for Medicaid coverage in their states. They now are eligible to have Medicaid pay all Medicare cost-sharing charges for them — but to receive this assistance, they must file an application with the Medicaid office. Preliminary data indicate that many eligible elderly and disabled poor are not aware of this and have not applied. Major outreach efforts in this area appear to be needed. Such efforts are particularly significant in rural areas; a disproportionate share of the people eligible for this new benefit are rural residents.

Services Covered Under Medicaid

In addition to having discretion over many Medicaid eligibility rules, states have considerable discretion over which medical services will be covered. While federal law requires coverage for nine core services, whether to provide coverage for 33 additional services is left up to the state. In 1990, only two of the 10 most rural states covered more than 25 of the 33 optional services. By contrast, six of the 10 most urban states did.

States are also allowed to provide additional services for specific groups of beneficiaries. For example, states may choose to cover a number of special "enhanced prenatal services" for pregnant women. Half of the highly rural states fail to provide coverage for enhanced prenatal services. Most of the highly urban states do cover these services.

Provider Participation

For Medicaid beneficiaries, access to services is also determined by the willingness of health care providers to accept Medicaid patients. The scarcity of medical practitioners willing to accept Medicaid patients is a growing problem in many areas of the country. Participation among obstetricians is particularly low, and participation among pediatricians has declined in recent years. In rural areas, where there is a shortage of maternity care providers, concerns about the effect of low Medicaid participation by these providers is particularly acute. In a National Governors' Association survey, 35 states reported that lack of maternity care

providers was a significant problem for low income women in rural areas. Only three states reported such a problem in urban areas.

One reason physicians commonly cite for low Medicaid participation is the low rates the program pays for medical services. A study by the American Academy of Pediatrics found that pediatricians were less likely to participate in Medicaid in 1989 than they had been in 1978. Those who did participate in 1989 were more likely to limit their participation. When pediatricians were asked to identify reasons for not participating in Medicaid or for limiting participation, 71 percent cited low Medicaid reimbursement rates. A survey by the American College of Obstetricians and Gynecologists finds considerable variation among states in Medicaid reimbursement rates with the rates for routine obstetrical care generally lower in rural states than in urban ones.

Recommendations

The recommendations in this report focus on several programs that could improve rural residents' access to health care — the National Health Service Corps, Community and Migrant Health Center Programs, and Medicaid. This approach emphasizes changes that can have positive effects now. In the long term, both a restructuring of the health insurance system and a policy to insure that health care services are widely available are needed. But the lack of agreement about how to restructure the health care system and finance major changes in it makes it unlikely large-scale restructuring is imminent. Moreover, if major health care reform legislation is enacted and financing becomes available, such changes are likely to take some years to implement. In the interim, existing programs will need to be as strong as possible. In addition, these programs may also become part of a reformed health care system.

The National Health Service Corps

Congressional action in 1990 reauthorizing the National Health Service Corps through the year 2000 represents a federal commitment to improve access to health care in areas with a shortage of primary health care providers. With adequate funding of the NHSC, the supply of health practitioners in rural areas should increase. The critical issue is funding. To build a strong National Health Service Corps, substantial increases are needed.

Unfortunately, the large federal budget deficit and the new spending ceilings on domestic non-entitlement programs make it probable the amounts appropriated will remain insufficient to achieve the program's goals in full. If primary health

care services are to be available in all areas of the country, state efforts will need to complement the work of the Corps.

- Substantial increases are needed in the federal funds appropriated for the National Health Service Corps.

- States should establish programs that offer financial assistance in return for a commitment from recipients to practice medicine in designated areas of the state.

- Financial aid should be directed to the training of primary care practitioners.

Community and Migrant Health Centers

The majority of community and migrant health centers are located in rural areas, and they improve access to health care for many rural residents. The centers provide health services to many low income rural people who might otherwise go without care. But Community and Migrant Health Center programs could have a greater impact if existing centers could serve more patients and if more centers could be established.

- Funding for community and migrant health centers should be increased significantly so that waiting lists can be sharply reduced or eliminated and necessary improvements made at these centers — and also so that centers can be established in more medically underserved areas.

- The Federal Tort Claims Act should be extended to cover all practitioners providing obstetrical care in community and migrant health centers so that the centers do not have to use large portions of their federal grants to pay for escalating malpractice insurance costs.

The Medicaid Program

Efforts to expand Medicaid eligibility, to reach and enroll newly eligible people, and to insure that those with Medicaid coverage are able to receive the health care services they need can significantly increase access to health care for the low income rural population.

While the federal government pays at least half of all Medicaid costs, any expansion requires state funds. With the current economic downturn, some states will have difficulty contemplating further Medicaid expansions in the near future.

But economic problems are more severe in some states than in others. In addition, states may be able to consider these improvements when the economic downturn ends and the economy — and state revenues — begin to grow at a more normal pace.

In assessing the Medicaid recommendations discussed here, states should consider longer-term effects as well as short-term costs. In particular, since the federal government pays a substantial share of Medicaid costs in all states, Medicaid brings federal funds into state economies.

This is particularly significant for rural states, because the percentage of Medicaid costs paid by the federal government is generally higher there than in urban states. In the 10 most rural states, the federal government pays from 62.8 percent to 80.2 percent of Medicaid costs. In six of these states, the federal matching rate exceeds 70 percent.

Since Medicaid is administered and financed through a federal-state partnership, some changes are most appropriately made at the federal level, while other changes involve state decisions to take greater advantage of program options.

Federal Action

- Income eligibility limits should be increased to provide Medicaid for all pregnant women and infants with family incomes below 185 percent of the federal poverty line.

- The assets test for pregnant women, infants, and young children should be eliminated.

- Congress should give states the option to increase income eligibility limits to provide Medicaid for children with family incomes below 185 percent of the federal poverty line.

- Elderly people and people with disabilities should be permitted to apply at Social Security offices to become Qualified Medicare Beneficiaries.

- Efforts should be made to better publicize the availability of Qualified Medicare Beneficiaries.

State Action

- In the absence of federal mandates, states should expand Medicaid coverage for pregnant women and infants with family incomes up to 185 percent of the poverty line.

- Medicaid offices should work with community and migrant health centers to establish systems for the on-site acceptance and initial processing of applications for Medicaid from pregnant women and children.

- All Medicaid programs should offer "presumptive eligibility" for pregnant women.

- States with automatic Medicaid eligibility for SSI recipients should remove the requirement for elderly people and people with disabilities to file a separate application for Medicaid.

- States should publicize new Medicaid income eligibility limits and emphasize that Medicaid coverage is available apart from participation in the AFDC or SSI program.

- Outreach efforts should be targeted to reach families who do not ordinarily participate in public assistance programs.

- States should publicize the Medicaid EPSDT program so more families are aware that comprehensive coverage for preventive and curative services is available for children.

- Outreach efforts should be targeted to reach elderly people and people with disabilities who do not ordinarily participate in public assistance programs.

- Medicaid programs should provide coverage for a wide range of enhanced prenatal services.

- States should take steps to improve the likelihood that beneficiaries are able to find a provider who will deliver the services their Medicaid program offers.

- Medicaid programs should provide coverage for home and community-based services for the frail elderly.

- Medicaid programs should offer higher reimbursement rates for obstetricians and pediatricians who practice in areas with provider shortages.

- Medicaid programs should provide other incentives to encourage the participation of health care providers who practice in geographic areas or medical specialties with a shortage of Medicaid providers.

I. Health Status of Rural and Urban Residents

Rural residents tend not to be as healthy as residents of urban areas. And poor rural residents are less healthy than either other rural residents or poor urban people.

People living in rural areas have less favorable perceptions of their own health status than people in urban areas do. In addition, the data show that rural residents are more likely than urban residents to be affected by chronic health conditions and to have injuries. There is also evidence suggesting that the severity of medical conditions may be greater among the rural population. A greater proportion of rural than urban residents report they restrict their activities because of illness.

The magnitude of the differences between the urban and rural populations is not great for most individual health measures. Nonetheless, a consistent pattern emerges. On one health status measure after another, the rural population consistently fares less well than the urban population does.

Assessments of Health Status

One indication that health problems are somewhat greater in rural than in urban areas comes from the National Health Interview Survey, a survey conducted annually by the National Center for Health Statistics at the U.S. Department of Health and Human Services. In this survey, respondents are asked to assess their own health as excellent, very good, good, fair, or poor. Self-assessments are a subjective measure and are not as reliable as other, more objective measures of health status. The consistency of the differences in the survey between metro and nonmetro residents, however, suggests the nonmetro population is likely to be in poorer health than the metro population.

Defininging Rural and Urban Areas

In this report, the terms "urban," "metropolitan," and "metro" are used interchangeably to describe those areas designated by the Census Bureau as metropolitan statistical areas. The Census Bureau defines a metropolitan statistical area as a "geographic area consisting of a large population nucleus, together with adjacent communities which have a high degree of economic and social integration with that nucleus. The definitions specify a boundary around each large city so as to include most or all of its suburbs. Entire counties form the MSA building blocks, except in New England where cities and towns are used...An area qualifies for recognition as an MSA if (1) it includes a city of at least 50,000 population, or (2) it includes a Census Bureau-defined urbanized area of at least 50,000 with a total metropolitan population of at least 100,000 (75,000 in New England)."

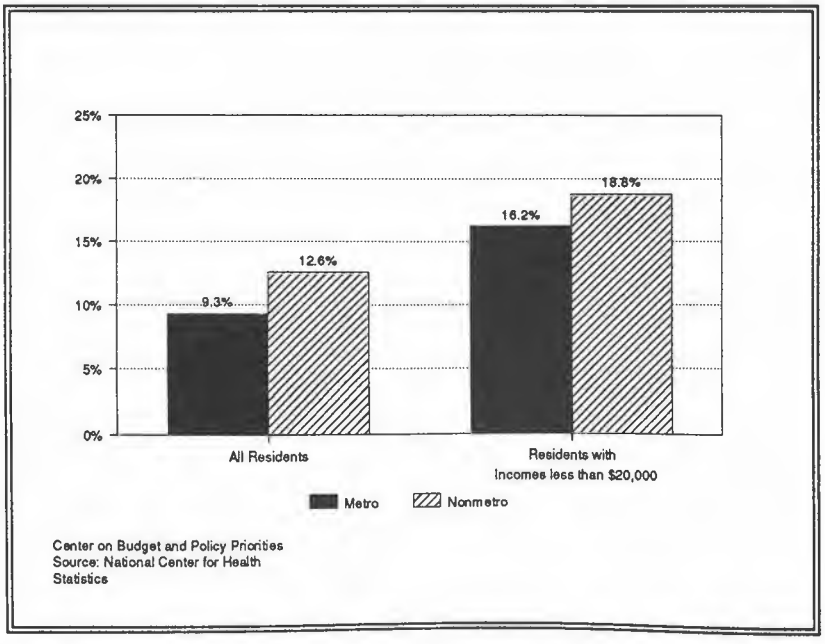
The terms "rural," "nonmetropolitan," and "nonmetro" are used interchangably to describe those areas that the Census Bureau designates as being outside the metropolitan statistical area. (Bureau of the Census, U.S. Department of Commerce, *Poverty in the United States: 1986*, Series P-60, N. 160, June 1988, p. 151.)

From 1985 to 1987, for example, 12.6 percent of nonmetro residents responding to the survey reported themselves in fair or poor health. This compared with 9.3 percent of metro residents who gave a similarly low assessment of their health status.

Among low income residents (those with household incomes below $20,000), some 18.8 percent of those in nonmetro areas rated their health as fair or poor, while 16.2 percent of those in metro locations gave such an assessment.

A similar disparity shows up across racial groups. Some 8.6 percent of the white population in metro areas reported being in fair or poor health. Some 11.9 percent of the white population in nonmetro areas did. Similarly, 14.4 percent of blacks living in metro areas rated their health as fair or poor, but 20.6 percent of nonmetro blacks did.

Figure 1
Health Status of Low Income Residents:
Percent Reporting Fair or Poor Health

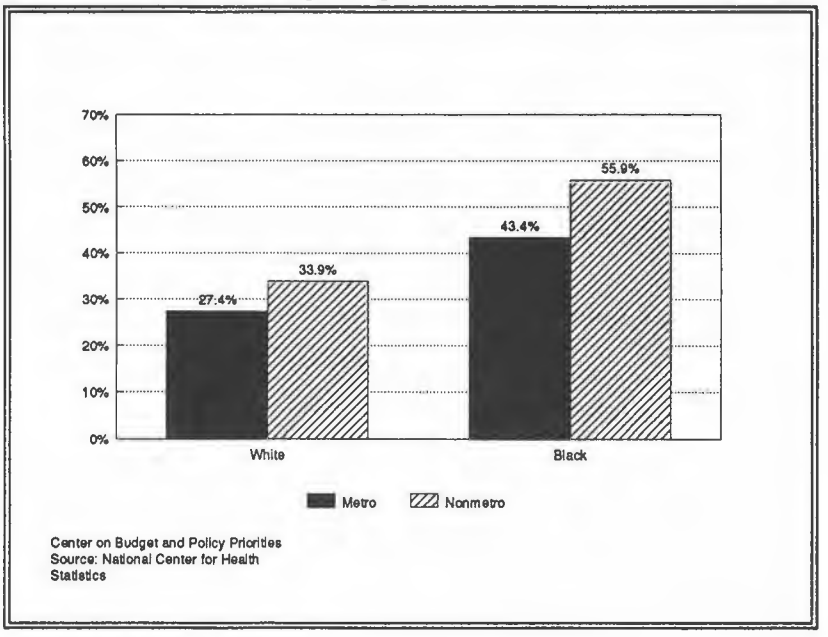


As urban and rural residents get older, the disparities between their

assessments of their health appear to widen. Some 27.4 percent of elderly whites in metro areas said they were in fair or poor health, but 33.9 percent of nonmetro elderly whites gave this response. And while 43.4 percent of urban elderly blacks rated their health as fair or poor, 55.9 percent of rural elderly blacks did.

Differences in health assessments between urban and rural residents are accompanied by a second, even sharper set of differences — those between low income rural individuals and the rest of the rural population. Some 5.7 percent of nonmetro residents with family income of $20,000 or more rated their health as fair or poor. Among nonmetro residents whose incomes fell below this level, however, the proportion describing their health as fair or poor was 18.8 percent, or more than three times as high.

Figure 2
Health Status of Elderly Residents:
Percent Reporting Fair or Poor Health



Medical Conditions

Data from the National Health Interview Survey on the incidence of medical conditions — and their effect — provide a more objective measure of the health status of rural and urban residents. These data show the incidence of *acute* conditions to be similar for the nonmetro and metro populations. In nonmetro areas in 1988, there were 174.6 acute conditions for every 100 persons. In metropolitan locations, there were 175.5 acute conditions for every 100 residents.

Yet the data also reveal that the rate of "restricted activity days" associated with acute conditions — days on which a person must restrict ordinary activities — is greater among nonmetro residents. For every 100 residents in nonmetro areas, there were 734 restricted activity days associated with acute conditions during 1988. In metro areas, there were 690 restricted activity days per 100 persons that year. This suggests that the severity of these conditions may be somewhat greater among the nonmetro population.

The National Health Interview Survey

Much of the information about the health status of the U.S. population comes from the National Health Interview Survey, a nationwide survey of health characteristics conducted annually by the National Center for Health Statistics.

The data presented in this chapter and the next chapter are from a 1989 publication of the National Center for Health Statistics, "Current Estimates from the National Health Interview Survey, 1988", and from a special NCHS analysis entitled "Health of Black and White Americans, 1985-87." The special analysis relies on pooled data from the National Health Interview Surveys conducted in 1985, 1986, and 1987.

Acute and Chronic Conditions

The National Health Interview Survey contains data on the incidence among the population of various acute and chronic health conditions. An *acute* condition, as defined in the National Health Interview Survey, is a type of illness or injury that ordinarily lasts less than three months, was first noticed less than three months before the date of the survey interview, and was serious enough to have had an impact on behavior. *Chronic* conditions are defined as those that either were first noticed at least three months before the date of the survey interview or belong to a group of conditions, such as heart disease or diabetes, that are considered chronic regardless of when they began.

The survey also measures "restricted activity days" associated with acute and chronic conditions and injuries. Four types of restricted activity are measured: days lost from work for currently employed persons, school days missed, days spent in bed, and days on which a person cuts down on the things he or she usually does.

Acute conditions also account for more days lost from work in rural areas. In 1988, the number of lost work days associated with acute conditions was 318 per 100 persons in nonmetro areas. This compared with 309 lost work days per 100 persons in metro locations.

When *chronic* conditions are examined, rural residents are more likely than their urban counterparts to be affected. For 50 of 65 chronic conditions studied in the 1988 National Health Interview Survey, the likelihood of having the condition was greater among nonmetro than metro residents. Also, chronic conditions restricted the activities of a larger proportion of the nonmetro population (16.3 percent) than of the metro population (13 percent).

In both rural and urban areas, people with lower incomes suffer more activity limitations due to chronic conditions than do people at higher income levels. Low income rural residents face these problems somewhat more frequently than their urban counterparts. The 1987 National Health Interview Survey found that 22 percent of all nonmetro residents with family incomes below $20,000 had to restrict their activities at some point during the year because of chronic

conditions. By comparison, 19.8 percent of metro residents in this income category had activity restrictions.

Injuries, also, are somewhat more common in nonmetro areas. In 1988, there were 25.8 injuries for every 100 nonmetro residents. In the same year, there were 23.4 injuries for every 100 metro residents. As with other types of infirmities, the restricted activity resulting from injuries was greater in rural than in urban locations. The number of restricted activity days associated with injuries in 1988 was 273 per 100 persons in nonmetro areas. This compared with 245 restricted activity days per 100 persons in metro areas.

* * * * *

The consistency of these patterns indicates that rural residents are probably not as healthy as their urban counterparts and that low income rural residents have the poorest health of all. Accordingly, poor rural residents are likely to have as much or more of a need for health care services as any other group.

II. The Use of Health Care Services

Do rural residents receive adequate health care? Data on the use of health care services by rural residents help answer this question.

By themselves, data on the use of health care services do not indicate whether the care is adequate. To determine this, health status must be taken into account. For example, two groups may see physicians with the same frequency. However, people in the first group may visit the doctor infrequently because they are healthy and not in need of services. Those in the other group may make infrequent visits because, despite their need for health care, doctors are not available or they can not afford the services.

In this chapter, data on the use of health services are examined in the context of the health status of the rural population. The data show that many nonmetro residents in fair or poor health visit physicians less frequently than metro residents in fair or poor health. Also, while pregnant women in nonmetro and metro areas are equally likely to have medical conditions that could affect their pregnancies adversely, those in nonmetro areas are less likely to receive adequate prenatal care. The conclusion that emerges is that the health care needs of nonmetro residents are not being met adequately.

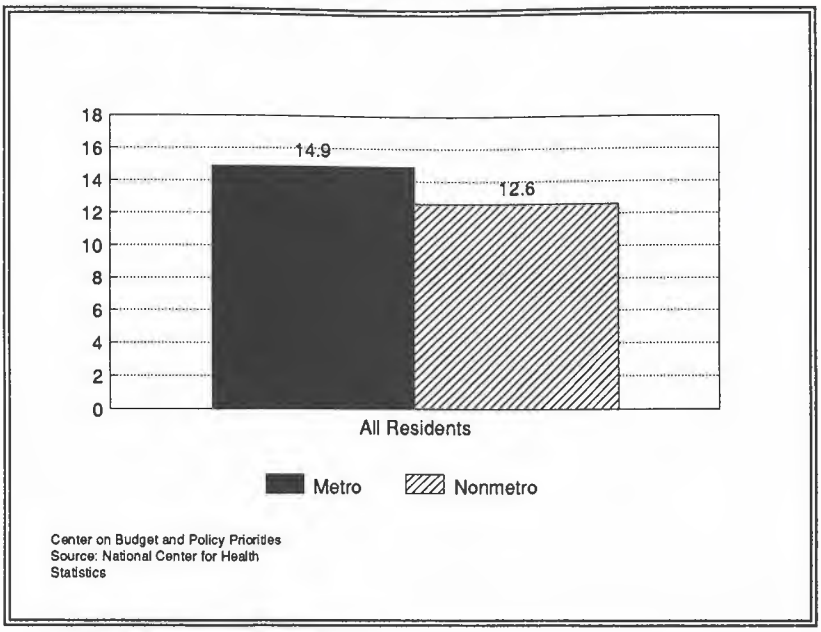
Use of Medical Services By Residence

Care from Physicians

Rural residents in fair or poor health have less contact with physicians than their urban counterparts. While the average annual number of physician contacts

was similar for *all* people living in nonmetro and metro areas from 1985 through 1987,[1] the number of contacts was lower for nonmetro residents in fair or poor health than it was for their metro counterparts. Nonmetro residents in fair or poor health averaged 12.6 physician contacts per year. Metro residents in fair or poor health had an average of 14.9 contacts.[2]

Figure 3
Annual Physician Contacts for Residents in Fair or Poor Health



Hospital Care

Data from the National Health Interview Survey track the extent to which members of a population are hospitalized during the course of a year. Data for 1985 through 1987 show that hospitalization rates were higher for nonmetro residents than for their metro counterparts.[3] Nonmetro residents averaged 13.5 annual discharges per 100 persons, compared with 11.4 discharges per 100 residents for the metro population. However, there was little difference in hospitalization rates among nonmetro and metro residents who rated themselves as being in fair or poor health.

The higher overall hospitalization rate for nonmetro residents may result from the hospitalization of patients for simple procedures that might be done on an outpatient basis if other facilities were more readily available in nonmetro areas.

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[1]The average number of contacts during the period was 5.1 per year for nonmetro residents and 5.4 per year for metro residents.

[2]Contacts are defined in the National Health Interview Survey as "a consultation with a physician, in person or by telephone, for examination, diagnosis, treatment, or advice."

[3]Hospitalization rates are measured as the average annual number of discharges from a "short-stay" hospital per 100 persons. A "short-stay" hospital is one in which the type of services provided is general; maternity; eye, ear, nose, and throat; children's; or osteopathic.

Use of Specific Services

Prenatal Care

Data from the 1980 National Natality Survey — the latest data available — indicate that approximately 20 percent of metro and nonmetro women alike had medical conditions that could adversely affect their pregnancies. A smaller proportion of pregnant women in nonmetro areas, however, received adequate prenatal care.[4] [5]

Only 63.2 percent of pregnant women in nonmetro areas received adequate prenatal care in 1980. By comparison, 67.2 percent of pregnant women in metro areas received adequate prenatal care.

A lower proportion of both married and unmarried women in nonmetro areas received sufficient prenatal care. For example, just over one third of unmarried women in nonmetro areas — 35.8 percent — received adequate prenatal care. In metro areas, 44.5 percent of unmarried women received adequate care.

In assessing the adequacy of prenatal care, the point when care begins is a particularly important element to consider. Prenatal care should begin in the first trimester of pregnancy. However, a large proportion of poor women, particularly poor women living in nonmetro areas, begin care after the first trimester.

- In 1980, more than one quarter of poor pregnant women in both nonmetro and metro areas did not make their first prenatal care visit until after the first trimester. Some 26.9 percent of poor pregnant women in metro areas did not have their first visit until the second trimester or later. In nonmetro areas, the percentage was even higher, with 28.9 percent of pregnant women having no prenatal visits in the first trimester.

