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Medicaid Reform: A Rural Perspective

Any attempt to reform Medicaid must give special consideration to the impacts on rural America. Any changes proposed in eligibility, benefits, or reimbursements will have a disproportionate effect on rural populations and their communities.

Introduction

Medicaid is the largest joint, state, and federal health care entitlement program and serves more people than any other U.S. health program.¹ It is a significant state-federal partnership. While there are important program variations across the states and in the ratio of state to federal funding, the federal government is the predominant payer of Medicaid costs.

Across the nation, Medicaid supports more than 52 million people by paying for a variable range of medical, behavioral, and dental services, as well as long-term care. In some states, more than 20 percent of the population is covered by Medicaid. In some rural areas, the percentage is higher.

Medicaid is a “mainstream” program in America; it is not “just” a welfare program. Medicaid covers more than 40 percent of non-elderly Americans living in poverty and about a quarter of the near-poor. It covers approximately 40 million low-income children and parents, most of whom are in working families. It is a key source of coverage for low-income pregnant women, covering more than one in three births in the United States. Medicaid also provides health coverage for more than 7 million of

Medicare’s almost 44 million enrollees (37 million elderly and 7 million non-elderly individuals with permanent disabilities.) About one in six Medicare beneficiaries, based on their low income, also are covered by Medicaid for payment of Medicare’s premiums and cost-sharing, and also for other services that Medicare limits or does not cover, most importantly, long-term care.² Medicaid is the nation’s major source of funding for long-term care, covering six of ten nursing home residents. Medicaid also covers many individuals with disabilities who have not yet qualified for Medicare disability benefits.

On average, states spend about 18 percent of their general funds on Medicaid, making it the second largest item in states’ budgets.³ Between 2000 and 2004, Medicaid spending increased between 6.9 percent and 11.9 percent each year.⁴ Growth has primarily been fueled by increases in utilization, downturns in the economy that lead to more enrollees, and increasing medical prices, notably pharmaceuticals. There has been some growth in reimbursement to Federally Qualified Health Centers, Rural Health Clinics, and hospital-based provider practices. In many states this increase also includes the extension of cost-based reimbursement to Critical Access Hospitals. However, these latter factors are minimal when compared to the predominant cost-drivers.⁵

Growth in the number of eligible individuals has occurred despite many state efforts to limit or reduce eligibility. The predominant driving force has been the downturn in the economy, coupled with the loss of employer-sponsored

health insurance. Nonetheless, over the last five years some states expanded eligibility to certain coverage groups—such as women with breast and cervical cancer or the working disabled—however, many others cut those eligible including in some states, the medically needy.

The Congressional Budget Office projects federal Medicaid expenditures to increase annually by 8.4 percent from FY2008 through FY2015. However, some factors such as increasing challenges of recruiting rural providers at current levels of Medicaid reimbursement and the needs of some states to “catch up” with underpayments to providers may increase these estimates.

There have been numerous Medicaid reform efforts over the last decade aimed at decreasing costs in response to the steady growth in specific service costs and the growing number of Medicaid enrollees. All states are trying to decrease or constrain their Medicaid costs. Nonetheless, some have sought to expand Medicaid coverage for more uninsured individuals and families, and have tried to finance this through savings anticipated in other areas. This has certainly not always been possible. While there has been some meaningful focus on access and quality, the primary goal of most federal and state Medicaid reform efforts has been budgetary savings.

The current administration has previously attempted to gain better control of its Medicaid commitment by seeking to fund Medicaid through “block grants” to states, putting an upper limit on federal dollars. In addition, a simplified waiver process allows states to make sweeping changes in eligibility and the scope of benefits provided as long as this is federal-budget-neutral, again setting a limit on federal funds. There are some potential benefits to states associated with increased flexibility, but there are also significant risks to eligibles and providers. Examples of risks include waivers of statewide rules that disproportionately affect rural benefit plans, service access, eligibility, or reimbursement.

Defining Rural Characteristics and Unique Considerations for Rural Medicaid

Rural populations are generally older, poorer,

and more frequently report inferior health status than non-rural populations. Thus, they often have disproportionate health needs. Medical needs across age groups can be exacerbated by comorbid conditions for which there are significant access barriers in rural communities, e.g., behavioral health services for mental illness, alcoholism, other substance abuse, as well as oral health care. These circumstances, when combined with a higher percentage of Medicaid eligibility in rural areas, make the Medicaid program disproportionately critical to rural residents.

Important characteristics of rural populations that highlight the disproportionate reliance on Medicaid include the following:⁶

- In 2002, 14.7 percent of rural residents were enrolled in Medicaid compared to only 11.2 percent of urban residents.⁷
- Among individuals less than 65 years of age, 15.3 percent of rural residents, but only 11.2 percent of urban residents, report that Medicaid is their primary source of health insurance.⁸
- Among the rural elderly, 10.1 percent received Medicaid benefits compared to 8.2 percent of urban elderly.⁹
- There are higher rates of poverty in rural areas: 14.7 percent of rural residents live in poverty compared to 11.8 percent in urban areas.¹⁰
- The percent of rural residents who have employer-sponsored insurance (55.1 percent) is also lower than for urban residents (60.8 percent).¹¹
- Rural areas generally have a higher proportion of older persons in their total population (20 percent) than do urban areas (15 percent).¹²
- Without Medicaid, there would be a larger percentage of the rural population without any health insurance coverage.