- Even among non-poor women who are pregnant, the proportion failing to receive prenatal care during the first trimester is substantial — and here, too, the proportion was higher in nonmetro than in

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[4]The adequacy of prenatal care is determined using a modified version of the Kessner Index. The index measures the adequacy of care by examining three elements: the point at which prenatal care began, the number of prenatal visits and the gestational length of the pregnancy. Gestational length refers to the number of completed weeks elapsed between the beginning of pregnancy and the date of delivery.

[5]Data from the 1990 National Mortality Survey are reported in *The Financing of Maternity Care in the United States*, the Alan Guttmacher Institute, December 1987.

metro areas. In 1980, some 12.6 percent of the non-poor pregnant women in metro areas had their first prenatal care visit in the second trimester or later. By comparison, 16.2 percent of non-poor pregnant women in nonmetro areas — nearly one in six — received no prenatal care in the first three months of their pregnancies.

- More recent data from the National Center for Health Statistics show a similar pattern. These data indicate that in 1987, some 20.8 percent of all mothers in metro areas and 24.2 percent of all mothers in nonmetro areas began prenatal care after the third month of pregnancy.[6]

Limited access to maternity care can have a profound effect on the outcome of a pregnancy. A recent study from Washington state examined the association between the local availability of obstetrical care and birth outcomes. Women from rural communities with relatively few obstetrical care providers in proportion to the number of births were likely to leave their communities to deliver babies. Women from these communities had a greater proportion of complicated deliveries, higher rates of prematurity, and higher costs of neonatal care than women from rural communities where most patients delivered in the hospital. The study suggests that the poor outcomes were related to the difficulties women from the underserved areas experienced in obtaining adequate prenatal care. It is also possible that for women living in rural areas, delivering outside the local community increases the risk of adverse birth outcomes. Increased stress associated with traveling long distances to the hospital and with delivering in an unfamiliar setting may cause problems for some women.[7]

The lack of adequate prenatal care is one factor contributing to high infant mortality rates in both metro and nonmetro areas. In 1987, the infant mortality rate was 10.2 deaths per 1,000 live births in metro areas and 9.8 deaths per 1,000 live births in nonmetro area. With a national infant mortality rate of 10.1 deaths per 1,000 live births in 1987, the United States ranked twentieth in infant mortality among industrialized nations. The high infant mortality rate in the United States is a reflection, in part, of the limited access pregnant women have to health care services.

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[6]Unpublished data from the National Center for Health Statistics reported in U.S. Congress, Office of Technology Assessment, *Health Care in Rural America*, October 1990.

[7]Nesbitt, Thomas, et al., "Access to Obstetric Care in Rural Areas: Effect on Birth Outcomes," *American Journal of Public Health*, Volume 80, Number 7, July 1990.

Pediatric Care

As with prenatal care, adequate pediatric care appears more scarce in nonmetro than in metro areas. From 1985 through 1987, white children under age 18 in fair or poor health averaged 16.4 physician contacts per year in metro areas, but just 13.1 contacts in nonmetro areas. Similarly, black children in fair or poor health averaged 6.9 annual physician contacts in metro locations, but just five in nonmetro areas.

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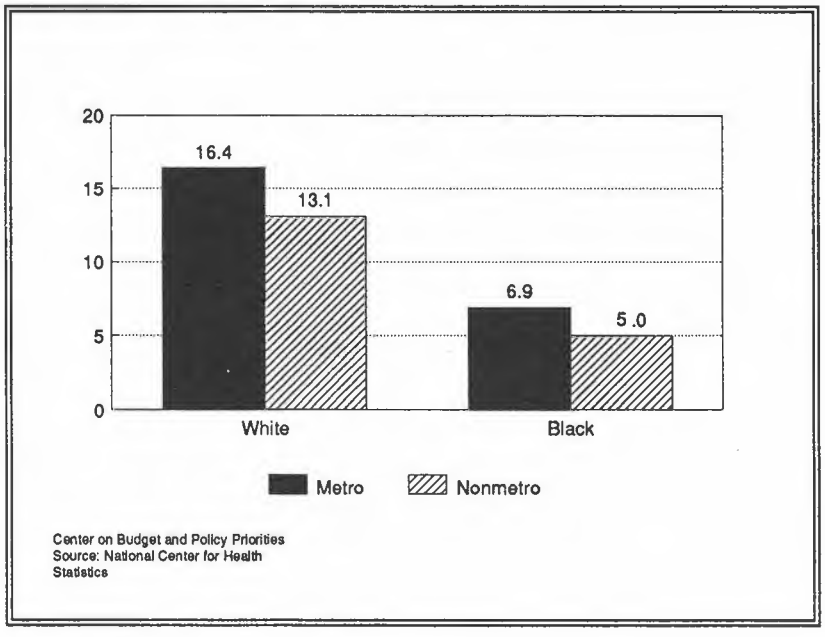
Figure 4
Annual Physician Contacts for Children in Fair or Poor Health



Nonmetro residents are less likely than their metro counterparts to receive services such as prenatal care or routine care from physicians. To be sure, hospitalization rates among individuals in fair or poor health are similar in metro and nonmetro areas, and hospitalization rates among *all* individuals are higher in nonmetro areas. But this may reflect a practice in nonmetro areas of admitting patients to the hospital for simple procedures that could be done on an ambulatory basis in another setting. The higher hospitalization rates may also reflect a less healthy rural population.

Thus, an important question is whether the relative lack of health care services contributes to poor health in rural areas. If rural residents do not seek preventive or primary health care services because the services are not readily available, their medical conditions may worsen and require hospitalization. Hospital care is generally less comfortable and convenient for patients than care delivered in an ambulatory setting. Moreover, the cost of hospital service is considerably higher than the costs of other types of health care services. To examine this matter further, the next two chapters assess the mix of health care services available in rural areas.

III. The Availability of Health Care Providers in Rural Areas

One factor limiting access to health care in rural areas is the scarcity of health care providers. In 1988, some 111 nonmetro counties in the United States had no physician at all. Primary care physicians — those in general practice, family practice, general internal medicine, general pediatrics, and obstetrics and gynecology — provide the majority of care in rural areas. But the supply of physicians participating in each of these primary care specialties is much more limited in rural than urban settings.

For most rural residents, access to hospital care does not seem as limited as access to care from physicians, but there are indications that the financial viability of some rural hospitals is threatened. If rural hospitals are forced to close, those who cannot travel to obtain health care — primarily the poor and the elderly — are likely to be affected most. Hospital closings can also have a significant impact on the availability of ambulatory medical services because communities without hospitals have a harder time attracting and retaining health care professionals.

Physicians

Despite an increase in the number of physicians practicing medicine in the United States, growth in the supply of physicians has been greater in metro than nonmetro areas. It lags most in those nonmetro areas with small populations.[8]

[8]U.S. Congress, Office of Technology Assessment, *Health Care in Rural America*, October 1990.

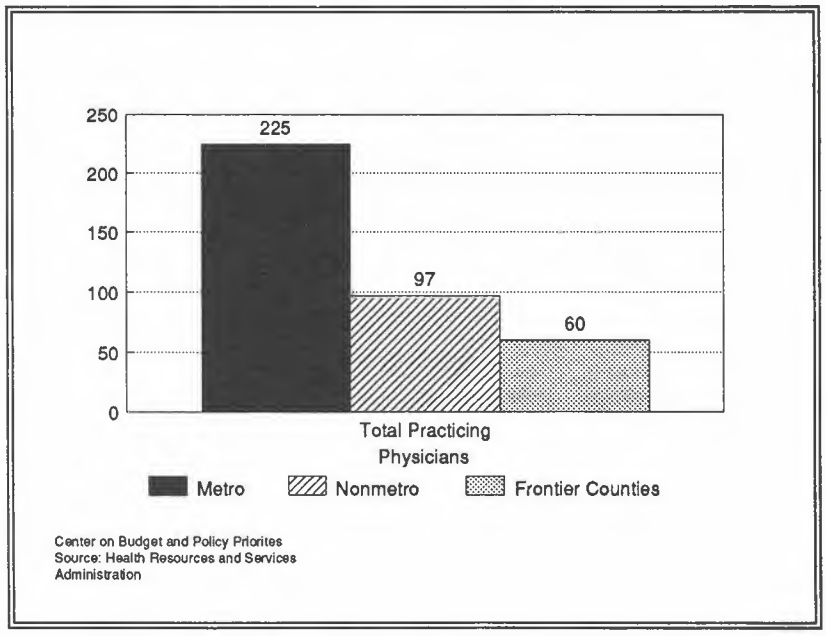
- In 1988, there were 97 practicing physicians per 100,000 people in nonmetro counties, compared with 225 per 100,000 people in metro counties.

- Nine of the 10 most rural states had physician-to-population ratios below the national average of 216 physicians per 100,000 people in 1986.

As the population of counties decreases, the ratio of practicing physicians to population also falls. In frontier counties, those with fewer than six persons per square mile, there was a ratio of only 60 practicing physicians per 100,000 people in 1988.

Moreover, 111 nonmetro counties had no physicians at all in 1988. These counties had a combined population of 325,100. By contrast, no metro county lacked a physician.

Figure 5
Practicing Physicians
Per 100,000 Residents, 1988



The physician shortage in rural areas shows no signs of abating. While the proportion of physicians (under age 35) is increasing in both rural and urban areas, the physicians practicing in rural counties are older as a group than those practicing in urban counties. The proportion of older physicians is highest in the smallest rural counties.

Furthermore, a 1988 survey of physicians in small rural counties found that one quarter — 26 percent — planned to leave their communities within the next five years. Half of these physicians were under age 45.

Definitions

Defining Rural and Urban States

In examining the operations of certain health programs administered by state governments, it is often useful to make comparisons among states. States can be distinguished by the proportion of the population that lives in nonmetro and metro areas.

Using 1988 data from the Census Bureau, this report looks at the 10 "most rural" states and the 10 "most urban" states. The "most rural states are those in which at least 60 percent of the population lives in nonmetro areas. These are: Idaho, Vermont, Montana, South Dakota, Wyoming, Mississippi, Maine, West Virginia, North Dakota, and Arkansas.

The 10 "most urban" states are: New Jersey, the District of Columbia, California, Maryland, Connecticut, Rhode Island, Florida, Massachusetts, New York, and Pennsylvania. In these states, less than 16 percent of the population lives in nonmetro areas.

Defining Frontier States

Population density is another important factor in studying access to health care. Residents of sparsely populated areas must often contend with geographic barriers.

The Department of Health and Human Services uses the term "frontier counties" to identify very sparsely populated locations. Frontier counties are those with six or fewer persons per square mile. In this report, frontier states are states in which at least about half of the counties are frontier counties. The nine "frontier states" are: Montana, Wyoming, North Dakota, Nevada, Utah, South Dakota, New Mexico, Colorado, and Idaho. At least 48 percent of the counties in these states are frontier counties.

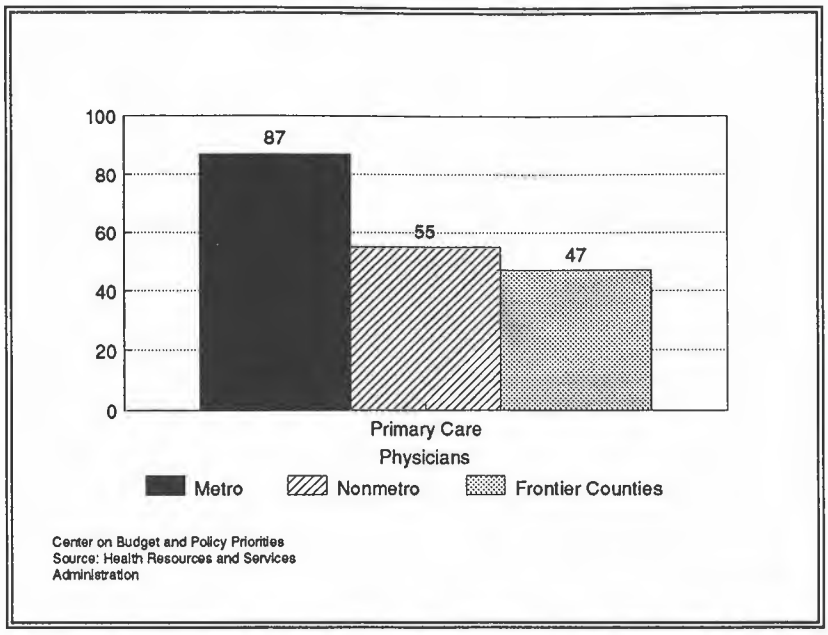
Five of the frontier states are also among the 10 "most rural" states. They are: Idaho, Montana, South Dakota, Wyoming, and North Dakota.

Primary Care

Primary care physicians account for the majority of all physicians who provide private patient care in rural areas. Nevertheless, the supply of primary care physicians in rural areas is declining. As a result, the gap between urban and rural areas in the availability of primary care physicians has grown quite large. In 1988, there were 87 practicing primary care physicians for every 100,000 people in metro counties. But in nonmetro counties, there were 55 primary care physicians for every 100,000 people. The ratio was lowest in frontier counties, where there were 47 primary care physicians per 100,000 residents.

Some 176 nonmetro counties had no primary care physicians at all. In these counties, which had a combined population of 713,700, there were no family practitioners, general practitioners, or doctors of internal medicine, general pediatrics, or obstetrics and gynecology. All 176 of the counties had populations under 25,000, and 112 of them were frontier counties.

Figure 6
Primary Care Physicians
Per 100,000 Residents, 1988



Obstetrical Care

Even larger numbers of nonmetropolitan counties lack the services of specific primary care specialists. In 1988, some 1,473 counties — all of them nonmetropolitan — lacked doctors of obstetrics and gynecology. This means that approximately 62 percent of nonmetro counties lacked a doctor of obstetrics and gynecology. The American College of Obstetricians and Gynecologists reported in 1988, that 22 states — including the 10 most rural states — had large regions with no practicing obstetrician.[9]

- In nonmetro areas in 1988, there were 24.5 practicing obstetricians per 100,000 women of childbearing age.
- In metro areas, by contrast, the ratio was 61.4 per 100,000 women of childbearing age.[10]

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[9]Hughes, Dana and Sara Rosenbaum, "An Overview of Maternal and Infant Health Services in Rural America," *The Journal of Rural Health*, Volume 5, Number 4, October 1989.

[10]Office of Technology Assessment, *Health Care in Rural America*, October 1990.

The availability of other physicians — general and family practitioners or doctors of osteopathy — who also provide obstetrical care eases the shortage of obstetricians somewhat. However, even when other providers are taken into account, obstetrical care is still less available to rural women.

- The ratio of *all* obstetrical care providers to women of childbearing age is lower in nonmetro areas (192.4 providers per 100,000 women) than in metro areas (213.4 per 100,000).

- Some 147 nonmetro counties have no obstetrician, family or general practitioner, or doctor of osteopathy.

Unfortunately, it is probable that these figures overstate the availability of obstetrical care providers because of the tendency of physicians, over the past several years, to stop practicing obstetrics. Economic factors, including escalating malpractice insurance rates, low reimbursement rates from public and private insurers, and an increasing proportion of patients who cannot pay for maternity care, have contributed to the decline of maternity care providers.

In 1987, the American College of Obstetricians and Gynecologists reported that 12.2 percent of its members no longer provided maternity care. The American Academy of Family Physicians has reported that of the 76.5 percent of its members who ever provided obstetrical services, 64.3 percent have discontinued or decreased these services.[11]

The impact of the continuing decline in maternity care providers is likely to be most severe in rural areas. In 1988, family practice physicians in rural areas were almost twice as likely as their urban counterparts to practice obstetrics routinely. Some 43 percent of family physicians in rural areas practiced obstetrics routinely that year, compared with 23 percent of family physicians in urban locations.[12] If family physicians continue to leave the obstetrical field, rural residents will be those affected most sharply.

The shortage of obstetrical care providers is of particular concern because it is probably one of the principal factors contributing to the high proportion of the rural population receiving inadequate prenatal care.

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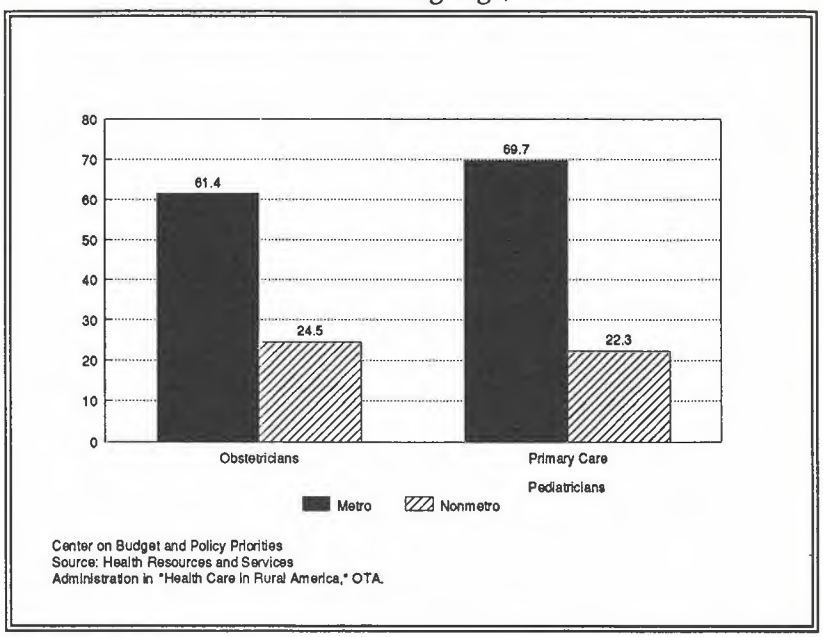
[11]Hughes and Rosenbaum, "An Overview of Maternal and Infant Health Services in Rural America," October 1989.

[12]Office of Technology Assessment, *Health Care in Rural American*, October 1990.

Pediatric Care

Pediatricians, too, are more scarce in rural than in urban areas. In 1988, some 1,488 nonmetro counties, or almost two-thirds of all nonmetro counties, lacked pediatricians. The number of primary care pediatricians for every 100,000 women of childbearing age was only 22.3 in nonmetro areas that year, compared with 69.7 in metro areas.

Figure 7
Physicians Per 100,000 Women Of Childbearing Age, 1988



Center on Budget and Policy Priorities
Source: Health Resources and Services Administration in "Health Care in Rural America," OTA.

Nonmetro counties fall short by another measure as well, the standards established by the American Academy of Pediatrics. These standards call for one practicing physician for every 2,500 children, an objective achieved in metro counties in 1985 (the latest year for which these data are available) but not in nonmetro counties. In the smallest nonmetro counties, those with fewer than 10,000 residents, there was only one pediatrician for every 28,962 children. That ratio was more than 10 times the Academy's standard.

When family practitioners and general physicians — other physicians who provide health care for children — were also counted, the number of children per practicing child health care provider was considerably lower. Nevertheless, many nonmetro counties failed to meet the standard of one provider for every 2,500 children even when these other practitioners were counted.[13]

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[13]Croft, Candice, *A Profile of Pediatricians Based Upon Data from the 1985 American Association Masterfile*, Statistical Note 8, American Academy of Pediatrics, May 1988.

Midlevel Practitioners

With the shortage of doctors in rural areas, midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives take on added importance as providers of health care. Physicians are a focus of discussion in this report primarily because most of the data on the supply of health care providers pertain to physicians. Also, the availability of physicians is likely to affect that of midlevel practitioners, since they must rely on physicians for supervision. State regulations regarding the degree to which midlevel practitioners must be supervised by physicians vary a greatly. In some states, midlevel practitioners are effectively excluded from practice in isolated areas because physicians are not available to provide the backup support required by law.

Traditionally, a substantial proportion of midlevel practitioners have worked in rural settings. The demand for physician assistants, nurse practitioners, and nurse midwives, however, has increased in other settings in recent years. Physician assistants are now moving away from providing primary care; some 74 percent were in family practice in 1978, but this dropped to 65 percent by 1986. Increasingly, physician assistants are choosing to practice in medical and surgical subspecialities, types of medicine that require more specialized supervision and facilities — and are not as compatible with rural practice.[14]

Hospitals

For most rural residents, access to hospital care does not appear as limited as access to ambulatory health care. As the previous chapter indicates, hospitalization rates are somewhat higher for nonmetro residents than for people residing in metro area.

Rural residents do not always receive hospital care at rural hospitals. Many rural residents travel to urban centers for health care either because the specialized care they need is not available at local hospitals or because they believe care is better at an urban hospital. Low income rural residents and those who have personal physicians in the community are much more likely to use local hospitals.[15] Of course, some rural residents cannot use a local hospital because none is available. Particularly in small isolated communities, the lack of hospital facilities necessitates that residents travel elsewhere to be hospitalized.

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[14]Office of Technology Assessment, *Health Care in Rural America, October, 1990.*

[15]Hart, L. Gary, Roger A. Rosenblatt, and Bruce A. Anundson, "Rural Hospital Utilization: Who Stays and Who Goes?" WAMI Rural Health Research Center, *Rural Health Working Paper Series*, Volume 1, Number 1, March 1989.

Table I
Statistics for Community Hospitals
In Rural and Urban Areas, 1981-1988

	1981	1988	Change
Number of Hospitals			
Nonmetro	2,765	2,549	-7.8%
Metro	3,048	2,984	-2.1%
Hospital Admissions			
Nonmetro	8.4 million	5.9 million	-29.8%
Metro	28.1 million	25.6 million	-8.9%
Occupancy Rate			
Nonmetro	68.6%	55.7%	-18.8%
Metro	78.4%	67.4%	-14.0%

Center on Budget and Policy Priorities
Source: American Hospital Association

Whether hospital services are available to rural residents should be distinguished from whether there are adequate hospital facilities in rural locations. In 1986, the ratio of community hospital beds to population was about the same in rural and urban areas. Rural communities, however, may not be able to maintain those ratios since rural hospitals are increasingly becoming financially vulnerable.[16]

From 1981 through 1988, some 398 community hospitals closed. Nearly half of those — 48 percent — were in nonmetro areas. The decline in the number of nonmetro hospitals during that period — 7.8 percent — was nearly four times the decline in metro hospitals, which equaled 2.1 percent. Additional closings would be likely to limit access, particularly for those who have difficulty traveling to other locations.

Two recent reports from the U.S. General Accounting Office examined factors that make rural hospitals vulnerable to closure. From interviews with federal and state health officials and rural hospital administrators, the first GAO report identified four factors contributing to the financial problems of rural hospitals:

- Low patient volume resulting in higher costs per case.

[16]Office of Technology Assessment, *Health Care in Rural America,* October 1990.

- Limited ability to compete with other hospitals for patients and physicians because fewer technological resources — and fewer services — are available.

- Limited patient and non-patient revenues.

- Increased administrative and staffing costs associated with the need to satisfy state regulatory requirements.[17]

The second GAO study examined specific operating and financial characteristics of rural and urban community hospitals. The study found that from 1985 through 1988, the rate of hospital closures was 29 percent higher in rural than urban areas. Rural hospitals had a rate of 5.3 closures per 100 hospitals, while the closure rate for urban hospitals was 4.1 per 100 hospitals. The report concluded that several factors associated with a high risk of closure — low occupancy, small size, and ownership by a for-profit organization — were more prevalent among rural than urban hospitals.[18]

The GAO also found that all of the rural hospitals studied that closed from 1985 to 1988 had financial losses from patient care during the three years before closure. In those hospitals, low occupancy resulted in high costs per case and made the hospitals financially vulnerable. More than three quarters of the closed hospitals had occupancy rates below 40 percent.

The GAO study highlights a particular problem for rural hospitals: many of their hospital beds go unused. Hospital admissions and occupancy rates for nonmetro hospitals have decreased steadily since 1981. The extent of the decrease has been greater for nonmetro than for metro hospitals.

- Between 1981 and 1988, admissions to rural hospitals declined 30 percent — from 8.4 million to 5.9 million — while admissions to urban hospitals declined only nine percent — from 28.1 million to 25.6 million.

- In 1988, the occupancy rate in rural hospitals was 55.7 percent. The occupancy rate had been 68.6 percent in 1981.

- In urban hospitals, the occupancy rate was 67.4 percent in 1988, well above the occupancy rate in rural hospitals that year. Still, this, too,

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[17]U.S. General Accounting Office, *Rural Hospitals, Federal Leadership and Targeted Programs Needed*, June 1990.

[18]U.S. General Accounting Office, *Rural Hospitals, Factors that Affect Risk of Closure*, June 1990.

represented a significant decline from 1981, when the occupancy rate in urban hospitals was 78.4 percent.

Medicare Reimbursements

Another factor in examining the changing financial status of rural hospitals is the method used to reimburse hospitals for treating Medicare patients. Prior to 1983, Medicare reimbursed hospitals for the actual cost of care provided. Since 1983, Medicare reimbursement for inpatient hospital care has been based on a Prospective Payment System. The Prospective Payment System uses a payment schedule that reflects the average cost of treatment for each of about 470 "diagnosis related groups" or DRGs. Hospitals are paid a fixed amount for treating each Medicare patient, based on the primary diagnosis of the patient's condition.[19]

The prospective payment system was developed to encourage efficiency. A hospital that treats a patient for less than the amount allowed by Medicare makes a profit on that case. Hospitals with costs higher than the Medicare payment lose money on that patient.

For rural hospitals, the primary concern related to the prospective payment system has been that Medicare adjusts the standard payments to reflect differing costs in urban and rural areas. Historically, rural hospitals have had lower average costs that urban hospitals. Therefore, the standardized amounts used to pay hospitals in rural areas have been set significantly lower than the standard payment amounts in urban areas. In fiscal year 1989, Medicare payments to rural hospitals were based on an average standardized amount about 11 percent lower than the average standardized amount used to pay urban hospitals.[20]

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[19]In addition to the DRG payment rates, additional Medicare payments are made to hospitals for "outliers" — atypical cases that either require extremely long hospital stays or have extremely high costs relative to most other cases with the same DRG classification. Medicaid also makes additional payments to hospitals for direct and indirect costs attributable to approved medical education programs. Also, adjustments to the prospective payment rates apply to certain types of facilities. "Disproportionate share hospitals" — hospitals that serve a disproportionate number of low income patients — qualify for increased reimbursement from Medicare. (State Medicaid programs also reimburse disproportionate share hospitals at a higher rate than their usual Medicaid rate.) "Sole community hospitals" are the sole source of inpatient services reasonably available in a geographic area. Medicare reimbursement for these hospitals is based, in part, on the prospective payment system and in part on the basis of the individual hospitals' costs. As of September 1989, 308 hospitals were classified as sole community providers. Medicare also makes adjustments to increase perspective payments for rural hospitals classified as "referral centers." As of September 1989, Medicare classified 195 hospitals as referral centers.

[20]U.S. General Accounting Office, *Rural Hospitals, Federal Leadership and Targeted Programs Needed*, June 1990.

In its studies, the General Accounting Office concluded that very small rural hospitals have been hurt by these changed Medicare reimbursement levels. In addition, a study by the Prospective Payment Assessment Commission found that differences between Medicare reimbursement rates and actual operating costs per patient were greatest in the smallest rural hospitals.[21] [22]

In the fall of 1990, Congress took action to address the problems that differences in Medicare reimbursement rates for urban and rural areas have caused for rural hospitals. Congress passed legislation directing the Department of Health and Human Services to phase out the separate average standardized amounts on which payments to urban and rural hospitals are based, so that the urban/rural payment differential would be closed by fiscal year 1995. This provision was included in the deficit reduction law passed in October and signed by the President the following month.

Other Problems Facing Rural Hospitals

Another factor contributing to the decline in revenues experienced by rural hospitals in recent years has been an increase in the uncompensated care these hospitals provide. From 1984 to 1988, the uncompensated care provided by rural hospitals increased from $1.16 billion to $1.47 billion, an increase of 11.4 percent after adjusting for inflation.

Adding further to the problems of rural hospitals is the tendency of many rural residents who can afford it to travel to an urban center to be hospitalized. When rural residents who can afford to pay travel elsewhere to receive care, rural hospital beds are empty, and the mix of paying and nonpaying patients that the rural hospitals serve is also affected. This, too, contributes to the financial decline of those hospitals.

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When rural hospitals close, it can become more difficult for rural residents to receive adequate health care. Those who cannot readily travel to obtain care, primarily the poor and the elderly, are most vulnerable. In addition, communities

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[21]The Prospective Payment Assessment Commission is appointed by the Congressional Office of Technology Assessment. The Commission makes recommendations regarding Medicare payments for inpatient hospital services to the Secretary of the Department of Health and Human Services.

[22]Office of Technology Assessment, *Health Care in Rural America*, October 1990.

without hospitals have a harder time attracting and retaining health care professionals. Many physicians are reluctant to practice in a community where they are unable to admit patients to a local hospital. Without hospitals, providers also have fewer colleagues for consultation and backup. Consequently, hospital closings can have a significant impact on the availability of ambulatory medical services. With the already limited supply of physicians and midlevel practitioners in rural areas, this poses a serious problem.

IV. Health Insurance

Nonmetro residents are less likely than metro residents to have health insurance coverage. As a result, they are more likely to have difficulty in obtaining health care services they need.

Some people who lack insurance fail to seek care, while others are unable to find health care providers willing to treat patients who cannot pay. In rural areas where a scarcity of health care providers also limits access, obtaining health services may be particularly problematic for the uninsured.

Insurance Rates

Data from the Current Population Survey conducted by the U.S. Census Bureau indicates that in 1988, some 15 percent of the nonelderly population — or 33.3 million Americans — had no health insurance coverage.[23] Data from another Census survey, the Survey of Income and Program Participation, show that an even larger proportion of the population — about 28 percent, or 63.6 million Americans — lacks *continuous* health insurance coverage. This Census survey found that during a 28-month period ending in May 1987, some 28 percent of the U.S. population had no health insurance coverage for at least one month.[24]

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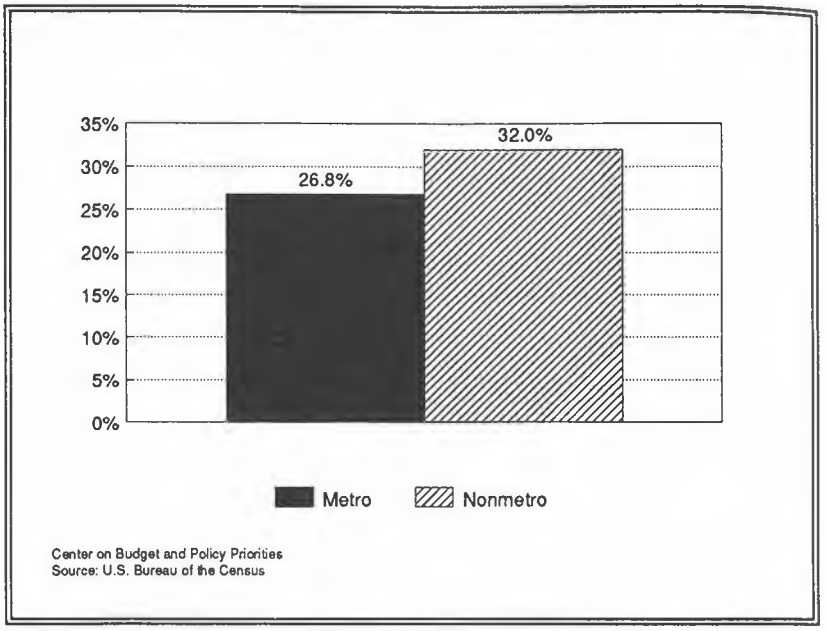
[23]Chollet, Deborah, Jill Foley, and Collen Mages, *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1988*, Employee Benefit Research Institute, September 1990.

[24]U.S. Bureau of the Census, Current Population Reports, Series P-70, Number 17, *Health Insurance Coverage: 1986-88*, U.S. Government Printing Office, March 1990.

By several measures, the lack of health insurance coverage is somewhat more widespread in rural than in urban areas.

Figure 8
Proportion of Residents Lacking Continuous Health Care Coverage, February 1985 - May 1987



In 1988, some 16.9 percent of nonelderly residents in nonmetro areas had no health insurance coverage. By comparison, 15.4 percent of nonelderly metro residents lacked coverage.[25]

During a 28 month period ending in May 1987, almost a third of nonmetro residents — 32 percent — lacked health insurance for at least a month. Some 26.8 percent of metro residents lacked continuous coverage during this period.[26]

Health insurance coverage rates are particularly low for certain population groups — the poor, women of childbearing age, and single parent families. For these groups, nonmetro residents have a lower rate of health insurance coverage than metro residents.

The Poor

The proportion of nonelderly poor people lacking coverage is greater in nonmetro than metro areas, although in both cases, more than one-third of the poor lack coverage.

- Some 34.3 percent of nonelderly poor metro residents had no health insurance coverage in 1988.

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[25]Chollet et al., *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1988*, September 1990.

[26]U.S. Bureau of the Census, *Health Insurance Coverage: 1986-88*, March 1990.

- Among nonelderly poor residents of nonmetro areas, 37.1 percent lacked coverage.[27]

Women of Childbearing Age

Regardless of marital status, the proportion of women of childbearing age with no health insurance is higher in nonmetro areas.

- In nonmetro areas, 14 percent of married women of childbearing age — and 25 percent of unmarried women of this age — were uninsured in 1985.

- In metro areas, the proportions lacking insurance coverage were 10 percent for married women and 23 percent for unmarried women.

Single-Parent Families

In both metro and nonmetro settings, a large proportion of single-parent families lack health insurance coverage. Here, too, however, coverage rates are lower in nonmetro areas.

- In 1988, some 23.1 percent of single-parent families with children were uninsured in nonmetro areas.

- In metro areas, 19.6 percent lacked insurance.

Two-parent families are more likely than single-parent families to have insurance. Yet among these families as well, the proportion lacking health insurance was higher in nonmetro areas in 1988 (13.5 percent) than in metro areas (11.9 percent).

Factors Associated with Low Health Insurance Coverage

Poverty

Poor people are more likely to be uninsured than those with higher incomes — and a higher proportion of the nonmetro than of the metro population is poor. As a result, health insurance coverage rates are lower among rural residents.

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[27]Chollet et al., *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1988*, September 1990.

Table II
Distribution of Rural and Urban Households
Within National Income Quintiles, 1989

National Income Category	Nonmetro	Metro
Richest fifth	10.6%	22.7%
Next richest fifth	17.0	20.9
Middle fifth	21.4	19.6
Next poorest fifth	24.6	18.7
Poorest fifth	26.5	18.1
Total	100%	100%

This table reads: 10.6 percent of nonmetro households had incomes placing them in the top income quintile in 1989.

Center on Budget and Policy Priorities
Source: Unpublished data, Current Population Survey, Bureau of Census

- In 1989, some 15.7 percent of the population living in nonmetro areas had incomes below the poverty level. In metropolitan areas, 12 percent of the population was poor.[28]

- Similarly, in 1989, some 26.5 percent of all rural households had incomes placing them among the poorest fifth of U.S. households. By contrast, 18.1 percent of urban households had incomes this low.[29]

Medicaid Coverage

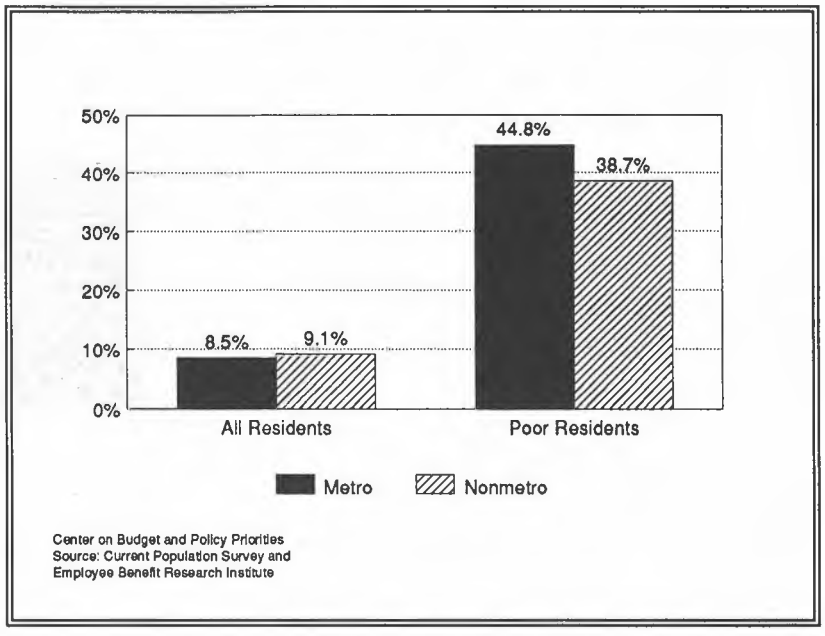
Government-sponsored health insurance is available for some low income individuals through the Medicaid program. Since Medicaid is funded and administered jointly by state and federal governments, the program differs from state to state.

The Medicaid program covers a slightly larger proportion of the nonelderly population in rural than in urban areas. Some 9.1 percent of the nonmetro population — and 8.5 percent of the metro population — received Medicaid in 1988. However, this does not mean the Medicaid program works more effectively

[28]U.S. Bureau of the Census, *Money Income and Poverty Status in the U.S.: 1989*, October 1990.

[29]U.S. Bureau of the Census, Current Population Survey, unpublished data, 1989.

Figure 9
Proportion of Nonelderly Residents
With Medicaid Coverage, 1988



in nonmetro areas. In fact, the opposite appears to be true. The higher rate of Medicaid coverage among the nonmetro population reflects the higher poverty rates in nonmetro areas. In other words, a greater proportion of the nonelderly population in nonmetro areas has low incomes and needs Medicaid benefits. In fact, due to more restrictive Medicaid eligibility rules in rural states, low income residents in rural areas are not as well served by Medicaid as their urban counterparts.

- In 1988, only 38.7 percent of the nonelderly nonmetro poor had Medicaid coverage.

- By contrast, 44.8 percent of nonelderly poor residents in metro areas were enrolled in Medicaid.

Employment

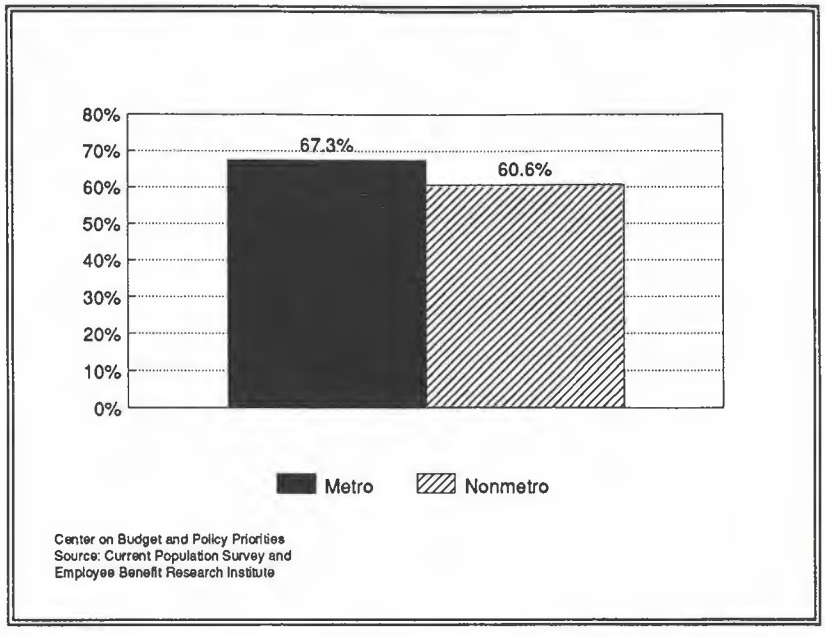
Health insurance coverage is closely related to employment. A majority of the nonelderly people who are insured — 65.8 percent in 1988 — receive coverage through employers. However, the rate of employer-sponsored insurance is lower for the nonmetro population.

- Employers provided coverage for 60.6 percent of the nonmetropolitan population in 1988.

- By comparison, 67.3 percent of the metropolitan population had employer-provided coverage that year.

With higher unemployment rates in rural areas, nonmetro residents are less likely to have access to employer-sponsored health insurance than metro residents.

Figure 10
Proportion of Nonelderly Residents with Employer-Sponsored Health Insurance, 1988



In 1989, the nonmetro unemployment rate averaged 5.7 percent, while the metro rate averaged 5.2 percent.[30]

In addition, a recent study from the Economic Policy Institute, based on data from the Bureau of Labor Statistics' Displaced Worker Survey, indicates that a proportionately larger number of rural than of urban workers experienced permanent job loss due to layoffs in the 1980s. While all displaced workers face the risk of losing group health insurance, displaced rural workers appear to have a more difficult time obtaining new coverage than displaced urban workers do.

- The Economic Policy Institute found that only 65 percent of the workers displaced in rural areas between 1981 and 1984 had obtained new health insurance coverage by 1986.

- By comparison, 75 percent of the displaced workers in urban areas had new coverage by 1986.[31]

One reason for the lower rates in rural areas is that many of the rural residents were not reemployed. Even among those with new jobs, however, rural workers were less likely than urban workers to have new health insurance benefits.

The availability of employer-sponsored health insurance benefits is also influenced by the types of employers located in rural areas. A substantial proportion of rural workers are employed in small firms or are self-employed. These workers are less likely than employees of larger businesses to have health

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[30]U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings*, January 1990.

[31]Podgursky, Michael, *Job Displacement and the Rural Worker*, Economic Policy Institute, 1989.

insurance benefits provided. In 1988, almost half of all uninsured workers nationwide were employed in firms with fewer than 25 workers.[32]

Furthermore, small businesses located in rural areas are less likely to provide health insurance coverage for their employees than are small businesses in urban areas. A survey of employers by the National Federation of Independent Business in 1989 found a substantial difference between the proportion of small businesses offering health insurance coverage in urban and rural areas.[33]

- Nearly 46 percent of small businesses in rural areas reported not sponsoring health insurance for their employees.

- This far exceeded the 28 percent of small businesses in urban areas that reported not offering insurance.[34]

These survey results suggest that businesses in rural areas may not find it necessary to offer health insurance benefits to attract employees, probably because they operate in more isolated labor markets.

Agricultural workers have a particularly low rate of health insurance coverage. These workers are located primarily in rural areas. In 1988, some 40 percent of all rural agricultural workers and their families had no health insurance.[35] Moreover, a 1986 survey found that about half of all agricultural workers and family members with incomes below the poverty level were uninsured.[36]

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[32]Chollet et al., *Uninsured in the United States: The Nonelderly Population with Health Insurance, 1988*, September 1990.

[33]The study was based on a survey of National Federal of Independent Business members. The authors note that the figures may be biased due to the membership differences across regions of the country and the resulting nonrandom nature of the sample. They conclude, however, that there is clearly an urban-rural difference in business sponsorship of health insurance.

[34]Hall, Charles P. and Kuder, John M, *Small Business and Health Care*, the NFIB Foundation, 1990.

[35]Chollet et al., *Uninsured in the United States: The Nonelderly Population without Health Insurance*, 1988, September 1990.

[36]Chollet, Deborah, *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1986*, Employee Benefit Research Institute, October 1988.

Private Insurance

Nonmetro residents who are not covered by employers appear more likely to purchase other private insurance policies than do metro residents who lack employer-related coverage. This is true among nonelderly people in all income groups.

- In 1988, some 12.8 percent of all nonmetro residents who were not elderly were covered by a private insurance policy not sponsored by an employer. By comparison, 8.6 percent of nonelderly metro residents had private insurance that was not employer-related.

- Private insurance not provided by employers covered 13.6 percent of poor nonmetro residents who were not elderly, compared with 9.4 percent of poor nonelderly residents in metro areas.[37]

The higher levels of privately purchased insurance among the poor in nonmetro areas is not surprising, since Medicaid covers fewer of the nonmetro poor who lack employer-sponsored coverage. Many poor rural residents who do purchase health care coverage are left with limited resources to purchase other necessities.

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The lower rates of health insurance coverage in rural areas can also affect rural communities and rural health care facilities. Some rural residents travel outside their community to obtain certain health care services. Those most able to pay for services are most likely to seek health care elsewhere. The result can be that a substantial proportion of the patients seeking treatment locally are patients who lack insurance. Where this occurs, rural health care facilities can be financially squeezed.

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[37]Chollet et al., *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1988*, September 1990.

V. Federal Health Programs for Low Income Residents in Rural Areas

The scarcity of health care providers affects many rural residents, but those with low incomes are most likely to have difficulty obtaining care. Geographic barriers are often more difficult for low income residents to overcome. If care is not available locally, the time required for travel can be a significant barrier, particularly if it results in a loss of income from hours lost at work. In addition, transportation may be difficult to arrange. Public transportation is generally not available in rural areas, and private transportation is often not affordable for low income households.

Rural residents, particularly those with low incomes, have benefitted considerably from federal programs designed to increase the availability of health care providers serving the low income population, such as the National Health Service Corps and the Community and Migrant Health Centers programs. While these programs serve urban as well as rural residents, they have been particularly effective in rural areas. They could have an even greater impact, however, if additional funds were available to expand services.

National Health Service Corps

The National Health Service Corps was established in 1972 to address problems stemming from the uneven geographic distribution of health care providers in the United States and the resulting inadequate access to health care services for many population groups. The Corps recruits physicians and other health professionals to serve in areas with a shortage of health professionals.

These areas are known as health professional shortage areas, or HPSAs.[38] Specific geographic areas, population groups, or public or nonprofit health care facilities that are not served by enough primary care health professionals are designated as HPSAs by the U.S. Department of Health and Social Services.[39] In 1990, there were 1,956 primary care health professional shortage areas. Some 70 percent of them were in nonmetro locations.[40]

The National Health Service Corps is staffed primarily by health professionals who agree to serve in exchange for financial assistance with their educational expenses. After completing their education, they practice in health professional shortage areas for a specified period of time. The Corps is also staffed by a small number of commissioned officers from the Public Health Service and by a small number of other health professionals, some of whom have completed their financial obligation to the Corps, but have decided to stay on. NHSC providers may establish private practices or join existing practices in health professional shortage areas. They may also work in the Indian Health Service, in federal prisons, or in federally funded community and migrant health centers.

Over the years, the National Health Service Corps has placed thousands of health care practitioners in needy communities. Unfortunately, the effectiveness of the Corps has diminished sharply over the past decade, as funding for the program has been reduced. Funding peaked in fiscal year 1980, with an NHSC appropriation of $153.6 million. By contrast, the appropriation for fiscal year 1990 was only $50.7 million. After adjusting for inflation, this represents a decline of 77 percent.

As a result of these funding constraints, the field strength of the National Health Service Corps has declined. At its peak, the Corps had 3,300 health care

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[38]Prior to November 1990, areas lacking health personnel were termed Health Manpower Shortage Areas. With the reauthorization of the National Health Service Corps, the term was changed to Health Professional Shortage Areas. The new term is used throughout this report.

[39]For the designation purposes, primary care physicians include family and general practitioners, general pediatricians, obstetricians and gynecologists, and general internists. The majority of primary care HPSAs are geographic areas with a population-to-primary-care ratio equal to or greater than 3,500 to 1. Specific population groups within geographic areas may also be designated as HPSAs if access barriers such as language differences prevent the group from using many of the primary care providers in the area and if the ratio of persons in the population group to primary care physicians serving the group is equal to or greater than 3,000 to 1. Finally, some public or nonprofit private medical facilities may be designated as primary care HPSAs if they have insufficient capacity to serve designated areas or population groups in need of services.

[40]Since population density is a major factor in designating HPSAs, the majority are located in rural areas.

professionals. By 1989, the Corps had dwindled to 1,944 professionals. Yet the U.S. Department of Health and Human Services estimated that 4,172 health care practitioners were needed in 1990 to provide services in health professional shortage areas. Some 1,903 of these were needed to provide services in rural HPSAs.

In the fall of 1990, Congress reauthorized the National Health Service Corps program through the year 2000 and modified the program to increase the supply of health care providers in underserved areas. Congress also substantially increased the appropriation for the NHSC for fiscal year 1991 in an effort to rebuild the Corps. The FY 1991 funding level, however, remains far below the levels of a decade earlier.

When funding for the National Health Service Corps was cut in the early 1980s, the rationale was that a surplus of physicians was anticipated in the next decade and more physicians would be available to practice in all areas. This rationale proved faulty. Few physicians chose to practice in health professional shortage areas. In addition, few of the physicians placed in HPSAs through the National Health Service Corps chose to remain after completing their obligation to the Corps. The Corps consequently had little lasting impact on the supply of health care providers in needy areas.

During the 1980s, the nature of the NHSC program changed as its resources were reduced. As the program originally operated, students from the health professions received scholarships and grants in return for agreeing to serve in HPSAs after completing their education. Scholarship recipients were required to spend one year in the National Health Service Corps for each year of NHSC scholarship money they received. Because of the lag time between award of a scholarship and a student's availability for service, scholarship recipients would not serve in the Corps until some years after they were initially recruited and provided financial aid. Thus, although NHSC funding was cut in the early 1980s, the field strength of the Corps reached its peak in 1986. In that year, 3,300 practitioners served in the Corps, including 1,200 individuals who were newly available for service. The growth in the field strength of the Corps in the first half of the 1980s reflected the large number of scholarships awarded in the late 1970s.

In 1987, however, the scholarship program was discontinued. As a result, few scholarship recipients remain available for service today. A recent study by the General Accounting Office reported that only 215 new scholarship recipients

were available to serve in 1989 and that fewer than 135 were expected to become available for service in 1990.[41]

When the scholarship program was discontinued, a loan repayment program was established in its place. Under the loan program, the NHSC would repay loans that health professionals incurred for their education at the rate of up to $20,000 for each year served in an HPSA. The NHSC was also authorized to provide grants to states to help them establish loan repayment programs of their own to recruit small numbers of additional health care professionals to serve in needy areas.

An advantage of the loan repayment programs is that recruits can be placed immediately. The loan repayment programs also have drawbacks. They may be less likely than the scholarship programs to attract health care professionals, who usually have many options once they complete their training. Newly graduated health professionals are likely to receive employment offers that are more financially rewarding than those from clinics in health professional shortage areas, even when the NHSC loan repayment incentives are taken into account.

The limitations of the loan programs, along with the reduction in federal funding for the Corps, resulted in the addition of very few professionals to the Corps in the late 1980s. Only 20 loan beneficiaries were placed in service in 1988; just 112 were place in 1989.

In just three years from 1986 to 1989, the number of practitioners serving in the Corps declined by more than 40 percent — from 3,300 in 1986 to 1,944 in 1989. As a result, many HPSAs that had health care providers only a few years ago lack such providers today.

Recent Legislation to Reauthorize the National Health Service Corps Program

The 1990 legislation reauthorizing the National Health Service Corps re-established the scholarship program terminated in 1987. It also continued the loan repayment program and reauthorized the component of the program under which grants are made to states to support state loan repayment programs. In addition, to enhance the attractiveness of the loan program, the annual ceiling on loan repayments made by the NHSC was increased from $20,000 to $35,000 for each year of obligated service.

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[41]U.S. General Accounting Office, *National Health Service Corps, Program Unable to Meet Need for Physicians in Underserved Areas*, August 1990.

The recruitment of NHSC professionals is important, but health professionals already practicing in health professional shortage areas also should be encouraged to stay. If a substantial portion of program funds must be used to keep replacing health professionals leaving HPSAs once they fulfill their obligation to the Corps, the program's impact on alleviating the shortage of health care providers in underserved areas will be limited.

Retaining health professionals in HPSAs is particularly crucial for the next several years. During this period, very few new NHSC scholarship recipients and only a limited number of loan repayment candidates will become available for service. The scholarship recipients being recruited under the re-established scholarship program will not become available for service until several years after they receive their grants. Thus, if current NHSC practitioners choose to leave underserved areas after completing their obligation, many will not be replaced. It will also be difficult to replace community health care providers who retire.

Several provisions in the new legislation are designed to increase the probability that health care providers will remain in health professional shortage areas after fulfilling their obligation to the Corps. The Secretary of Health and Human Services is required to determine the characteristics of health professionals who are most likely to continue to practice in HPSAs. In choosing which applicants will receive financial assistance, priority must be given to applicants having those characteristics.

A disadvantaged background is one such characteristic cited in the law. Accordingly, priority must be given to scholarship and loan applicants from disadvantaged backgrounds. Also, it is expected that health professions students with training in clinical settings that provide primary health care services in underserved areas will be among those more likely to choose to practice in those areas. As a result, the law directs the NHSC to enter into contracts with institutions providing that type of training.

The new law also requires that scholarship recipients receive counselling in school and when they begin to practice on the nature of service in the Corps. In addition, the law directs the Corps to offer flexible work options such as job sharing and the employment of couples to attempt to retain Corps members after they finish their obligated service.

Other new requirements reflect the notion that health care providers are more likely to be satisfied with their practice and to remain in an area if they are part of an organized health care system. The availability of ancillary services such as laboratory and X-ray services enhances the practice setting. Similarly, practitioners are able to provide better care, and thus are apt to be more satisfied

State Offices of Rural Health

With the reauthorization of the National Health Service Corps, Congress also established a federal program to provide grants to states, on a matching basis, for state offices of rural health. While many states already have offices of rural health, this is the first time federal funding has been available specifically to support their activities.

About $1.5 million will be used in fiscal year 1991 to make approximately 35 very modest state grants of $43,000 each. A match of $14,333 will be required from each state. The first grants are expected to be awarded in April 1991 and will be available to states that already have offices of rural health, as well as to states wishing to establish offices of rural health.

With federal funding, offices of rural health will be required to maintain a clearinghouse for information on rural health care issues and to coordinate activities in the state that relate to rural health. The offices must also help public and nonprofit private health care providers participate in state and federal programs related to rural health.

A survey conducted by the Office of Technology Assessment in 1990 identified offices of rural health in 19 states. In some states, offices of rural health were involved with the recruitment and retention of health care personnel. Other activities in which the offices were involved included advocacy work on behalf of rural populations, research and evaluation related to rural health care, and the dissemination of information about rural health initiatives.

professionally, if they have colleagues who will accept referrals and provide consultation. The new law specifies that in placing NHSC professionals, priority must also be given to settings in which the delivery of primary health care services is coordinated with related health and social services.

Finally, health care professionals often have difficulty practicing in health professional shortage areas because they feel isolated. To address this issue, the new law directs the NHSC to assist Corps members in establishing professional relationships, including faculty appointments at medical and professional schools. Exchange programs with teaching centers must also be established. The Corps must assist in finding temporary replacements so that Corps members can leave the area for professional enrichment or vacation. The Corps may also obligate funds to provide temporary relief for practitioners who are the sole provider in a geographic area.

Funding for the National Health Service Corps

This new legislation should help revitalize the National Health Service Corps — *if* funds are available to implement these initiatives and to recruit a sufficient number of health care providers. Congress took a major step in this direction when it appropriated $91.7 million for the Corps for fiscal year 1991. This

Table III
Appropriations,
National Health Service Corps

Fiscal Year	Total	NHSC Field	Scholarships	Loan Repayment
		(in millions of dollars)		
1980	$153.6	$74.1	$79.5	
1981	149.0	85.6	63.4	
1982	131.4	85.6	42.8	
1983	104.4	88.6	15.8	
1984	74.5	68.2	6.3	
1985	48.0	45.7	2.3	
1986	60.8	58.5	2.3	
1987	42.2	39.9	2.3	
1988	38.8	36.6	2.2	
1989	47.0	39.8	2.2	$5.0
1990	50.7	41.8	3.0	5.9
1991	91.7	42.9	48.8*	

*Combined scholarships and loan payments

Center on Budget and Policy Priorities
Source: Bureau of Health Care Delivery and Assistance, HHS

represents an increase of $41 million over the FY 1990 appropriation and should enable many more students in the health professions to receive aid. It should ultimately result in more NHSC health care providers in underserved areas.

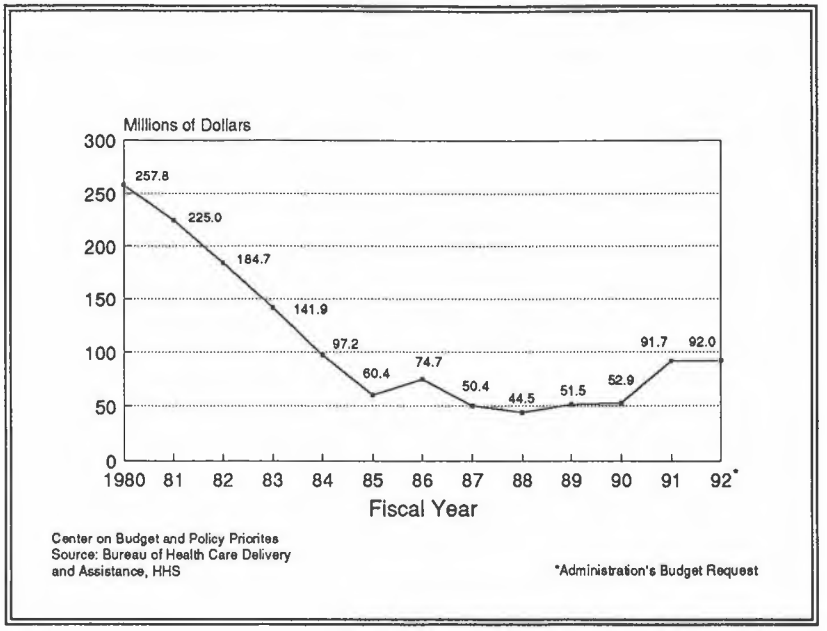
Yet even with this funding increase, the NHSC will not be restored to its earlier levels of effectiveness. The appropriation for fiscal year 1991 remains far below the amount appropriated for fiscal year 1980. After inflation is taken into account, the FY 1991 funding level for the National Health Service Corps is 64 percent lower than a decade earlier. Funding for scholarships and loans is 63 percent lower than in fiscal year 1980.[42]

As a result, while the number of providers delivering health care services in HPSAs will eventually increase, the Corps will still be able to supply only a modest fraction of the health care providers needed in such areas. Furthermore,

[42]In early February, the Bush administration released its proposed federal budget for fiscal year 1992. The proposal includes an increase of $5 million above the amount appropriated for the NHSC program in fiscal year 1991. This increase should account for inflation, but will not result in any real increase in program funding.

the current scarce supply of NHSC providers will continue to leave many rural communities without health care providers for the immediate future, a problem that can threaten the viability of some community and migrant health centers and other health facilities that have traditionally relied on the National Health Service Corps to provide professional staff.

Figure 11
Total Appropriations,
National Health Service Corps
(constant 1991 dollars)



Community and Migrant Health Centers

Community health centers provide primary health care services to poor and medically underserved populations. They are located in Medically Underserved Areas, or MUAs, which are designated by the Department of Health and Human Services.[43] The Migrant Health Centers program funds health care facilities that serve migrant and seasonal agricultural workers and their families. Many health centers receive funding from both the Community Health Centers program and the Migrant Health Centers program.

The health services provided by community and migrant health centers are available to anyone, regardless of income, who lives in the medically underserved area. However, the centers primarily serve patients with limited resources. The centers routinely provide health care for the uninsured, charging patients who lack health insurance according to a sliding fee scale. In 1989, almost half of

[43]The original MUA designations were made by the Department of Health and Human Services in 1976. New designations are made in response to requests from the states. To support a request, a state must provide HHS with data on four criteria: the infant mortality rate, the percentage of the population 65 years of age or older, the percentage of the population living in poverty, and the ratio of primary care physicians to the population. HHS determines when an MUA designation should be granted. In 1987, at the direction of Congress, HHS also began to review requests from states to designate Medically Underserved Populations, population groups affected by unusual local conditions which limit their access to health care.

community and migrant health center patients — 49 percent in rural centers and 48 percent in urban centers — were uninsured. An additional 37 percent of patients in rural centers were publicly insured, as were 41 percent of the patients in urban centers.[44]

Community and migrant health centers are a particularly important source of health care services for low income rural residents. In 1989, some 60 percent of the community health centers (320 of 523) were located in rural areas. Almost all funding for the migrant health centers supports centers in rural areas. Nevertheless, there are many rural areas in which residents lack access to a community or migrant health center. Three of the 10 most rural states have only a tiny number of community or migrant health centers. North Dakota has just one community health center, while Montana has two. Wyoming has two migrant health centers but no community health centers.[45]

Problems Facing Community and Migrant Health Centers

Several problems beset the community and migrant health centers. As noted, many medically underserved areas, including a substantial number in nonmetro counties, lack such a center. In areas that do have a center, the need for health care services often outstrips the ability of the center to provide them.

A survey conducted by the National Association of Community Health Centers in 1987 found long waiting lists of new patients seeking care. Center waiting lists averaged between 15 percent and 28 percent of current patient enrollment.

Moreover, this problem appears to be intensifying, as growing numbers of people seek care. Between 1984 and 1988, for example, the number of visits to rural community health centers rose 18 percent, from 9.3 million to 11 million, even though the number of centers did not increase.[46]

Funding for the Community and Migrant Health Centers programs has not kept pace with the increased demand for services. Funding for community health centers has remained virtually unchanged since 1981, after adjusting for inflation,

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[44]National Association of Community Health Centers, *A Snapshot View of Community Health Centers After 25 Years*, February 1991.

[45]National Association of Community Health Centers, *Access to Community Health Care: A Data Book 1990*, February 1990.

[46]Office of Technology Assessment, *Health Care in Rural America*, October 1990.

Table IV
Appropriations,
Community and Migrant Health Centers

Fiscal Year	CHCs	MHCs	Infant Mortality*
	(in millions of dollars)		
1981	$323.7	$43.2	
1982	281.2	38.2	
1983	360.0	38.1	
1984	351.4	42.0	
1985	383.0	44.3	
1986	400.0	45.4	
1987	419.6	45.4	
1988	396.3	43.5	$19.1 (CHC) 1.0 (MHC)
1989	414.8	45.7	19.5 (CHC) 1.0 (MHC)
1990	427.3	47.4	31.6
1991	478.2	51.7	

*Funding for special infant mortality initiatives was provided for the Community Health Center program and the Migrant Health Center Program in 1988, 1989, and 1990. In 1991, funds for the infant mortality initiatives were included in the appropriations for community and migrant health centers.

Center on Budget and Policy Priorities
Source: Bureau of Health Care Delivery and Assistance, HHS

while funding for migrant health centers has decreased significantly. Many centers find it increasingly difficult to meet local health care needs.

In fiscal year 1981, some $323.7 million in federal funds were appropriated to support community health centers. The appropriation for fiscal year 1991 is $478.2 million. After adjusting for inflation, this represents a decline of about two percent over this 10-year period.

The appropriation for migrant health centers stood at $43.2 million in fiscal year 1981; for fiscal year 1991, some $51.7 million has been provided. After adjusting for inflation, this represents a decline of 21 percent.[47]

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[47]The Bush administration's fiscal year 1992 budget request funds the Community and Migrant Health Center Programs at the same level as the previous year. After inflation, program funding will actually decline by about four percent in fiscal year 1992.

Moreover, these figures — which show a small decline in funding for community health centers and a large decline in funding for the migrant centers — significantly understate the growing fiscal squeeze many centers face. In adjusting the annual appropriations levels for inflation, this report uses the Consumer Price Index, a measure of inflation in the economy as a whole. But between 1981 and 1990, medical costs rose more than twice as fast as the overall inflation rate.[48] Had the inflation adjustment used the component of the CPI that measures inflation in medical costs, rather than the overall CPI, the decline in the budgets for these programs would appear much greater.

In fact, many centers have incurred increasing expenses over the past decade, due to such factors as the rising cost of health care services, changing staffing needs, and necessary capital improvements. The centers also face very high costs for medical malpractice insurance premiums. Based on data from the Department of Health and Human Services, the National Association of Community Health Centers estimates that community and migrant health centers spent approximately $52 million in 1990 on medical malpractice premiums for physicians providing primary care services.

In addition to increasing demands for services alongside stagnant or declining budgets, community and migrant health care centers face another problem — a drop in the supply of physicians provided through the National Health Service Corps. This can present centers with growing difficulty in staffing their clinics.

Traditionally, the National Health Service Corps has provided the centers with a substantial number of physicians. The National Association of Community Health Centers has reported that of the 2,100 physicians working in community health centers in 1990, some 900 — or 43 percent — were members of the National Health Service Corps. Over the next two years, however, 750 of these 900 NHSC physicians are expected to complete their obligation to the Corps, and most are expected to leave the health centers.[49] If new NHSC physicians are not available to replace them, community and migrant health centers may face staff shortages — and be forced to spend higher portions of their budgets recruiting other physicians and offering more competitive salaries. Eventually, legislative changes in the NHSC program should increase the number of physicians available

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[48]Overall costs measured by the Consumer Price Index rose 43.5 percent between 1981 and 1990. During that same period, medical care costs rose 95.7 percent.

[49]National Association of Community Health Centers, *Access to Community Health Care: A Data Book 1990*, February 1990.

through the Corps, but it will be at least several years before this occurs. Students in the health professions who receive scholarships under the reinstated NHSC scholarship program will not be available for service for some time.

Adding to the problems facing community and migrant health centers, there are indications that a growing number of patients treated by centers in rural areas are unable to pay for the care they receive. A study commissioned by the Joint Rural Health Task Force of the National Association of Community Health Centers and the National Rural Health Association examined changes in the financial position of rural community health centers between 1986 and 1987. The study found a patient caseload increasingly characterized by a lack of health insurance and an inability to pay for care.

The survey also found that many community health centers in rural areas had responded to the growing financial squeeze. A large proportion of the centers surveyed — 42 percent — indicated they had changed procedures related to sliding fee scales. Some increased the fees charged to patients at different income levels. Others established stricter methods for making income determinations. Centers also reported reducing the range of health services offered. The services most likely to be dropped were those such as nutrition education, which are not covered by insurance and used often by patients who cannot afford to pay for care. Many centers also reported they could not afford to make needed capital improvements.[50]

Recent Legislative Changes Provide Some Relief

Federal legislation enacted in both 1989 and 1990 should provide some financial relief to community and migrant health centers. The legislation should increase the reimbursement that the centers receive from both the Medicaid and Medicare programs. The legislation enacted in late 1989 established a new type of Medicaid provider, known as a federally qualified health center, or FQHC.[51] All community and migrant health centers fall into this new category. The centers should benefit from this change in two important ways.

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[50]Joint Rural Task Force of the National Association of Community Health Centers and the National Rural Health Association, *Community Health Centers and the Rural Economy: The Struggle for Survival*, December 1988.

[51]Federally qualified health centers are defined as health centers that receive funds from the Community Health Centers program, the Migrant Health Centers program, or the Health Care for the Homeless program. In addition, health centers that meet all the requirements to be eligible to receive such grants, but do not receive federal funds from these programs, may become certified as federally qualified health centers.

First, the law requires state Medicaid programs to pay for 100 percent of reasonable costs for services provided to Medicaid beneficiaries at FQHCs, rather than to pay only that part of the cost covered by the state's normal Medicaid reimbursement rates. Frequently, Medicaid reimbursement rates are set significantly lower than the actual cost of providing the services, and community and migrant health centers have had to use some of the funds they received under their federal appropriation to absorb the remaining costs of the services provided to Medicaid patients. Under the new law, the centers will no longer have to use their other funds to absorb these costs.

Second, the law requires state Medicaid programs to reimburse FQHCs for a package of FQHC health services, provided to Medicaid beneficiaries, including some services which may not generally be covered under the state's Medicaid program. For example, Medicaid is now required to pay for the services of nurse practitioners, physicians' assistants, clinical social workers, and clinical psychologists when they are provided to Medicaid beneficiaries at federally qualified health centers.

Both of these changes should increase the revenues that community and migrant health centers receive from the Medicaid program.[52] The additional funds in Medicaid reimbursements should be substantial, since 28 percent of the patients at community and migrant health centers in rural areas — and 34 percent the of patients at centers in urban locations — had Medicaid coverage in 1989.[53]

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[52]Rural Health Clinics are another type of Medicaid and Medicare provider. Under the Rural Health Clinics Act, health care facilities in rural areas can be certified by the Health Care Financing Administration as rural health clinics if they meet several criteria. The clinics must be located in HPSAs or MUAs. They must have a midlevel practitioner (generally a nurse practitioner or physician assistant) available at least 50 percent of the time. They must also be able to provide or arrange for certain diagnostic services and for inpatient hospital care.

Once a health care facility is certified as a rural health clinic, Medicaid and Medicare will reimburse the clinic for a wide range of specified "core services." These are the same services that Medicaid must now pay for when they are delivered to beneficiaries at FQHCs. A special, all inclusive rate per visit is calculated for rural health clinics. The rate is generally more favorable than the usual rates offered by Medicaid and Medicare.

Despite these advantages, relatively few rural health clinics have been certified. At the start of the program in 1977, it was anticipated there would be nearly 2,000 rural health clinics by 1990; in 1989, only 470 rural health clinics had been certified, however. Complicated and lengthy certification procedures and administrative requirements appear to have discouraged many health care facilities from applying for certification. Those community and migrant health centers that are certified rural health clinics will find that Medicaid and Medicare reimbursement under the federally qualified health centers program is a better option.

[53]An estimate prepared by the National Association of Community Health Centers for the Department of Health and Human Services indicates that when the FQHC program is fully

(continued...)

Under the law, these changes in Medicaid reimbursement for FQHCs were to take effect for services provided on or after April 1, 1990. In many areas, however, these provisions have not yet been implemented. Many states have been slow to establish Medicaid procedures to reimburse FQHCs at the higher levels called for under the new law. Some states have said they are uncertain about how the Health Care Financing Administration of the U.S. Department of Health and Human Services will interpret the new reimbursement requirements for FQHCs. The Health Care Financing Administration has issued some guidance on these issues, but will not issue regulations until later in 1991.

Increased Medicare Funding

Legislation enacted in the fall of 1990 will also benefit community and migrant health centers by increasing the reimbursement rates they receive from Medicare. Beginning October 1, 1991, the Medicare program will be required to reimburse federally qualified health centers on a "reasonable cost" basis for services provided to Medicare beneficiaries. Generally, these payments will be higher than the Medicare payments community and migrant health centers currently receive for the same service.

Medicare beneficiaries receiving services at FQHCs will benefit from the higher payments, as well. Usually they are required to pay an annual $100 deductible before Medicare will pay for services. However, the new law waives the deductible for services provided at FQHCs.

In addition to changing the reimbursement levels for Medicare services provided at FQHCs, the 1990 legislation expands coverage to include preventive services provided to Medicare beneficiaries at FQHCs. Health centers that already provide such services should benefit from this new reimbursement source. Other centers may be encouraged to expand their range of preventive services.

With their current mix of patients, the impact of these changes will not be as great for community and migrant health centers as the Medicaid reimbursement changes. Some 13 percent of the patients at centers located in rural areas, and nine percent of patients at centers in urban areas, were Medicaid beneficiaries in 1990. However, as Medicare beneficiaries learn they are not required to pay deductibles for services provided at the centers, and that coverage is available for preventive services, the centers may attract more Medicare patients.

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[53](...continued)

implemented, the increase in Medicaid revenue to community and migrant health centers could range from $36.2 million to $75.6 million a year. The figures represent calendar year 1989 dollars.

With increased financial support from Medicaid and Medicare, more Community and Migrant Health Center program funds will be available to provide care for individuals who have no health insurance coverage. In many areas, a reduction in waiting lists should be possible. In addition, some centers may be able to expand the range of services they offer.

* * * * *

Community and migrant health centers serve an important function in rural areas. Nevertheless, many medically underserved areas continue to lack community and migrant health centers. Where centers do exist, the demand for services often exceeds the capacity of the centers to provide them.

In addition, the continued viability of many centers is not assured. Some centers may become financially vulnerable if they cannot afford essential capital improvements or if there is a significant change in their mix of paying and non-paying patients. Attracting and retaining health care providers can also pose problems for centers.

The centers should benefit from the reauthorization of the National Health Service Corps and from the increased reimbursements for services provided to Medicaid and Medicare beneficiaries. If new community and migrant health centers are to be established in medically underserved areas, substantial increases in program appropriations will also be needed.

VI. The Medicaid Program

While many people benefit from Medicaid, the program still falls short of its goal of assuring access to health care for the disadvantaged. This is particularly true in rural areas.

In part, this is because Medicaid eligibility rules are generally more stringent in rural than in urban states. Consequently, a smaller proportion of the poor population in nonmetro than in metro areas is eligible for Medicaid.

In addition, some of those eligible for Medicaid benefits may not receive them because of a cumbersome application process. Eligibility determinations are generally made at the county welfare office, which can pose an additional problem in rural areas where applicants must travel great distances to apply. States have a number of options available to streamline the Medicaid application process, but few of the most rural states have taken steps to ease the burden of applying.

Furthermore, Medicaid beneficiaries are not guaranteed coverage for all medical services. Individual states determine which of a number of optional services they will cover, and whether limits will be imposed on certain services. In the area of service coverage, the most rural states are less generous than the most urban states.

For Medicaid beneficiaries, access to needed services is also determined by the willingness of health care providers to accept Medicaid beneficiaries as patients. States report that the availability of providers is limited in many rural areas, particularly for maternal and child health care.

Overall, rural residents benefit from the Medicaid program to a lesser extent than urban residents do, although recent legislative changes at the federal level should reduce this disparity somewhat.

This chapter examines these issues. It begins with a discussion of Medicaid coverage rates in urban and rural areas and an overview of Medicaid eligibility rules. The bulk of the chapter consists of an examination of four key areas where the Medicaid program is more limited in rural than in urban states: eligibility rules for families with children; eligibility rules for elderly people and people with disabilities; the range of medical services covered under the program; and the availability of health care providers willing to accept Medicaid patients.

Medicaid Coverage Rates in Rural and Urban Areas

The Medicaid program covers a slightly higher proportion of the rural than of the urban population. Some 9.1 percent of the nonmetro population was covered under Medicaid in 1988, compared with 8.5 percent of the metro population. This higher rate of Medicaid coverage among the nonmetro population reflects the higher poverty rates in nonmetro areas. A greater proportion of nonmetro residents are poor and thus in need of Medicaid services.[54]

When just the poverty population is considered, the picture changes significantly:

- Fewer than two of every five rural poor people — 38.7 percent — had Medicaid coverage in 1988.

- This was well below the coverage rate of 44.8 percent among the urban poor.

The principal reason for the lower Medicaid coverage rate among the rural poor is more restrictive eligibility rules in the more rural states. In addition, low-income people who are eligible for Medicaid may be less likely to apply for benefits in rural than in urban areas.

There are a number of reasons why rural residents who are eligible for Medicaid may not apply. Potential applicants may be discouraged by the need to travel great distances to apply for benefits or by a cumbersome application

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[54]Chollet, Deborah et al., *Uninsured in the United States: The Nonelderly Population Without Health Insurance, 1988*, Employee Benefit Research Institute, September 1990.

process. Residents of some communities may not apply if the community does not have a health care provider willing to accept Medicaid patients. Some residents may be reluctant to participate in a program that has traditionally been associated with welfare benefits. Finally, some rural residents, particularly those in more isolated communities, may simply be unaware they are eligible for Medicaid.

Overview of Medicaid Eligibility Rules

Medicaid is intended to provide health care coverage for two broad groups of beneficiaries: 1) low income families with children; and 2) low income elderly people and people with disabilities. Within each of these two groups, federal law defines categories of people who may receive Medicaid benefits. Coverage of certain categories of participants is mandatory, while other categories may be covered at state option.

In general, states must provide Medicaid coverage for individuals who receive cash assistance under a federally aided welfare program. Thus, individuals who receive cash assistance under the Aid to Families with Dependent Children or AFDC program are automatically eligible for Medicaid. Similarly, most beneficiaries of the Supplemental Security Income or SSI program are automatically eligible for Medicaid.[55]

As of April 1, 1990, states were required to extend Medicaid eligibility to another mandatory category: pregnant women, infants, and children under age six with family incomes below 133 percent of the federal poverty line. States have the option of providing Medicaid coverage for pregnant women and infants with incomes between 133 percent and 185 percent of the poverty line.

As of July 1, 1991, states will also be required to extend coverage to poor children from the ages of six through 18 who were born after September 30, 1983. This requirement will effectively phase in Medicaid coverage over the next 12 years for virtually all children in these age brackets whose families have incomes below the poverty line. By October 1, 2002, virtually all poor children less than 19 years of age will be eligible for Medicaid.[56]

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[55]In the majority of states, receipt of a federal SSI payment means automatic eligibility for Medicaid. However, states may exercise an option — known as the 209(b) option — to use Medicaid eligibility criteria more restrictive than the SSI criteria. There are 13 of these "209(b)" states. This matter is discussed in more detail in footnote 13.

[56]Determinations about financial eligibility for the Medicaid program generally are made on the basis of both an income and an assets test. In recent years, however, states have been given

(continued...)

In addition, there is a new mandatory category of low income elderly people and people with disabilities who are eligible for a limited form of Medicaid assistance. These are people, known as Qualified Medicare Beneficiaries, who have incomes below the poverty line but are not otherwise eligible for Medicaid coverage in their state. Under legislation enacted in 1988, state Medicaid programs must pay the premiums, deductibles, and other costs Qualified Medicare Beneficiaries must bear to receive health care coverage under Medicare.[57] Thus, while these people do not receive other Medicaid services, they are absolved of the substantial beneficiary costs associated with participating in the Medicare program.[58]

In addition to covering these mandatory categories of beneficiaries, states also have the option of covering additional groups. As noted, states may elect to set income limits for pregnant women and infants anywhere between 133 percent and 185 percent of the poverty line. States also have the option to expand Medicaid coverage for elderly people and people with disabilities by establishing income eligibility limits for these groups at up to 100 percent of the poverty line. In states electing this option, elderly people and people with disabilities who have incomes below the poverty line receive full Medicaid coverage.

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[56](...continued)

the option to eliminate the assets test for pregnant women and children. All but five states have done so. In those five states, some children with family incomes below the poverty line may still not qualify for Medicaid coverage if the family has assets in excess of the limit established by the state.

[57]Under the 1988 legislation, state Medicaid programs were given the option to phase in coverage of QMBs on a timetable ending January 1, 1992, or January 1, 1993 in 209(b) states. With the passage of the 1990 Omnibus Budget Reconciliation Act, however, states are required to extend QMB coverage by January 1, 1991 (or in the case of the 209(b) states, by January 1, 1992), to elderly people and to people with disabilities who have incomes up to 100 percent of the poverty line.

In addition, the 1990 Omnibus Budget Reconciliation Act also requires that by January 1, 1993, state Medicaid programs must also pay the Medicare premiums (but not the deductibles or other cost-sharing charges) for elderly people and people with disabilities who have incomes between 100 percent and 110 percent of the federal poverty line. By January 1, 1995, states must pay the Medicare premiums for elderly people and people with disabilities who have incomes between 100 percent and 120 percent of the poverty line.

[58]Medicaid also pays Medicare charges for elderly people and people with disabilities who receive full Medicaid coverage from their state and who meet the QMB income and assets standards. Some Medicaid beneficiaries qualify for Medicaid under the Medically Needy program because they have very high medical expenses. A small number of these people may actually have assets or incomes that exceed the QMB limit. Therefore the Medicaid program in some states may not pay Medicare charges for these Medicaid beneficiaries.

In addition, states have discretion over whether to operate a Medically Needy component as part of their Medicaid programs. Under the Medically Needy component, states may provide Medicaid coverage to families with children — and to elderly people and people with disabilities — whose medical expenses are so large that their remaining income, after medical expenses are deducted, falls below Medically Needy income limits established by the state.[59] Also, families with incomes between the state's AFDC income limit and the state's Medically Needy income limit become eligible for Medicaid even if they do not have medical bills to deduct from their income.[60] Some 36 states operate a Medically Needy component as a part of their Medicaid program.

Finally, because states have complete discretion over the income limits used to determine eligibility for AFDC — and partial discretion over SSI income limits[61] — states exercise considerable discretion over Medicaid eligibility in other ways as well.

State Variations in Medicaid Eligibility Rules for Families with Children

With states having such wide latitude in setting Medicaid eligibility requirements, a much larger proportion of the low income population is eligible for the program in some states than in others. The variations between urban and rural states are especially marked. A comparison of the Medicaid eligibility rules for families with children in the 10 most rural and the 10 most urban states shows the rules are generally more restrictive in the rural states. Medicaid eligibility policies for families with children are particularly restrictive in the nine frontier states.

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[59]Federal law mandates that when a state establishes a Medically Needy program, it must, at a minimum, cover pregnant women and children. A state may also cover certain additional categories, such as the elderly and individuals with disabilities. Of the 36 states with Medically Needy programs, 34 cover the elderly and individuals with disabilities.

[60]Medically Needy income limits can be set up to one-third higher than the state's maximum benefit level for AFDC.

[61]The federal government establishes basic SSI benefit levels, which are federally funded, and SSI income eligibility limits. States are allowed to supplement the federal benefit, and 27 states do so. In these states, SSI income limits are usually increased when SSI state supplemental benefits are provided.

Variations in Eligibility Rules for Pregnant Women and Infants

States are required to provide Medicaid benefits to pregnant women, infants, and children under age six with family incomes below 133 percent of the federal poverty line. States have the option, however, of going beyond this mandate and providing Medicaid coverage to pregnant women and infants with family incomes up to 185 percent of the poverty line. Expanding coverage in this manner is an important step to bringing adequate health care to more pregnant women and infants during a critical period for growth and development.

- As of July 1990, only four of the 10 most rural states had set their income eligibility limits for pregnant women and infants higher than 133 percent of the poverty line. By contrast, eight of the 10 most urban states had done so.

- None of the frontier states had set income limits for pregnant women and infants higher than 133 percent of the poverty line.[62]

Table V
Federal Poverty Line by Family Size, 1990*

Family Size	Annual Income
1	$6,280
2	8,420
3	10,560
4	12,700
5	14,840

*The poverty line figures cited throughout this chapter are those issued by the Department of Health and Human Services each year for use in Medicaid and other federal programs. The 1990 figures were published in the February 16, 1990, issue of the Federal Register. These figures differ slightly from the poverty line figures used by the Bureau of the Census.

Variations in AFDC Income Limits and in Use of the Medically Needy Option

For many members of low income families — especially women who are not pregnant and (until October 1, 2002) some poor children age six and older — Medicaid eligibility remains based either on eligibility for AFDC or, in states with a Medically Needy program, on having income below the state's Medically Needy

[62]For pregnant women, these coverage rules apply during pregnancy and for the first 60 days after the child is born. Many women who are not on welfare, but who qualify for Medicaid during pregnancy because their incomes are below 133 percent of the poverty line (or in some states, below 185 percent of the poverty line), lose their health insurance coverage two months after their pregnancy ends.

income limit. AFDC income limits vary greatly among states, with rural states tending to have substantially lower income limits than urban states do.

- In July 1990, seven of the 10 most rural states had AFDC income eligibility limits below 45 percent of the poverty line.

- Six of the nine frontier states had AFDC income eligibility limits below 45 percent of the poverty line.

- But AFDC income eligibility limits were below 45 percent of the poverty line in only one of the 10 most urban states.

These disparities are compounded because many rural states fail to offer the Medically Needy program, while most urban states do.

- Only five of the 10 most rural states have adopted the Medically Needy program.

- All 10 of the most urban states have Medically Needy programs.

Medicaid income eligibility limits for poor women who are not pregnant and for some poor children are based on the higher of the AFDC or the Medically Needy income limit. These limits remain far below the poverty line in most of the highly rural states.

- In eight of the 10 most rural states, Medicaid income limits for these groups are below 50 percent of the poverty line. This is true in only one of the 10 most urban states.

- In 1990, the median Medicaid income limit for a family of three was $373 per month in the 10 most rural states. By contrast, it was $638 per month in the 10 most urban states. This difference far exceeds any variation in the cost-of-living.

Given these differences, the mandate that took effect in April 1990 and raised income limits for pregnant women, infants, and children under six to 133 percent of the poverty line — along with the new mandate that phases in Medicaid coverage over the next 12 years to virtually all poor children between the ages of six and 19 — should have a profound impact in rural states. In many of these states, Medicaid income limits will rise from less than half of the poverty line to 133 percent of the poverty line for pregnant women and young children and to 100 percent of the poverty line for older children.

Table VI
Medicaid Income Eligibility Limits
For Families With Children, 1990
(As a Percentage of the Poverty Line)

	AFDC Family of Three	Medically Needy Family of Three	Pregnant Women and Infants
Most Rural States			
Idaho	36%	___	133%
Vermont	77	100%	185
Montana	42	48	133
South Dakota	44	___	133
Wyoming	41	___	133
Mississippi	42	___	185
Maine	74	69	185
West Virginia	29	33	150
North Dakota	46	49	133
Arkansas	23	___	133
Most Urban States			
New Jersey	48%	64%	133%
District of Columbia	47	62	185
California	79	106	185
Maryland	46	53	185
Connecticut	66	88	185
Rhode Island	63	84	185
Florida	33	46	150
Massachusetts	66	88	185
New York	71	81	185
Pennsylvania	48	53	133
Frontier States			
Montana	42%	48%	133%
Wyoming	41	___	133
North Dakota	46	49	133
Nevada	38	___	133
Utah	59	59	133
South Dakota	44	___	133
New Mexico	35	___	133
Colorado	48	___	133
Idaho	36	___	133

Center on Budget and Policy Priorities
Source: National Governors' Association, *MCH Update*, July 1990.

The magnitude of the impact, however, will depend on whether families with newly eligible pregnant women and children are made aware of the greatly expanded eligibility rules. If families do not learn of this change in the Medicaid program, they are unlikely to apply.

Variations in Assets Limit

Another area where states can exercise an important option to broaden Medicaid coverage is whether to apply an assets test. States may choose to determine financial eligibility for pregnant women, infants, and young children on the basis of family income alone — and to dispense with an assets test. This can be particularly advantageous in rural areas where low income families are more likely to have property or vehicles that may disqualify them under an assets test. Moreover, dispensing with the assets test can help streamline the application process by reducing the need for applicants to provide various types of documentation and for eligibility workers to examine these documents.

Most rural and urban states alike have opted to dispense with use of an assets test when determining eligibility for these groups. California, Illinois, Iowa, North Dakota, and Texas continue to impose assets tests on pregnant women, infants, and children.

The Presumptive Eligibility Option for Pregnant Women

States also have an option that can facilitate timely entry into the Medicaid program by pregnant women. This option, known as "presumptive eligibility," is designed to enable eligible pregnant women to begin receiving Medicaid coverage as early as possible.

Under the presumptive eligibility option, certain publicly funded health care providers are permitted to make temporary determinations of Medicaid eligibility at the site where pregnant women receive care. These women thus do not need to travel to the Medicaid office — usually the county welfare office — and wait for a Medicaid application to be processed before they can receive health care coverage. Pregnant women who are determined to be presumptively eligible by a publicly supported health clinic must apply at the local Medicaid office by the end of the following month to retain their coverage.

In states that fail to elect the presumptive eligibility option, women must apply for benefits at the Medicaid office first and then wait up to 45

Table VII
Medicaid Program Characteristics
In the Most Rural and Urban States, 1990

	Women and Children		
	Presumptive Eligibility	Enhanced Prenatal Services	Outstationing
Most Rural States			
Idaho	Y	Y	
Vermont		Y	Y
Montana			
South Dakota			
Wyoming			
Mississippi		Y	Y
Maine	Y		
West Virginia		Y	Y
North Dakota			
Arkansas	Y	Y	Y
Most Urban States			
New York	Y	Y	
District of Columbia			
California		Y	Y
Maryland	Y	Y	
Connecticut		Y	
Rhode Island			
Florida	Y		Y
Massachusetts	Y	Y	
New York	Y	Y	
Pennsylvania	Y	Y	
Frontier States			
Montana			
Wyoming			
North Dakota			
Nevada			
Utah	Y	Y	Y
South Dakota			
New Mexico	Y	Y	
Colorado	Y		
Idaho	Y	Y	

Center on Budget and Policy Priorities
Source: National Governors' Association, *MCH Update*, July 1990.

days for the Medicaid program to determine whether they are eligible. Consequently, pregnant women may have to wait up to six and a half weeks *after* they apply for Medicaid before they begin receiving health care coverage. Often health care services are not available for women who have no health insurance. Therefore, women often receive no prenatal care while they wait for the Medicaid office to process their applications. The medical advantages of receiving care early in pregnancy are well documented. Women who receive early and regular prenatal care are less likely to have complications during pregnancy and more likely to have healthy infants.

Presumptive eligibility can be particularly effective in rural areas because it removes the initial barrier of having to travel long distances to reach the county welfare office. Women apply for Medicaid at the same place and time they begin prenatal care. Nevertheless, a number of rural states have failed to adopt presumptive eligibility.

- As of July 1990, only three of the 10 most rural states had a presumptive eligibility program. Six of the 10 most urban states did.

- Four of the nine frontier states had a presumptive eligibility program.

Outstationing Medicaid Eligibility Workers at Prenatal Care Sites

Another Medicaid option allows states to "outstation" Medicaid eligibility workers at sites where women receive prenatal care. This option provides an additional mechanism to overcome transportation barriers and make Medicaid more accessible for pregnant women.

As of July 1990, four of the 10 most rural states, along with two of the 10 most urban states, stationed eligibility workers at some prenatal care sites. Only one of the nine frontier states outstationed eligibility workers.

Greater use of outstationing should, however, occur in coming years. A new federal mandate requires state Medicaid programs to accept and begin processing applications from pregnant women and children at locations other than county welfare offices. Beginning July 1, 1991, pregnant women and children must be permitted to apply for Medicaid at federally qualified health centers, which include all community and migrant health centers, and at "disproportionate share" hospitals. The new law also requires that simplified and shortened applications be developed and be available at the new application sites for women and children who wish to apply just for Medicaid, rather than for both Medicaid and AFDC. These changes in the application procedure should make Medicaid more accessible for women and children.

Variations in Medicaid Eligibility for the Elderly and Those with Disabilities

Medicaid eligibility rules for the elderly and for people with disabilities, like the rules for families with children, vary among the states. Here, also, the eligibility criteria tend to be more restrictive in rural than in urban states.[63]

The Medicaid eligibility rules for these groups are tied closely to eligibility for the Supplemental Security Income program. In most states, SSI beneficiaries are automatically eligible for Medicaid. Since the SSI income limits vary somewhat among the states — although not to the extent AFDC income limits do — Medicaid income limits for the elderly and disabled vary as well.

Medicaid eligibility criteria for these groups are also affected by other state decisions. As noted above, states may elect to establish a Medically Needy program component. States may also choose to provide Medicaid coverage for elderly people and people with disabilities who have incomes below the poverty line but do not qualify for SSI.[64]

Variations in Medicaid Income Limits for SSI Recipients

In about half of the states, the federal SSI income limit effectively serves as the Medicaid income limit for people who are elderly or have disabilities. For most of these people — that is, for those who do not have earnings — the federal SSI income limit equals the maximum federal SSI benefit level plus $20 a month.

In 1989, the maximum federal SSI benefit, which is provided to people with no countable income, was $368 a month for an individual and $553 for a couple.[65] Thus, the federal SSI income limit was $388 a month for elderly and disabled individuals and $573 a month for elderly and disabled couples.

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[63]The focus in this report is on Medicaid eligibility for elderly people and people with disabilities who live in the community rather than in long-term care institutions. Medicaid financial eligibility requirements are less stringent for people residing in such institutions.

[64]As noted earlier, the federal government has established nationally uniform income eligibility limits for the Qualified Medicare Beneficiary program. Under the QMB program, state Medicaid programs pay the Medicare premiums, deductibles, and copayments for elderly people and people with disabilities who have incomes below the poverty line. However, elderly and disabled people who qualify for the QMB program — but are not otherwise eligible for Medicaid — do not receive any of the other benefits of regular Medicaid coverage.

[65]Figures from 1989 are used here to correspond with data from a 1989 study pertaining to Medicaid income eligibility limits for the elderly. These are the most recent data on Medicaid income limits available on a national basis. For 1991, the federal SSI benefit for 1991 is $407 for an individual and $610 for a couple.

While these income limits are higher, when measured as a percentage of the poverty line, than those used in most states in the AFDC program, they still are modest. In 1989, the federal SSI benefit limit for individuals equalled 74 percent of the poverty line; the benefit limit for couples was 83 percent of the poverty line. The SSI income limits are somewhat higher than this for people with earnings, but few elderly and disabled SSI recipients have earned income.

In most of the remaining states, Medicaid income limits are higher than the federal SSI income limits.[66] In part, this is because the federal SSI benefit levels leave elderly and disabled people below the poverty line — and 27 states add a state supplemental SSI benefit that brings beneficiaries closer to or in a few cases, above the poverty line. In these states, SSI income eligibility limits are automatically raised when state supplemental benefits are provided. In most of these states, this leads to an increase in Medicaid income limits as well, since in most of these states, elderly and disabled people who qualify for state SSI benefits also are automatically eligible for Medicaid.

Rural states are less likely than urban states to provide these SSI supplemental benefits. Furthermore, among the states that do pay these supplemental benefits, the amount of the benefit — and hence the amount by which the SSI and Medicaid income limits generally are raised — tends to be smaller in rural states than in urban jurisdictions. As a result, Medicaid income limits for SSI beneficiaries tend to be significantly lower in rural than in urban states.

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[66]There are three states where Medicaid income limits are set a at *lower* level than the federal SSI income limits and not all recipients of federal SSI benefits are eligible for Medicaid. These three states — which have elected to use Medicaid income eligibility criteria more restrictive than the federal SSI income eligibility criteria — are Hawaii, Ohio, and North Carolina.

When the federal SSI program was implemented in 1974, it replaced state assistance programs for the aged and people with disabilities. At that time, states were permitted to choose between extending Medicaid to all SSI recipients or — under what is known as the 209(b) option — making Medicaid eligibility dependent upon the eligibility criteria in effect in the states before SSI was established. In states electing the more restrictive 209(b) option, some SSI recipients are ineligible for Medicaid. In these states, for example, the definition of disability may be more restrictive than that used in SSI, or the income or assets limits may be lower.

Some 13 states have elected this option. They are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia. Three of these 13 states set their Medicaid income limits at a lower level than the federal SSI income limits.

State Eligibility Options for People *Not* on SSI

States also have several options that allow them to extend Medicaid eligibility to certain categories of elderly people and people with disabilities who are not on SSI. One of the most significant of these is an option allowing states whose SSI income limits are below the poverty line to provide Medicaid coverage to elderly and disabled people who are not on SSI but who still are poor. Essentially, states making use of this option can cover elderly people and people with disabilities whose incomes fall between the state's SSI income limit and the poverty line.[67]

As of July 1989, some 13 states had adopted this option. Urban states made greater use of the option than rural states did.

- Five of the 10 most urban states had elected this option, thereby raising their Medicaid income limits for people who are elderly or have disabilities. In several other urban states, this option was not relevant because either the SSI income limits or the Medically Needy income limits were equal to or greater than the poverty line for both individuals and couples.

- By contrast, only two of the 10 most rural states had elected to expand Medicaid coverage in this manner, and one of these states only raised the limit to 85 percent of the poverty line. This is especially noteworthy since none of the highly rural states had SSI income limits or Medically Needy income limits that equaled or exceeded the poverty line for both individuals and couples.

- None of the nine frontier states had elected this option.

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[67]Another state option is the option to establish a Medically Needy program. Under this program states provide Medicaid coverage to families with children that do not receive AFDC — and to elderly and disabled people not on SSI — if a household's medical expenses are so large that income after medical expenses are deducted falls below Medically Needy income limits set by the state. The Medically Needy program is important for some elderly people and people with disabilities whose medical expenses are high. For elderly and disabled people without high medical expenses, however, the Medically Needy program does not have a very large impact in expanding Medicaid eligibility. Federal law specifies that the Medically Needy income limits may not exceed 133 percent of a state's maximum AFDC benefit level. Since AFDC benefit levels are far below SSI benefit levels in most states, state Medically Needy income limits generally fall below the SSI income limits. Therefore, among elderly people and people with disabilities, those who qualify for Medicaid through the Medically Needy program usually have income, before medical expenses are incurred, higher than the SSI limits, but below the medically needy income limits after medical expenses.

Taking into account all the options states have regarding Medicaid income eligibility limits for people who are elderly, the most urban states have considerably more generous Medicaid eligibility rules than the most rural states do.[68]

- In 1989, Medicaid income eligibility limits for elderly individuals and couples were equal to or greater than the poverty line in eight of the 10 most urban states.

- By contrast, in eight of the 10 most rural states, Medicaid income limits for elderly individuals and couples fell below the poverty line.

- In all nine frontier states, Medicaid income limits for elderly people were below the poverty line.

Variations in the Application Process for the Elderly and Those with Disabilities

There are also variations in the application process states use to enroll elderly people and people with disabilities in Medicaid. It is much easier for SSI recipients in some states than in others to enroll in Medicaid. These differences do not, however, have a distinct urban/rural character.

States use three methods to enroll SSI recipients in Medicaid. Under the process most favorable to beneficiaries, states enter into agreements with the Social Security Administration to provide Medicaid coverage *automatically* to SSI recipients. In these states, no separate Medicaid program application is required; as a result, this process greatly facilitates Medicaid enrollment. Thirty-two states use this arrangement.

By contrast, in 13 states, SSI recipients wishing to receive Medicaid coverage must file a separate application. These states, known as "209(b) states" have elected an option to make Medicaid eligibility rules more restrictive than the federal SSI criteria — and to deny Medicaid coverage to some people receiving federal SSI benefits.[69] Medicaid eligibility is not automatic for SSI beneficiaries in these states.

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[68]The figures used here reflect income eligibility limits for the elderly. In some states, income eligibility limits for people who have disabilities may vary somewhat from those used for the elderly.

[69]See footnote 14.

Finally, in six states, Medicaid eligibility is automatic for SSI recipients, but only if a separate application is filed with the state Medicaid agency. These states could enter into an agreement with the Social Security Administration so that no separate application is needed, but have failed to do so. Three of these states — Idaho, Nevada, and Utah — are frontier states.[70]

The requirement in these six states that SSI recipients file a separate application for Medicaid can be an unnecessary burden for poor elderly people and people with disabilities who live in rural areas and particularly in frontier areas, where the population is widely dispersed and public transportation often is not available.

State Variations in Health Care Services Offered to Medicaid Beneficiaries

Mandatory Service and Optional Services

In addition to having considerable discretion over Medicaid income limits and various other Medicaid eligibility rules, states exercise some discretion over which medical services are covered. Not surprisingly, the most rural states are less generous in these areas than the most urban states.

Federal law requires that for all mandatory categories of Medicaid beneficiaries, state programs must provide coverage for nine core services. For 33 additional medical services, the states decide whether to provide coverage.[71]

- In 1990, only two of the 10 most rural states covered more than 25 of the 33 optional services.
- By contrast, six of the 10 most urban states did.

States are also allowed to expand their benefit package to provide additional services for specific groups of beneficiaries, even if the additional services are not available to all other beneficiaries. For example, states may provide enhanced prenatal services for pregnant women or home and community based services for the frail elderly.

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[70]The other states that require SSI recipients to file a separate application with the Medicaid office are Alaska, Kansas, and Oregon.

[71]States with Medically Needy programs may choose to offer the same package of covered benefits to both mandatory categories of Medicaid beneficiaries and to the Medically Needy or they may offer a more restrictive package to those who qualify for Medicaid through the optional Medically Needy program.

Table VIII
Medicaid Income Eligibility Limits
For Elderly Individuals, 1989
(As a Percentage of the Poverty Line)

	SSI Benefit Limits	Medically Needy	Expansion to Poverty Line	Highest Income Eligibility Limits
Most Rural States				
Idaho	86%	—	—	86%
Vermont	86	147%	—	147
Montana	74	74	—	74
South Dakota	74	—	—	74
Wyoming	78	—	—	78
Mississippi	74	—	85%	85
Maine	76	80	100	100
West Virginia	74	40	—	74
North Dakota	74	69	—	74
Arkansas	74	22	—	74
Most Urban				
New Jersey	80%	70%	100%	100%
District of Columbia	77	78	100	100
California	121	120	—	121
Maryland	74	75	—	75
Connecticut	112	91	—	112
Rhode Island	86	110	—	110
Florida	74	59	100	100
Massachusetts	100	100	100	100
New York	92	92	—	92
Pennsylvania	80	82	100	100
Frontier States				
Montana	74%	74%	—	74%
Wyoming	78	—	—	78
North Dakota	74	69	—	74
Nevada	81	—	—	81
Utah	74	68	—	74
South Dakota	74	—	—	74
New Mexico	74	—	—	74
Colorado	85	—	—	85
Idaho	86	—	—	86

Center on Budget and Policy Priorities
Source: Diane Rowland et al., *The Medicare Buy-In: Variations in State Medicaid Policy*, Report to Families USA Foundation, February 1990.

Table IX
Medicaid Income Eligibility Limits
For Elderly Couples, 1989
(As a Percentage of the Poverty Line)

	SSI Benefit Limits	Medically Needy	Expansion to Poverty Line	Highest Income Eligibility Limits
Most Rural States				
Idaho	86%	—	—	86%
Vermont	100	110%	—	110
Montana	83	77	—	83
South Dakota	83	—	—	83
Wyoming	86	—	—	86
Mississippi	83	—	85%	85
Maine	85	66	100	100
West Virginia	83	41	—	83
North Dakota	83	60	—	83
Arkansas	83	32	—	83
Most Urban				
New Jersey	87%	65%	100%	100%
District of Columbia	102	62	100	102
California	167	140	—	167
Maryland	83	62	—	83
Connecticut	107	90	—	107
Rhode Island	100	89	—	100
Florida	83	45	100	100
Massachusetts	100	100	100	100
New York	99	99	—	99
Pennsylvania	90	64	100	100
Frontier States				
Montana	83%	77%	—	83%
Wyoming	86	—	—	86
North Dakota	83	60	—	83
Nevada	94	—	—	94
Utah	83	62	—	83
South Dakota	83	—	—	83
New Mexico	83	—	—	83
Colorado	(NA)	—	—	(NA)
Idaho	86	—	—	86

Center on Budget and Policy Priorities
Source: Diane Rowland et al., *The Medicare Buy-In: Variations in State Medicaid Policy*, Report to Families USA Foundation, February 1990.

Enhanced Prenatal Services

States may choose to cover any or all of a number of special enhanced prenatal services for pregnant women, such as care coordination, risk assessment, nutrition counseling, health education, psychosocial counseling, home visiting, and extra transportation services.

Nationally, 30 states provided Medicaid coverage for one or more of these enhanced prenatal services in 1990. These services were more likely to be found in urban than in rural states.

- Five of the 10 most rural states — and three of the nine frontier states — provided enhanced prenatal services through the Medicaid program.

- Seven of the 10 most urban states did.

Services such as home visiting and transportation are of particular importance in frontier areas where residents often have to travel great distances to obtain health care. Of the frontier states offering enhanced prenatal services, two covered home visits. None, however, had made special plans to insure that pregnant women had transportation services available to help them keep appointments for prenatal care.

Home and Community-Based Services for the Frail Elderly

Legislation enacted in 1990 gives states an important new option to expand Medicaid services for frail elderly people. The new law allows states to provide home and community-based long-term care services for "functionally disabled" elderly individuals.[72] States may select the services they wish to cover from a broad range of medical and social services, such as homemaker or health aid services, personal care services, chore services, nursing services, and outpatient services for those with chronic mental illness. This new option is designed to help frail individuals remain in their homes and community rather than being committed to an institution.

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[72]Functional disability is defined as an inability to perform certain basic activities of daily living.

Transportation Services

Transportation is one Medicaid service that is of particular importance for rural residents whose access to medical care may be limited by distance. Federal law requires all state Medicaid agencies to assure the availability of necessary transportation to medical care. The law directs states to include descriptions, in their Medicaid state plans, of methods used for transporting both ambulatory and non-ambulatory patients in emergency and non-emergency situations.

Transportation to care remains a problem, however, for Medicaid recipients in many states. In 1987, the Intergovernmental Health Policy Project at George Washington University conducted a 50-state survey of Medicaid transportation services. Twenty-four states reported that transportation needs had not been met sufficiently in rural areas.[73] A 1990 report from the National Governors' Association notes that although states are already required to make transportation available to all Medicaid beneficiaries, the regulations have rarely been enforced and states have been unable to consistently meet the transportation needs of beneficiaries.[74]

Before this option became available, Medicaid paid for such services only when the beneficiary lived in a nursing home or mental health institution, or if the state had a waiver from the Department of Health and Human Services. Waivers were only granted to states if they could demonstrate that providing coverage for services in a home or community setting rather than in a nursing home, would entail no additional Medicaid cost. If states choose to provide home and community-based services under the new option, however, they are not required to demonstrate that the services will cost less than the same services provided in an institutional setting.

Federal spending for Medicaid services provided under the new option is capped at $580 million over the next five years. Since the funding is limited, states are allowed to designate particular categories of functionally disabled elderly people and to restrict services to people in these categories. For example, coverage could be limited to people in certain localities, to individuals over a certain age, or to individuals with Alzheimer's disease.

The opportunity to remain in one's community and receive needed care may be advantageous for many elderly Medicaid beneficiaries and their families living in rural areas, particularly if there are no nursing homes in the vicinity. Also,

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[73]Hill, Ian T. and Trude Bennett, *Enhancing the Scope of Prenatal Services*, National Governors' Association, 1990.

[74]Howe, Mary and Sheila S. Ray, *A 50 State Review of Medicaid Transportation Services*, Intergovernmental Health Policy Project, George Washington University, February 1987.

rural communities that lack nursing home facilities can benefit economically when Medicaid funds are used to pay for the work of caregivers in the community rather than to cover costs in long-term care institutions located outside the community. Since this new option just became law in late 1990, it is too early to know how extensively it will be used — or whether rural states will take advantage of it.

Variations Between States in the Availability of Medicaid Providers

Finally, there are variations among states in the availability of Medicaid providers. Here, also, the problems are more acute in rural than in urban areas.

At the heart of this problem is the fact that people who have Medicaid coverage are not assured of receiving medical care. The Medicaid program covers the costs of certain health care services, but does not provide the services itself. Physicians and other health care practitioners provide the services and are reimbursed by Medicaid. As a result, if most or all of the practitioners in an area decline to participate in the Medicaid program, beneficiaries may be unable to find health care they can afford.

The lack of availability of practitioners who will participate in Medicaid is a growing problem in many areas of the country. Participation among obstetricians is particularly low. A National Governors' Association study in 1987 found that substantial numbers of pregnant women who were eligible for Medicaid were having difficulty obtaining prenatal care — because they could not find physicians willing to accept Medicaid beneficiaries. In surveying state Medicaid and Maternal and Child Health agencies, NGA found the lack of maternity care providers particularly acute in rural areas.[75]

Specifically, 35 of the 50 states reported in the NGA survey that general reductions in obstetrical practice and low participation in the Medicaid program by providers were significantly curtailing the availability of care for low income women in rural areas. Only three states reported similar problems in urban or suburban areas.

One reason physicians commonly give for their reluctance to participate in Medicaid is the low reimbursement rates in many states. A survey by the American College of Obstetricians and Gynecologists found considerable variation among states in the reimbursement rates Medicaid pays for routine obstetrical care.

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[75]Lewis-Idema, Deborah, *Increasing Provider Participation*, National Governors' Association, 1988.

And while a number of states have recently raised their Medicaid reimbursement rates for obstetrical services, the rates remain low in many areas — with rates in rural states often falling well below the rates paid in more urban states.[76]

The ACOG survey showed, for example, that in the 10 most rural states, reimbursement rates for routine prenatal care and delivery ranged from $499 to $1,070 in 1990, with just one state paying more than $865. By contrast, in the 10 most urban states, the rates paid by Medicaid for obstetrical care ranged from $468 to $1,361, with six of the states paying $1,000 or more.[77] Differences like these are likely to contribute to the scarcity of Medicaid providers for low income residents in many rural areas.

Low reimbursement rates also appear to be limiting participation in Medicaid by pediatricians. A study by the American Academy of Pediatrics found that pediatricians were less likely to participate in Medicaid in 1989 than they had been in 1978. During this period, the proportion of pediatricians participating in the Medicaid program decreased from 85 percent to 77 percent. Those who did participate in 1989, were more likely to limit their participation. The study reported that between 1978 and 1989, the proportion of pediatricians restricting their practices by caring for only some of the Medicaid beneficiaries requesting care rose from 26 percent to 39 percent. The study did note that in 1989, pediatricians in nonmetro areas were more like to participate in the Medicaid program, and less likely to restrict their practices, than pediatricians in metro areas.[78]

Pediatricians in the study were asked to identify reasons for not participating in Medicaid or for limiting participation. Some 71 percent cited low reimbursement rates. A decade earlier, 60 percent of the doctors cited this as a factor affecting their decision concerning participation. Other factors included unpredictable payments, complex regulations, payment delays, and restrictions on health care services covered by Medicaid.

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[76]American College of Obstetricians and Gynecologists, *Medicaid Reimbursement for Obstetric Care (Specialist) by State*, May 1990.

[77]Most states establish a single rate for obstetrical care. The rate includes payment for prenatal care, delivery, and postpartum care. Some states reimburse separately for office visits and delivery. For this report, single rates were calculated for these states. The calculations were based on the assumption that most women would make a total of 10 office visits. ACOG recommends that women make 13 prenatal visits.

[78]Yudkowsky, Beth et al., "Pediatrician Participation in Medicaid: 1978 to 1989", *Pediatrics*, Volume 85, No. 4, April 1990.

In 1989, Congress acted to help address the problem of low participation in Medicaid by maternal and child health care providers. The legislation directs states to set reimbursement rates for these providers at levels sufficient to attract enough providers so that care will be as accessible to pregnant women and children on Medicaid as it is to others in the same geographic area.

Under the 1989 law, the Health Care Financing Administration is required to review state reimbursement rates for obstetric and pediatric providers and to direct states to adjust the rates if necessary. Eventually, the review should lead to an increase in rates, but currently rates remain low in many states.

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The data presented in this chapter are cause for concern. They suggest not only that the rural poor are less likely to be covered by Medicaid than the urban poor are, but also that those rural residents who do have Medicaid coverage are often served less adequately than urban residents are.

Recommendations

Many rural residents, particularly those with low incomes, have limited access to health care services. Previous chapters have examined the factors preventing them from receiving care — limited financial resources, inadequate health insurance coverage, geographic barriers, and a limited supply of health care providers.

This chapter focuses on changes in several existing programs — the National Health Service Corps, community and migrant health centers, and Medicaid — that could improve rural residents' access to health care. The newly reauthorized National Health Service Corps is undergoing significant alterations and has been redesigned to increase the probability that health care providers will remain in underserved areas after fulfilling their obligation to the Corps. These program changes hold the potential to increase the supply of health care providers in rural areas, but the legislation must be implemented effectively — and sufficient funding must be made available — for this potential to be realized.

Community and migrant health centers are important health service providers for the low income rural population. They could play a still larger role, however. With the recent passage of federal legislation providing increased reimbursement through Medicaid and Medicare, centers have opportunities to enlarge their revenues — and both to increase the number of people served and the services provided.

Federal and state policy changes can also enhance the effectiveness of the Medicaid program and make Medicaid coverage for low income residents of rural states more comparable to the coverage provided to residents of other states.

Improvements in existing programs can benefit the medically underserved population. Yet, even with much improved programs, a substantial number of Americans will continue to lack health insurance coverage and access to health care services. In the long term, both a restructuring of the health insurance system and a policy to insure that health care services are widely available are needed. Unfortunately, the lack of agreement at the present time about how to restructure the health care system and how to finance major changes makes it unlikely that large-scale restructuring is imminent.

This chapter concentrates on immediate and short-term improvements in health care programs. This practical approach emphasizes changes that can have positive effects now. It is likely that even if major health care reform legislation is enacted and financing becomes available, the changes involved will take some years to implement. In the interim, existing programs must be as strong as possible and if the programs are effective, they might well become an integral part of a reformed health care system.

A discussion of alternative plans for achieving universal access to health care services is beyond the scope of this report. Nevertheless, it is important to recognize that efforts to extend health insurance to those who lack it could benefit rural residents to a disproportionate degree — because a larger proportion of the rural than urban population is uninsured. Much depends, of course, on the approach taken to increase health care coverage. For example, any plan that includes employer-based coverage must consider that a large portion of the rural workforce is employed in small firms or is self-employed. If small businesses were exempt from a requirement to provide health care coverage, a significant portion of the rural population may still be without insurance. At the same time, if small businesses are not exempted from an employer-based mandate, care would need to be taken to assure that the financial consequences of providing health insurance were not too burdensome for small employers. In the current market, small businesses typically pay higher health care premiums for employees than large businesses. Efforts to equalize or reduce disparities in premiums could be helpful. To be effective for the rural population, plans to extend health care coverage on a large scale may require some special tailoring.

While attempts to increase health insurance coverage are essential to improving health care in rural areas, they are not sufficient to insure access to health care. In many rural areas, the demand for health care services exceeds the local capacity to provide the services. Plans to increase health care coverage should be accompanied by efforts to increase the number of health care providers for medically underserved populations.

The National Health Service Corps

Congressional action in 1990 reauthorizing the National Health Service Corps program represents a federal commitment to improve access to health care in areas with a shortage of primary health care providers. A strong federal program is needed to insure not only that more primary health care providers practice in underserved areas, but also that the geographic distribution of primary health care providers in the United States is equitable.

In order to build a strong National Health Service Corps, substantial increases in funding are needed over the next several years. The persistence of the large federal budget deficit, however, and the new spending ceilings on domestic nonentitlement programs probably mean that appropriations will remain insufficient to achieve fully the program's goals. If primary health care services are to be available in all areas of the country, state efforts will be needed to complement the work of the Corps.

- **Substantial increases are needed in the funds appropriated for the National Health Service Corps.**

With the passage of the National Health Service Corps revitalization amendments of 1990, it is possible to begin rebuilding the Corps. Sufficient funds are needed, however, both to recruit NHSC personnel and to retain health care providers in health professional shortage areas.

Retaining health professionals in HPSAs is particularly crucial. During the next several years, very few new NHSC scholars will be available for service, and the number of loan beneficiaries will be limited. Because of the lag time between the award of scholarships and the availability of fully trained health professionals, students recruited under the scholarship program will not become available for service until several years after they receive their grants. Therefore, if current NHSC practitioners choose to leave HPSAs after completing their obligation to the Corps, it will not be possible to replace all of them. On the other hand, if efforts are successful to retain health care practitioners in HPSAs, health care services will be maintained, and the Corps will need to supply fewer practitioners in future years.

The $91.7 million appropriated for the Corps for fiscal year 1991 is substantially more than the $50.7 million appropriated for fiscal year 1990. Yet, after adjusting for inflation, it is 64 percent lower than the funding level in fiscal year 1980. The number of loans and scholarships that can be financed with the FY 1991 appropriation represents only a fraction of the more than 4,000 health care providers needed in the nation's primary care health professional shortage areas.

Some 1,900 primary health care providers are needed just in rural HPSAs. And, despite the emphasis in the recent legislation on efforts to retain health care providers in HPSAs, little funding has yet been provided to implement this aspect of the legislation.

To eliminate the shortage of health care providers in HPSAs and then to assure that these areas remain adequately staffed, the National Health Service Corps needs substantial annual increases in funds for both recruitment and retention.[79]

- **States should establish programs that offer financial assistance in return for a commitment from recipients to practice medicine in designated areas of the state.**

Most states make substantial contributions to subsidize medical education but do not usually obligate recipients of state aid to practice in an underserved area. A survey by the Congressional Research Service examined state funding for medical education in five large states. A total of $831.8 million was spent on medical education in the five states in 1989. The proportion of funding specified for programs that carry service obligations ranged from zero to 5.4 percent.[80]

This lack of action by states in attempting to influence the distribution of health care providers underscores the need for a strong federal program. A national program is also needed to assure that states with limited resources will be as likely as wealthier states to provide health care services for all of their residents. It is clear, however, that funding constraints limit the effectiveness of the National Health Service Corps. If states are not willing to impose some practice requirements on the health professionals they train, they will continue to have shortages of health care providers in certain areas.

The NHSC state loan repayment program provides federal matching funds for the operation of state loan repayment programs. Under such programs, as with the federal program, financial assistance is offered in return for a commitment from the recipient to practice medicine in a health professional shortage area.

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[79]On February 4, 1991, the Bush Administration released its proposed federal budget for fiscal year 1992. The funding level of $96.1 million for the NHSC program is just $5 million more than the amount appropriated for the program for fiscal year 1991.

[80]Congressional Research Service, "State Funding of Medical Instruction in Selected States," Memorandum to the House Committee on Energy and Commerce, August 1990.

In addition to participating in the NHSC state loan repayment program, states should consider linking more state assistance to service obligations.

- **Financial aid should be directed to the training of primary care practitioners.**

The recent National Health Service Corps legislation redesigns the program to improve recruitment and retention of primary health care providers. Yet with more health professionals choosing to specialize, the Corps has more difficulty recruiting practitioners with the skills necessary to provide primary care in health professional shortage areas. When Congress reauthorizes the health professions training programs in 1991, the legislation should favor programs that emphasize primary care. Efforts are also needed to develop health care systems to link primary care providers with subspecialists such as surgeons or cardiologists who will provide consultation and accept referrals. Similarly, systems must be developed to insure that in geographically isolated areas, primary care practitioners are able to arrange hospital admissions for their patients.

To help establish those linkages, federal or state financial assistance could be made available to medical schools that make practice in a health professional shortage area a required part of training for interns and residents. Similar arrangements are needed to assure that midlevel practitioners practice in shortage areas during their training. Such arrangements have several advantages. First, more practitioners become available to provide services in underserved areas. Second, students are exposed to a practice setting with which they might otherwise not be familiar. Finally, primary care practitioners and patients in shortage areas gain greater access to the specialized services available at academic institutions. State offices of rural health can help rural providers develop relationships with specialists who practice in other areas of the state. They can also work with academic institutions to establish training programs in rural settings.

Community and Migrant Health Centers

The majority of community and migrant health centers are located in rural areas, and they play an important part in improving access to health care for rural residents. The centers provide health care services for a segment of the population that might otherwise go without care. But Community and Migrant Health Center programs could have a greater impact if centers could serve more patients and if more centers could be established.

- **Funding for community and migrant health centers should be increased significantly so that the centers can continue to operate effectively and so that centers can be established in more medically underserved areas.**

Many community and migrant health centers have increasing expenses associated with the provision of health care services as well as the need for capital improvements, the need to use more costly means to recruit and retain staff, and a patient population increasingly unable to pay for services. However, funding for community health centers has declined slightly since 1980, after adjusting for inflation, and funding for migrant health centers has decreased significantly. (If the rise in *medical care costs* is taken into account, the decline in funding for the Community and Migrant Health Centers programs appears much greater. The rate of increase in medical care costs was more than twice the overall inflation rate between 1981 and 1990.)

Community and migrant health centers should benefit financially from recent legislative provisions requiring Medicaid and Medicare to provide increased reimbursement for the services that beneficiaries receive at federally qualified health centers, including community and migrant health centers. With increased financial support from Medicaid and Medicare, centers should have more grant funds available to provide care for individuals who lack health insurance coverage. Some centers may be able to expand the range of services they offer.

There is also a need to establish new health centers, particularly in areas where health care providers are not available, even for people who have health care coverage through Medicaid, Medicare, or private insurance. Many such medically underserved areas are located in rural settings. If residents of all medically underserved areas are to have access to a regular source of primary health care, the number of community and migrant health centers must be increased substantially. After a decade that has seen no growth, funding increases should be sufficient to establish a number of new health centers each year.[81]

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[81]The National Association of Community Health Centers has developed a proposal called Access 2000, which is designed to assure that by the year 2000, no community in the United States will be without access to comprehensive community-based primary health care services. Under the proposal, the number of community and migrant health centers would increase steadily to provide services for all medically underserved areas and populations by the year 2000. NACHC estimates that approximately 30 million people in the United States currently lack access to primary care services. By the year 2000, NAHC estimates that 3,000 health centers will be needed to provide services.

- **The Federal Tort Claims Act should be extended to cover all practitioners providing obstetrical care in community and migrant health centers.**

The cost of malpractice insurance for obstetrical care poses a significant financial burden for community and migrant health centers. The centers must use increasingly large portions of their budgets to pay for escalating malpractice insurance costs. Based on data from the Department of Health and Human Services, the National Association of Community Health Centers estimates that community and migrant health centers spent approximately $52 million in 1990 on medical malpractice premiums for physicians providing primary care services at the centers. Yet the ability of many centers to raise revenues is limited by a high volume of uninsured patients and by low reimbursement rates from public insurers such as Medicaid.

This burden could be eased if the federal government were to provide malpractice insurance for practitioners working in community and migrant health centers. Presently, under the Federal Tort Claims Act, the federal government provides malpractice insurance for health care providers employed by the U.S. Public Health Service and other agencies of the federal government. This coverage should be extended to professional health employees of community and migrant health centers who provide obstetrical services.

The Medicaid Program

Efforts to expand Medicaid eligibility further, to reach and enroll people newly eligible for Medicaid, and to insure that those with Medicaid coverage are able to receive the full complement of health care services they need can significantly increase access to health care for the low income population.

In the last several years, Medicaid has changed considerably from a program linked almost entirely to the welfare system to one with closer ties to the health care system. As a results, the Medicaid program has helped strengthen the public health care system in many states. In some states, for example, pregnant women who have Medicaid coverage can now receive a number of enhanced prenatal care services provided through local health departments — and the health departments are reimbursed for the services by Medicaid. Previously, if those services were available, they had to be financed with state or local funds or, in some cases, by funds from the federal Maternal and Child Health block grant program.

While the federal government pays at least half of Medicaid costs, any Medicaid expansion requires the expenditure of state funds. Accordingly, the recent Congressional mandates extending Medicaid coverage to more low income pregnant women and children have increased state costs. In light of these cost increases and the current economic downturn, some states will have difficulty contemplating further Medicaid expansions in the near future.

Economic problems are more severe in some states than in others. A study released in January 1991 by the National Association of State Budget Officers and the National Governors' Association found that 28 states faced budget shortfalls for fiscal year 1991. All of the 10 most urban states were among those with shortfalls, while three of the 10 most rural states fell into that category. The study noted a strong regional pattern in fiscal conditions, with states in the eastern part of the country in relatively weak condition and those in the western United States in somewhat stronger condition. The study observed, however, that the fiscal condition of western states is likely to deteriorate as the recession continues.

There is also wide variation in the proportion of state budgets that are devoted to Medicaid. Spending for Medicaid ranges from 3.6 percent to 19.3 percent of total state expenditures. The 10 most rural states spend between 3.6 percent and 14.1 percent of their budgets on Medicaid, while the range for the 10 most urban states is from 8.2 percent to 18.5 percent.[82] These variations reflect differences both in states' ability to pay and in their inclination to finance health care for their low income residents.

In assessing the Medicaid recommendations set forth below, states should consider the longer-term effects of these recommendations as well as the short-term costs. If states cannot afford to implement these recommendations in the current economic climate, they may be able to consider some improvements when the economic downturn ends and the economy — and state revenues — begin to grow at a more normal pace.

Since the federal government pays a share of Medicaid costs in all states, Medicaid brings federal funds into state economies. The federal government pays between 50 percent and 83 percent of a state's cost in providing health care services to Medicaid recipients. The federal share is calculated based on a formula providing a higher percentage of federal matching funds to states with lower per capita incomes.

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[82]National Association of Budget Officers, "State Expenditure Report, 1990" in EBRI Issue Brief, January 1991.

The percentage of state Medicaid costs paid by the federal government is generally higher in rural than in urban states. In the 10 most rural states, the percentage of Medicaid costs paid by the federal government ranges from 62.8 percent to 80.2 percent. In six of these states, the federal matching rate exceeds 70 percent. By contrast, in the 10 most urban states the percentage of Medicaid costs paid by the federal government ranges from 50 percent to 56.9 percent.

This means that when these rural states expand Medicaid coverage or services, the federal government bears most of the cost. A number of these rural states have rather restrictive Medicaid eligibility rules and fail to offer a number of optional Medicaid services. These states are forgoing a substantial match of federal dollars as a result.

Also, where state funds are used to subsidize health care for the uninsured, actions to enroll more of the uninsured population in Medicaid may ease the state's financial burden — because federal funds can be used to pay part of the costs for those individuals' care. In many of the most rural states, federal funds pay more than two-thirds of the cost of care for Medicaid beneficiaries.

Some data suggest that the federal contribution for Medicaid services can also have a favorable impact on a state's economy. An economic impact analysis conducted by researchers at the University of Mississippi noted that with a federal matching rate of almost 80 percent for fiscal year 1991, each state dollar spent on Medicaid is matched by a contribution of $3.99 in federal funds. The researchers estimated these funds would have a "multiplier" effect on Mississippi's economy, with each dollar of state money (plus the accompanying $3.99 in federal money) generating $10.83 in personal income through wages and salaries for state residents. This additional income and economic activity would, in turn, generate an additional $.86 in state revenue for each state dollar that was invested in Medicaid.[83] The study suggests that due to the high Medicaid matching rate for Mississippi, state expenditures for Medicaid can strengthen the state's economy while providing more health care coverage for residents.

While some of the Medicaid recommendations that follow are costly, many are not. A number of the proposals are designed to simplify and streamline the application and enrollment process and would not affect program eligibility rules. In addition, the federal eligibility expansions recommended here — such as mandating that all states cover pregnant women and infants with incomes up to

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[83]Center for Policy Research and Planning, "Economic Impact of the Mississippi Medicaid Program on the Economy of Mississippi," Mississippi Institutions of Higher Learning, 1990.

185 percent of the poverty line, as 19 states now do — are few in number and modest compared with the mandates Congress has passed in recent years.

Since Medicaid is administered and financed through a federal-state partnership, some changes are most appropriately made at the federal level. Other changes involve state decisions to take greater advantage of available program options.

Federal Action

Expand Medicaid Coverage

- **Income eligibility limits should be increased to provide Medicaid for all pregnant women and infants with family incomes below 185 percent of the federal poverty line.**

States currently have the option to extend Medicaid coverage to pregnant women and infants with incomes below 185 percent of the poverty level, and 19 states do so. This eligibility expansion requires additional expenditure on the part of the federal government and states, but the expenditure represents a sound investment. The medical and financial benefits of providing adequate prenatal care — and routine pediatric care in the first year of life — are well established. Women are less likely to have low birthweight babies if they receive sufficient prenatal care. A study conducted by the Institute of Medicine at the National Academy of Sciences found that for each dollar spent on providing prenatal care to low income women, some $3.38 in medical expenses could be saved during an infant's first year of life. The savings result from a lower incidence of low birthweight infants.[84]

Several blue-ribbon panels have made this a key recommendation for improving the health of infants. In a 1988 report to Congress, the National Commission to Prevent Infant Mortality recommended that the Medicaid program be expanded to cover all pregnant women and infants who have family incomes at or below 200 percent of the federal poverty line. A report by the White House Task Force on Infant Mortality, reported by the media in the summer of 1990, recommended that the mandatory Medicaid income eligibility level for pregnant women and infants be raised to 150 percent of the poverty line in fiscal year 1991. The report also recommended a study of the appropriate timing and relative benefits of mandating further expansion to 185 percent of the poverty line and beyond.

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[84]Institute of Medicine, *Preventing Low Birthweight*, National Academy Press, 1985.

Medicaid - Recommendations for Federal Action

- Income eligibility limits should be increased to provide Medicaid for all pregnant women and infants with family incomes below 185 percent of the federal poverty line.
- The assets test for pregnant women, infants, and young children should be eliminated.
- Congress should give states the option to increase income eligibility limits to provide Medicaid for children with family incomes below 185 percent of the federal poverty line.
- Elderly people and people with disabilities should be permitted to apply at Social Security offices to become Qualified Medicare Beneficiaries.
- Efforts should be made on the federal level to publicize the availability of QMB benefits.

Only four of the 10 most rural states set Medicaid income eligibility limits for pregnant women and infants above 133 percent of the poverty line. None of the nine frontier states takes advantage of this option. With expanded eligibility, more pregnant women in rural areas would have health care coverage and be likely to seek prenatal care.

As with previous Medicaid expansions, this change could be phased in. For example, coverage could be mandated first for pregnant women and infants with family incomes below 150 percent of the poverty level, and subsequently for those below 185 percent of the poverty line.

- **The assets test for pregnant women, infants, and young children should be eliminated.**

All but five states have eliminated the assets test on pregnant women, infants, and young children. The test should be dropped in the final five states as well. Dispensing with the assets test can be particularly advantageous in rural areas, where a number of low income families own items that can disqualify them when an assets test is applied.

Eliminating the test also allows the application process to be streamlined. Without the test, there is no need for applicants to submit various types of documentation related to assets, and no need for eligibility workers to verify the authenticity of documents or process them. Congress recently directed states to develop simplified Medicaid application forms for pregnant women and children

wishing to apply only for Medicaid, rather than for Medicaid and AFDC. States that retain the assets test will have more difficulty in fulfilling this requirement.

- **Congress should give states the option to increase income eligibility limits to provide Medicaid for children with family incomes below 185 percent of the federal poverty line.**

States are now required to provide Medicaid coverage for children under age six with family incomes below 133 percent of the federal poverty and to phase in coverage for virtually all poor children by the year 2002. Even with these mandates, however, a substantial number of low income children will still lack health insurance coverage. These include children age six and older whose families have incomes between 100 percent and 185 percent of the poverty line, as well as children below age six whose families have incomes between 133 percent and 185 percent of the poverty line.[85]

In addition to increasing health care coverage for low income children, the Medicaid expansions recommended here have the potential to strengthen state and local public health care systems on which many of these children rely. Low income children who have no health insurance coverage often receive subsidized health care services through state and local health departments and hospitals. If more of these children were covered by Medicaid, state and local public health care systems might benefit financially because they would be reimbursed for more of the services they provide. Also, since the federal government pays a share of Medicaid costs, some state and local health care systems may benefit from additional federal assistance.

Ease the Medicaid Application Process

- **Elderly people and people with disabilities should be permitted to apply at Social Security offices to become Qualified Medicare Beneficiaries.**

Currently, the elderly people and people with disabilities are required to apply for QMB benefits at local welfare offices, the same offices that take most Medicaid applications. If the elderly were able to apply for QMB benefits at

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[85]In 1990, an income of approximately $10,500 was equal to 100 percent of the poverty line for a family of three. An income of about $14,000 was equal to 133 percent of the poverty line while an income of about $19,500 was equal to 185 percent of poverty for a family of three. The poverty line figures cited here are those issued each year by the Department of Health and Human Services for use in Medicaid and other federal programs. These figures differ slightly from the poverty line figures used by the Bureau of the Census.

Social Security offices as well, QMB enrollment probably would increase. One reason for this is that elderly people must already go to Social Security offices to sign up for Medicare benefits. In addition, in 32 states, Social Security offices process Medicaid applications for elderly persons and persons with disabilities who qualify for cash assistance from the SSI program.

Changing the QMB application site would allow the elderly to apply for Medicare, QMB, and, in some states, Medicaid benefits at one location. This would be particularly helpful for rural residents who have difficulty traveling to both Social Security and welfare offices that may be miles apart.

Another advantage is that fewer people would associate QMB benefits with welfare programs. Consequently, many of the people who are potentially eligible for QMB benefits would likely feel more comfortable applying for these benefits. To many senior citizens, applying for a benefit at the Social Security office involves far less stigma than going to the welfare office. This is likely to be particularly true in rural areas where there may be more sensitivity about participating in an income-tested program.

Increase Outreach Efforts for Medicaid

- **Efforts should be made on the federal level to publicize the availability of QMB benefits.**

Many people outside the welfare system are eligible to become QMBs, but may not be aware they qualify. The federal government should help to publicize the availability of these benefits.

In the summer of 1989, the Health Care Financing Administration mailed letters describing the new QMB program to all Social Security beneficiaries whose monthly benefit checks were less than 100 percent of the federal poverty line. The letters had a standard format, but were designed to provide state specific information about income eligibility and where to apply for benefits. HCFA should continue this practice on an annual basis and should eventually send these letters to Social Security beneficiaries whose checks equal less than 120 percent of the poverty line, since the eligibility for the QMB program will rise to 120 percent of the poverty line by 1995.

State Action

Expand Medicaid Coverage

- **In the absence of federal mandates, states should expand Medicaid coverage for pregnant women and infants.**

There are both medical and financial benefits associated with early prenatal care and routine pediatric care. Expanded Medicaid coverage can increase access to medical care. States should exercise the option of providing Medicaid benefits to pregnant women and infants with family incomes up to 185 percent of the poverty line. Also, states should dispense with the use of an assets test for pregnant women, infants, and children.

A policy statement issued at the Southern Legislative Summit on Healthy Infants and Families in the fall of 1990 urged states to increase access to Medicaid by expanding Medicaid eligibility for pregnant women and children to 185 percent of the federal poverty line. The summit was sponsored by the Southern Governors' Association and the Southern Legislative Conference.

Ease the Medicaid Application Process

- **State Medicaid offices should work with community and migrant health centers to establish systems for the on-site acceptance and initial processing of applications for Medicaid from pregnant women and children.**

Beginning July 1, 1991, states are required to make arrangements for the receipt and initial processing of Medicaid applications from pregnant women and children under age 18 at certain facilities where families go to seek health services. States are also required to develop simplified Medicaid applications for pregnant women and children who wish to apply only for Medicaid rather than for Medicaid and AFDC.

The law specifically requires that applications be taken at federally qualified health centers, including community and migrant health centers, and at disproportionate share hospitals. States may also accept and begin processing applications at other health care settings. Doing so at sites where large numbers of low income women and children receive health services, such as local health departments and WIC agencies, could be very effective.

With the recent expansions in Medicaid eligibility rules, many people are unaware they are eligible for Medicaid. A logical time and place to make them

Medicaid - Recommendations for State Action

- In the absence of federal mandates, states should expand Medicaid coverage for pregnant women and infants.
- State Medicaid offices should work with community and migrant health centers to establish systems for the on-site acceptance and initial processing of applications for Medicaid from pregnant women and children.
- All State Medicaid programs should offer "presumptive eligibility" for pregnant women.
- States with automatic Medicaid eligibility for SSI recipients should remove the requirement for elderly people and people with disabilities to file a separate application for Medicaid.
- States should publicize the new Medicaid income eligibility limits and emphasize that Medicaid coverage is available apart from participation in the AFDC or SSI program.
- Outreach efforts should be targeted to reach families who do not ordinarily participate in public assistance programs.
- States should publicize the Medicaid EPSDT program so more families are aware that comprehensive coverage for preventive and curative services is available for children.
- Outreach efforts should be targeted to reach elderly people and people with disabilities who do not ordinarily participate in public assistance programs.
- State Medicaid programs should provide coverage for a wide range of enhanced prenatal services.
- States should take steps to improve the likelihood that beneficiaries are able to find a provider who will deliver the services their Medicaid program offers.
- State Medicaid programs should provide coverage for home and community-based services for the frail elderly.
- State Medicaid programs should offer higher reimbursement rates for obstetricians and pediatricians who practice in areas with provider shortages.
- State Medicaid programs should provide other incentives to encourage the participation of health care providers who practice in geographic areas or medical specialties with a shortage of Medicaid providers.

aware of their potential eligibility — and to begin to process their Medicaid applications — is when they seek services at health care facilities. When the eligibility process can be initiated on the spot, some of the difficulties associated with applying for Medicaid are eliminated. Applicants do not have to make

separate appointments to receive care and to apply for health coverage benefits, nor do they have to arrange transportation to another office. Also, individuals who may have been reluctant to apply for benefits at the welfare office can apply in a more familiar setting.

It would be both difficult and inefficient for state Medicaid programs to outstation eligibility workers at every health care facility, given the large number of such facilities across a state. In remote rural areas, the volume of Medicaid applicants at some facilities is likely to be small and the distance between facilities may be great. Arrangements still should be made, however, to give women and children the opportunity to apply for Medicaid at health care facilities. In many cases, health centers and hospitals already employ staff who could help with the Medicaid application process. Or, if staff are not already available, they could be hired locally. With training from the Medicaid office, these employees could accept and begin processing Medicaid applications. Health care facilities could bill Medicaid for the administrative services provided by the employees. Another possible approach is for Medicaid to employ circuit-riders, eligibility workers assigned to travel to a number of health centers and hospitals in a geographic area, on a regular basis, to provide assistance with processing applications. If circuit-riders were based at disproportionate share hospitals but also visited health centers in the area, the links between community hospitals and health centers might be strengthened.

Although the recent Congressional mandate to receive and begin processing Medicaid applications at certain health care facilities pertains to applications only from pregnant women and children, people who are elderly or have disabilities would also benefit from the opportunity to apply for Medicaid in a hospital or clinic setting. When states outstation eligibility workers, they should consider having these workers accept and process applications from all applicants.

- **All State Medicaid programs should offer "presumptive eligibility" for pregnant women.**

The Medicaid presumptive eligibility option is designed to enable eligible pregnant women to begin receiving Medicaid coverage as early as possible in pregnancy. In states that have adopted the option, certain publicly funded clinical providers can make temporary determinations of Medicaid eligibility where pregnant women receive care. One advantage of the presumptive eligibility program is that women can receive *immediate* Medicaid coverage for prenatal care. In states without presumptive eligibility programs, women must go to the Medicaid office first to apply for benefits.

In rural areas, and particularly in frontier areas, presumptive eligibility can be particularly effective because it removes the need to travel great distances to reach Medicaid offices before Medicaid coverage can be provided. With presumptive eligibility, this barrier to initial entry into the program is overcome. Pregnant women may apply for Medicaid and receive coverage at the same place and time as they begin prenatal care.

In addition to offering the presumptive eligibility option, states should be able in the near future to modify how this option works — and to make it even more effective. Currently, women who are determined presumptively eligible must go to the welfare office by the end of the next month to apply for Medicaid. But when states implement the new mandate to accept and begin processing Medicaid applications from pregnant women and children at certain health care facilities, they can eliminate the need for women to make a trip to the welfare office to apply for Medicaid after they have been determined presumptively eligible.

States that already use the presumptive eligibility option can arrange to have outstationed eligibility workers make final program eligibility determinations for pregnant women. This can be done either when the women first apply for presumptive eligibility or, if logistical factors make this impossible, at a later date. In either case, the women would be spared a trip to the welfare office.

States that were reluctant to use the presumptive eligibility option in the past because they wanted all applications to be made at the welfare office are now required to establish systems to accept and begin processing Medicaid applications at health care facilities, anyway. In doing so they should incorporate procedures to grant pregnant women presumptive eligibility.

At present, presumptive eligibility programs have been adopted in four of the nine frontier states. Just three of the 10 most rural states have presumptive eligibility programs. Six of the 10 most urban states have presumptive eligibility programs.

- **States with automatic Medicaid eligibility for SSI recipients should remove the requirement for elderly people and people with disabilities to file a separate application for Medicaid.**

In 32 states, the Social Security Administration has agreements with states to provide Medicaid coverage automatically to SSI recipients. No separate Medicaid program application is required. However, in six states, including three frontier states, SSI recipients are eligible for Medicaid only if a separate application is filed with the state Medicaid agency.

The requirement to file a separate application with the welfare office is burdensome for all applicants. For elderly people and people with disabilities living in isolated rural areas, this requirement can pose a significant barrier to participation.

This recommendation requires no change in income eligibility rules and could result in some administrative savings since the need to process a second set of applications would be eliminated.

Increase Outreach Efforts to Enroll Rural Residents in Medicaid

- **States should publicize the new Medicaid income eligibility limits and emphasize that Medicaid coverage is available apart from participation in the AFDC or SSI program.**

Making it possible for people to enroll in Medicaid where they receive health care services is an excellent form of outreach. But other methods are needed to reach people who are reluctant to seek health care because they do not have health insurance coverage or because they cannot afford to pay for care.

The federal government can help publicize the changes in the Medicaid program that extend coverage to more people. But the bulk of this work must be done at the state and local level. States must convey the message that Medicaid is now a broader health program that serves low income working families and people who are elderly and or have disabilities, but are not on public assistance.

In rural areas, some residents recently made eligible for Medicaid may be reluctant to enroll in cash welfare programs because participation in such programs is not considered socially acceptable or because they do not wish to go to the welfare office. However, they may be willing to enroll themselves or their children in a health care program for low income residents that is not associated with welfare and does not require a trip to the welfare office, at least not initially.

State offices of rural health can take the lead in helping to publicize the changes in Medicaid eligibility rules and in working with the state Medicaid office to facilitate the enrollment of rural residents. Since Medicaid eligibility rules are generally more stringent in the more rural states, recent federal mandates have made a large number of rural residents newly eligible for the Medicaid program. Enrolling a large proportion of these newly eligible people, many of whom have no health insurance, will increase the likelihood that rural residents will have access to health care services. Also, health care providers in rural areas may

benefit financially if reimbursement is available for a larger proportion of the population.

- **Outreach efforts should be targeted to reach families who do not ordinarily participate in public assistance programs.**

Many of those who are newly eligible for Medicaid have family incomes well above the former income eligibility limits. The increases in the income limits for young children are particularly dramatic in some rural states. For example, prior to April 1990, Medicaid coverage in Arkansas and West Virginia was available only to children with family incomes below 33 percent of the poverty line. Now children under age six in these states are eligible for Medicaid if their families have incomes up to 133 percent of the poverty line. In addition, beginning July 1991, poor children age six and over will be eligible for Medicaid if their families have incomes up to 100 percent of the poverty line.

Most of the families newly eligible for Medicaid are working families. They may be unaccustomed to dealing with the social service system, so referrals from other government benefit programs may not touch them. To reach them, information about Medicaid will need to be made available in other settings.

For example, churches and other religious institutions can play an important role in reaching rural residents with information about Medicaid eligibility rules and Medicaid benefits. Many churches have active social service and auxiliary organizations. In addition to educating church members about Medicaid, these groups could assist with the enrollment process for newly eligible members by arranging transportation to the Medicaid office when it is needed or by helping members complete applications. Community action agencies and other local service agencies can also make special efforts to alert low income people to the Medicaid expansions.

There is an important role for schools, as well. As the result of the Medicaid expansions enacted in the fall of 1990, a large number of poor school children will become newly eligible for Medicaid in the years ahead. Consequently, schools, particularly those located in low income areas, are a prime setting for outreach activities. At the very least, information about Medicaid eligibility rules and the Medicaid application process should be sent home from school with students.

Schools and day care centers can take other steps as well to improve the likelihood that children will enroll in Medicaid and receive the services they need. For example, the same simple Medicaid applications that states must now develop for women and children receiving care at federally qualified health centers should

also be made available at schools and day care centers. In addition, state Medicaid programs should consider making arrangements for the receipt and initial processing of Medicaid applications from students and their parents in school and day care settings. These arrangements could be similar to those that Medicaid programs must make to process applications at federally qualified health centers and could be accomplished with the assistance of school personnel. Alternatively, the Medicaid office could outstation eligibility workers at schools and day care centers for specific, well publicized, hours. States could arrange to have the Medicaid eligibility workers process the applications and enroll new beneficiaries on site, so that students and their parents would not have to travel to the county welfare office to apply for Medicaid benefits. This could be particularly beneficial in rural areas.

- **States should publicize the Medicaid EPSDT program so more families are aware that comprehensive coverage for preventive and curative services is available for children.**

State Medicaid programs are required to offer preventive and remedial health care services to all beneficiaries under age 21. These services are available from health care practitioners who participate in the component of Medicaid known as the Early and Periodic Screening Diagnosis and Treatment program, or EPSDT. At a minimum, states must provide coverage through the EPSDT program for routine screening visits to identify health problems in poor children, including physical, mental, vision, hearing, and dental problems. EPSDT beneficiaries are also entitled to treatment services for the problems identified during the screening visits.

Although states have been required to offer EPSDT services since 1967, EPSDT programs in many states have not effectively provided comprehensive care for children. As with other Medicaid services, there has been considerable variation among states, particularly in regard to rules about the types of practitioners who may provide services, the frequency with which children receive services, and the extent to which Medicaid pays for services needed to treat conditions discovered during EPSDT screening visits.

In 1989, Congress recognized that the EPSDT program could be much more effective and directed states to make the necessary changes in their EPSDT programs to insure that children receive the full range of mandated screening services at reasonable intervals, along with any services necessary to treat conditions identified during screening exams. States are now required to provide these treatment services even if some of these are services not generally covered by a state's Medicaid program.

Families may be more interested in enrolling their children in Medicaid if they are aware payment is available for such a broad range of services. For example, Medicaid must pay for EPSDT services such as immunizations or mental health counselling. With expanded Medicaid eligibility for children and improved EPSDT services, the Medicaid program has the potential to improve greatly the health of many low income children who formerly lacked access to health care services. A number of these are children living in rural areas. The Medicaid office should provide families with up-to-date information about the EPSDT program either directly or through organizations such as churches, schools, health clinics, and social service agencies.

- **Outreach efforts should be targeted to reach elderly people and people with disabilities who do not ordinarily participate in public assistance programs.**

Outreach activities directed at the elderly and people with disabilities are needed, as well. Information about Medicaid eligibility — including specific information about the Qualified Medicare Beneficiary program — should be made available at senior centers and through the elderly nutrition and Meals on Wheels programs administered by state and area agencies on aging. Program applications should be available in these settings. Whenever possible, state Medicaid offices should outstation eligibility workers at senior centers and congregate meals programs to enroll senior citizens.

Outreach activities relating to the Qualified Medicare Beneficiary program are particularly important. Preliminary data indicate that many people who are newly eligible for QMB benefits may not be aware of the program or of their eligibility for it. A study of 35 states in mid-1989 found that initial enrollment in the QMB program was low — and that half of those who enrolled in the program in its first six months were residents of a single state, North Carolina, that conducted an extensive outreach campaign.[86]

The findings of this study underscore the need for QMB outreach efforts. The QMB coverage that Congress legislated for elderly and disabled people who have low incomes but are not otherwise covered by Medicaid is likely to have only limited effect — unless the availability of QMB benefits are widely publicized and those eligible for the benefits learn of their status. The outreach efforts carried out in North Carolina suggest such activities can be effective.

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[86]Rowland, Diane et al., *The Medicare Buy-In: Variations in State Medicaid Policy*, Families USA Foundation, February 1990.

Efforts to help enroll elderly people and people with disabilities in the QMB program are particularly relevant in rural areas, where a disproportionate share of the elderly poor live.[87] In addition, SSI and Medicaid income limits tend to fall farther below the poverty line in rural than in urban states. The combination of these two factors means that a substantial and disproportionate share of the elderly and disabled people eligible for QMB benefits are people who reside in rural locations.

Outreach for the QMB program will become even more important in the years ahead, when the income limit for the program rises from 100 percent of the poverty line, where it stands today, to 120 percent of the poverty line, the level it reaches on January 1, 1995.

Some special difficulties may be associated with conducting outreach in rural areas. With people spread farther apart, there is a more limited network for disseminating information. Nevertheless, outreach efforts should be designed to reach rural residents in all areas, even remote ones. Information provided through the mail and the media can reach residents of both sparsely and densely populated areas. States can also establish toll-free numbers for residents in all areas to call for further information about Medicaid.

Expand the Scope of Covered Medicaid Services

- **State Medicaid programs should provide coverage for a wide range of enhanced prenatal services.**

In economic as well as medical terms, it makes sense for state Medicaid programs to cover enhanced prenatal services. The cost of providing the services is minimal compared with the cost of caring for a high-risk infant who requires hospitalization.

In 1989, the Department of Health and Human Services issued the findings of its expert panel on the content of prenatal care. The panel concluded that prenatal care should be defined to include all necessary psychological, social, and educational services as well as general medical care. The panel stressed that medical, psychological, and social risks often interact and concluded that a comprehensive approach to prenatal care has considerable potential for improving the health of women, infants, and families.[88]

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[87]Porter, Kathryn, *Poverty in Rural America: A National Overview*, Center on Budget and Policy Priorities, April 1989.

[88]U.S. Public Health Service, *Caring for Our Future: The Content of Prenatal Care*, 1989.

State Medicaid programs have the opportunity now to make more comprehensive prenatal care available for beneficiaries. They may choose to offer any of a number of special services for pregnant women, such as care coordination, risk assessment, nutritional counseling, health education, psychosocial counseling, or home visits. But while 30 states now provide Medicaid coverage for some enhanced prenatal services, only five of the 10 most rural states do. Only three of the nine frontier states offer some of these services.

Most of the 30 states providing enhanced prenatal services make care coordination services available. Care coordinators insure that pregnant women receive all the health-related services they need. In rural areas, these coordinators can be particularly helpful to pregnant women who have difficulty making logistical arrangements.[89]

Home visiting is another very beneficial service for pregnant women living in rural areas. Home visiting programs send professionals and paraprofessionals to families' homes to provide education and counselling services. A report from the U.S. General Accounting Office finds that home visiting programs can improve both the short and long-term health and well being of families and children. The report concludes that services delivered through home visits can reduce serious and costly problems later.

Home visiting is included among the prenatal care services recommended by the HHS panel on the content of prenatal care. In addition, the National Commission to Prevent Infant Mortality has strongly recommended that Medicaid pay for home visits for pregnant women in all states. In rural areas, home visiting programs also create much-needed jobs for community residents who can be trained and employed as home visitors.

Some 24 states cover home visiting services for high risk pregnant women. Yet only four of the 10 most rural states and just two of the nine frontier states do.

- **States should take steps to improve the likelihood that beneficiaries are able to find a provider who will deliver the services their Medicaid program offers.**

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[89]U.S. General Accounting Office, *Home Visiting: A Promising Intervention Strategy for At-Risk Families*, July 1990.

When states consider establishing special services, such as enhanced prenatal services for particular groups, they should consider not only which services to offer and how much to pay for the services, but also who will provide the services. In formulating requirements for enhanced prenatal services, for example, it may seem logical for a state to require that nutrition counselling services be provided by a registered dietitian or that home visits be made by a social worker. In some areas, however — particularly rural areas — there may be a dearth of these specialized providers. In such areas, it may be more practical to allow paraprofessionals to provide the services under the supervision of trained professionals.

In other instances, existing health care delivery systems can help assure that Medicaid beneficiaries receive services they need. For example, the WIC program, a federal program that provides supplemental food and nutrition counselling to low income pregnant women and children under age five, has clinics serving pregnant women and young children in almost every county in the United States. In some areas, the professionals and paraprofessionals who staff the WIC clinics might be able to provide some enhanced prenatal services such as additional nutrition counselling, care coordination, or home visiting services for pregnant women on Medicaid. Similarly, professionals and paraprofessionals employed at local health departments or at community health centers may be able to provide enhanced prenatal services. State Medicaid offices should consult with health departments and, when possible, with offices of rural health, to determine what providers are available in different areas of the state.

Arrangements such as these can be advantageous for clients and providers alike. Clients benefit because they can receive a number of related services at the same time from the same practitioner. Providers can benefit because they can receive new or additional reimbursement from Medicaid. A local the health department, health center, or WIC clinic may not have the funds to support practitioners on a full time basis, but with additional reimbursement from Medicaid for the provision of enhanced prenatal services, these facilities may be able to expand staff hours or hire additional staff.

- **State Medicaid programs should provide coverage for home and community-based services for the frail elderly.**

A new law allows states to provide Medicaid coverage for home and community-based long term care services for frail elderly people. This option is designed to help elderly individuals who need assistance with some basic activities of daily living to remain in their homes and communities. The alternative is for

them to receive care in an institution. States may select the services they wish to cover from a broad range of medical and social services.[90]

The new option represents a departure from the general Medicaid bias toward institutional care for the elderly. This change should be particularly welcome in rural areas. It gives elderly Medicaid beneficiaries living in such areas the opportunity to stay in familiar surroundings. In some instances, it will allow elderly parents who would otherwise be forced to leave the community to remain near their families. Also, rural communities that lack long-term care facilities can benefit economically when Medicaid pays caregivers in the community rather than paying for care provided in institutions located outside the community.

Improve Medicaid Provider Participation

- **State Medicaid programs should offer higher reimbursement rates for obstetricians and pediatricians who practice in areas with provider shortages.**

Many health care providers report their reluctance to treat Medicaid patients is due, in part, to low Medicaid reimbursement rates. Without adequate provider participation, Medicaid coverage does not assure access to health care. In 1987, the National Governors' Association reported that the lack of maternity care providers was particularly acute in rural areas.

In 1989, Congress recognized the need to increase the participation of obstetric and pediatric providers in the Medicaid program. Legislation enacted that year instructs states to provide sufficient payment to enlist maternal and child health care providers in Medicaid so that services are available to Medicaid recipients to the same extent they are available to others in the same location. States are required to review their reimbursement rates and adjust them if necessary. In an attempt to establish standards for reimbursement rates, the Health Care Financing Administration has undertaken a review of state reimbursement rates for obstetric and pediatric providers.

Eventually the HCFA review should lead to an increase in rates. In the meantime, while some states have raised their rates, rates remain low in many others. States need not await the establishment of the HCFA standards to raise their rates for obstetricians and pediatricians. This is particularly important for

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[90]Formerly state Medicaid programs had the option to pay for home and community-based services instead of institutional care for the frail elderly. But to do so they were required to demonstrate that the services provided in the community setting were no more costly than those provided in institutions.

rural areas, since lack of action may lead to a continuing stream of practitioners leaving the Medicaid program and even greater provider shortages. In addition, while state Medicaid programs are required to reexamine reimbursement rates only for maternal and child health care providers, it would be desirable for them to undertake a review of their reimbursement rates for other providers as well.

These issues hold considerable significance for low income rural residents. In areas where there is already a shortage of health care providers, it is important to offer reasonable reimbursement rates for Medicaid services so that providers will have more financial incentives to accept Medicaid patients. Higher reimbursement rates may also help health care providers remain in business in some areas. Financial difficulties cause a number of health care practitioners to leave rural areas, particularly medically underserved areas. Practitioners in these areas could benefit from a combination of increased fees from Medicaid and aggressive outreach to enroll newly eligible Medicaid beneficiaries who were formerly uninsured.

Although states have not done so, they have an option under the Medicaid law to set higher reimbursement rates for services provided in rural areas. This option should be given more serious consideration for obstetrical services.

- **State Medicaid programs should provide other incentives to encourage the participation of health care providers who practice in geographic areas or medical specialties with a shortage of Medicaid providers.**

Other factors, in addition to reimbursement rates, may also influence the decision of some providers about participating in Medicaid. Many practitioners are discouraged by burdensome requirements for filing claims and by long waits for payment. State Medicaid offices should consider expediting payment for providers who practice in areas where Medicaid patients have difficulty finding care or in medical specialties, such as obstetrics, where there are shortages of medical providers. Since provider shortages have their sharpest effects in rural areas, expediting payments could be particularly beneficial for rural residents.

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While most of the recommendations in this chapter are designed to improve access to care for the low income population, many of the changes will benefit rural residents at moderate and middle income levels as well. The recommendations to provide Medicaid coverage for additional low income families and to expand the scope of services covered by Medicaid should improve the financial position of rural health care providers. This, in turn, should increase the

likelihood that these providers will continue to offer services that the surrounding community needs. In addition, when public programs help support the establishment of new clinics, or assist such clinics with the recruitment of more health care professionals to practice in rural areas, more health care services become available for all residents. Finally, health care providers contribute to the local economy by employing local residents and purchasing local goods and services.

Appendix
Proportion of Each State's Population Residing in Nonmetropolitan Areas, 1988

	Proportion of Population Residing in Nonmetro Areas	Rank (1 equals highest Proportion of Nonmetro Residents)	Number of Nonmetro Residents (in thousands)
Idaho	80.0%	1	802
Vermont	76.7	2	428
Montana	75.8	3	610
South Dakota	70.9	4	506
Wyoming	70.8	5	339
Mississippi	69.5	6	1,821
Maine	63.9	7	771
West Virginia	63.5	8	1,192
North Dakota	61.6	9	411
Arkansas	60.3	10	1.445
Alaska	58.3	11	306
Iowa	56.6	12	1,603
Kentucky	53.9	13	2,009
Nebraska	52.4	14	840
New Mexico	51.1	15	769
Kansas	46.6	16	1,162
North Carolina	44.6	17	2,894
New Hampshire	43.7	18	474
Oklahoma	41.2	19	1,337
South Carolina	39.5	20	1,370
Georgia	35.2	21	2,230
Delaware	34.1	22	225
Missouri	34.0	23	1,746
Wisconsin	33.5	24	1,625
Minnesota	33.4	25	1,439
Tennessee	32.9	26	1,612
Alabama	32.5	27	1,335
Oregon	32.3	28	893
Indiana	31.9	29	1,773
Louisianna	30.8	30	1,358
Virginia	27.8	31	1,673
Hawaii	23.7	32	260
Arizona	23.6	33	822
Utah	22.6	34	382
Ohio	21.1	35	2,292
Michigan	20.1	36	1,855
Texas	18.7	37	3,153
Washington	18.4	38	856
Colorado	18.3	39	604
Illinois	17.5	40	2,028
Nevada	17.4	41	183
Pennsylvania	15.2	42	1,830
Massachusetts	9.4	43	555
Florida	9.2	44	1,140
New York	8.8	45	1,569
Rhode Island	7.4	46	73
Connecticut	7.4	47	241
Maryland	7.1	48	326
California	4.3	49	1,223
New Jersey	0.0	50	0
United States	22.9%		56,390

Bibliography

American College of Obstetricians and Gynecologists, *Medicaid Reimbursement for Obstetric Care (Specialist) by State*, May 1990.

Alan Guttmacher Institute, *The Financing of Maternity Care in the United States*, December 1987.

American Hospital Association, *Hospital Statistics*, 1981-1988.

Center for Policy Research and Planning, "Economic Impact of the Mississippi Medicaid Program on the Economy of Mississippi," Mississippi Institutions of Higher Learning, 1990.

Chollet, Deborah, *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1986*, Employee Benefit Research Institute, October 1988.

Chollet, Deborah, Jill Foley and Colleen Mages, *Uninsured in the United States: The Nonelderly Population without Health Insurance, 1988*, Employee Benefit Research Institute, September 1990.

Croft, Candice, *A Profile of Pediatricians Based Upon Data From the 1985 American Medical Association Masterfile*, Statistical Note 18, American Academy of Pediatrics, May 1988.

Employee Benefit Research Institute, "States and Their Role in the U.S. Health Care Delivery System," Issue Brief, Number 110, January 1991.

Hall, Charles P. and Kuder, John M., *Small Business and Health Care*, The NFIB Foundation, 1990.

Hart, L. Gary, Roger A. Rosenblatt, and Bruce A. Amundson, "Rural Hospital Utilization: Who Stays and Who Goes?" WAMI Rural Health Research Center, *Rural Health Working Paper Series*, Volume 1, Number 2, March 1989.

Hill, Ian T. and Trude Bennett, *Enhancing the Scope of Prenatal Service*, National Governors' Association, 1990.

Howe, Mary and Sheila S. Ray, *A 50 State Review of Medicaid Transportation Services*, Intergovernmental Health Policy Project, George Washington University, February 1987.

Hughes, Dana and Sara Rosenbaum, "An Overview of Maternal and Infant Health Services in Rural America," *The Journal of Rural Health*, Volume 5, Number 4, October 1989.

Institute of Medicine, *Preventing Low Birthweight*, National Academy Press, 1985.

Joint Rural Task Force of the National Association of Community Health Centers and the National Rural Health Association, *Community Health Centers and the Rural Economy: the Struggle for Survival*, December 1988.

Lewis-Idema, Deborah, *Increasing Provider Participation*, National Governors' Association, 1988.

National Association of Community Health Centers, *A Snapshot View of Community Health Centers After 25 Years*, February 1991.

National Association of Community Health Centers, *Access to Community Health Care: A Data Book 1990*, February 1990.

National Center for Health Statistics, Vital and Health Statistics, *Current Estimates from the National Health Interview Survey, 1988*, October 1989.

National Center for Health Statistics, Vital and Health Statistics, *Health of Black and White Americans, 1985-87*, January 1990.

National Center for Health Statistics, *Vital Statistics of the United States, 1986, Volume I, Mortality*, U.S. Government Printing Office, 1988.

National Center for Health Statistics, *Vital Statistics of the United States, 1986, Volume II, Mortality*, U.S. Government Printing Office, 1988.

Nesbitt, Thomas S., Frederick A. Connell, L. Gary Hart and Roger A. Rosenblatt, "Access to Obstetric Care in Rural Areas: Effect on Birth Outcomes," *American Journal of Public Health*, Volume 80, Number 7, July 1990.

Podgursky, Michael, *Job Displacement and the Rural Worker*, Economic Policy Institute, 1989.

Porter, Kathryn, *Poverty in Rural America: A National Overview*, Center on Budget and Policy Priorities, April 1989.

Rowland, Diane, Alina Salganicoff and Barbara Lyons, *The Medicare Buy-In: Variations in State Medicaid Policy*, Families U.S.A. Foundation, February 1990.

U.S. Bureau of the Census, Current Population Reports, Series P-70, Number 17, *Health Insurance Coverage: 1986-88*, U.S. Government Printing Office, March 1990.

U.S. Bureau of the Census, *Money Income and Poverty Status in the U.S.: 1989*, October 1990.

U.S. Congress, Congressional Research Service, "State Funding of Medical Instruction in Selected States", Memorandum to the House Committee on Energy and Commerce, August 1990.

U.S. Congress, Congressional Research Service, *Medicaid Source Book: Background Data and Analysis*, Government Printing Office, November 1988.

U.S. Congress, Office of Technology Assessment, *Health Care in Rural America*, U.S. Government Printing Office, September 1990.

U.S. Department of Health and Human Services, *Caring for Our Future: The Content of Prenatal Care*, 1989.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance, Office of Shortage Designation, *Selected Statistics on Health Manpower Shortage Areas*, March 1990.

U.S. Department of Labor, Bureau of Labor Statistics, *Employment and Earnings*, January 1990.

U. S. General Accounting Office, *Home Visiting: A Promising Early Intervention Strategy for At-Risk Families*, July 1990.

U. S. General Accounting Office, *National Health Service Corps, Program Unable to Meet Need for Physicians in Underserved Areas*, August 1990.

U.S. General Accounting Office, *Rural Hospitals, Factors That Affect Risk of Closure*, June 1990.

U.S. General Accounting Office, *Rural Hospitals, Federal Leadership and Targeted Programs Needed*, June 1990.

U.S. House of Representatives, Committee on Ways and Means, *Overview of Entitlement Programs, 1990 Green Book, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, Government Printing Office, June 1990.

Yudkowsky, Beth K., Jenifer D.C. Cartland; and Samual S. Flint, "Pediatrician Participation in Medicaid: 1978 to 1989," Pediatrics, Volume 85, No. 4, April 1990.