Some additional points to consider include the following, taken from “Health Insurance Coverage in Rural America.”¹³

- Families living below 200 percent of the Federal Poverty Level (FPL): 47 percent of families in rural non-adjacent (remote) coun-

ties compared to 27 percent in urban counties have household incomes below 200 percent of the federal poverty level.

- Uninsured: 24 percent of residents in remote rural counties are uninsured versus 18 percent in urban areas.
- Medicaid Children: 27 percent of children (ages 0 to 18) living in remote rural areas are covered by Medicaid versus 18.6 percent in urban areas.

In addition:

- Rural workers are 50 percent more likely to have Medicaid coverage than workers in urban counties, but this is not enough to compensate for their lower private coverage.
- Families in rural areas are more likely to have a child living in the house, which increases eligibility.¹⁴
- Rural residents may suffer most when Medicaid and SCHIP programs are diminished by states' budget constraints.¹⁵

Payment Policies and Implications for Access

Medicaid is a major source of funding for rural providers. It is particularly significant for rural safety net providers, contributing both to their bottom line and to their continued ability to provide services for rural underinsured. The strength and continuity of payment structures that support rural providers are therefore critically important.

The operating margins of many rural providers are substantially lower than many non-rural providers and working capital availability is often highly constrained. Many providers as well as rural "systems of care" are economically fragile. Medicaid payment policies that cause disruption in reimbursement are likely to put rural providers at disproportionate risk and have effects that ripple throughout the rural health and community infrastructure.

Of particular importance to rural economic stability are the reimbursement systems for Medicare and often Medicaid available to Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Critical Access Hospitals (CAHs), and emergency medical serv-

ice (EMS) providers. The interrelationships of Medicare funding with Medicaid payments are critical. (For example, states have the option to provide cost-based or other positive differential Medicaid reimbursement to Critical Access Hospitals.) While current reimbursement systems for these providers may offer a buffer in some states, this is not always the case. When present, they remain highly susceptible to reimbursement policy changes. In particular, changes in Medicaid eligibility rules that decrease the number of covered individuals may have negative effects on both access to services and the aggregate levels of provider income from all sources necessary to support sustainable services. The negative effects can be felt quickly and can be profound.

"Physicians in rural areas are more likely to serve Medicaid beneficiaries than are their urban counterparts. Almost 20 percent of rural physician patient revenue comes from Medicaid, compared to only 15 percent for physicians located in urban areas."^{16,17} Frequently, Medicaid reimbursement is inadequate and contributes to difficulties in sustaining providers' practices. In many areas (not just rural), non-hospital providers report low Medicaid reimbursement rates as the major reason they limit the number of Medicaid patients in their practices.¹⁸ In addition, inadequate payment policies can be a major barrier to providing rural residents with essential specialty services outside their local community (i.e., when specialists in non-rural areas limit the number of Medicaid recipients in their practices.)

Medicaid payments to individual health care providers, including but not limited to physicians and dentists, can be critical determinants of whether a provider can be recruited to a rural setting. Any financial or administrative disincentives that affect Medicaid providers further exacerbate access problems at the local level.

Frequently, recruitment, retention, and practice operations that ensure Medicaid access can only be accomplished through cross-subsidization by hospitals or through FQHCs.

It is likely that this may be a significant factor in the trend toward more rural, hospital-based physician practices, where the sponsoring hos-

pitals may subsidize inadequate Medicaid payments as well as other practice needs. Many small hospitals, even those with small operating margins must assume this risk in order to provide community access to physicians' services and to sustain the hospital itself. (This in turn increases hospital charges to non-governmental payers, shifting Medicaid's responsibility to provide adequate payments to private payers.)

In the case of rural pharmacies, both general reimbursement policies and the impact of mail-order pharmacies are significant. Data is needed to assess variations in Medicaid payments to rural areas versus non-rural areas that may disadvantage rural providers.

The movement of states as well as federal programs to managed Medicare may have significant effects, some of which may be negative. Of particular concern to Critical Access Hospitals is the lack of assurances for consistent and adequate payment to any rural providers that are currently cost-based. This is especially true in states providing cost-based reimbursement for Medicaid.

In rural communities, the costs of maintaining "threshold" services, (e.g. the core of physicians required to provide adequate call coverage necessary to recruit physicians or services, such as local pharmacy services) may often be higher than the cost in non-rural areas. Rather than focusing on cutting Medicaid budgets across the board, it also may be more important to consider whether Medicaid reimbursement for direct patient service costs should address Medicaid's "fair share" for these community costs, and if so, how.

Eligibility, Scope of Benefits, and Implications for Access

Access to care is an ongoing challenge for rural America. On the most basic level, the Medicaid program provides a vehicle through which beneficiaries can access needed care and services.

"Medicaid beneficiaries need access to an appropriate coverage benefits package that provides linkage and continuity of care between preventive health services and primary, acute and specialty care...This appropriate coverage

benefits package needs to be comprehensive in nature, so that Medicaid beneficiaries are fully insured, not underinsured."¹⁹ This is particularly essential if long-term health improvements and associated cost reductions are to be achieved with Medicaid populations.

Attempts to vary benefit packages by waiving "state-wideness" must be carefully analyzed and viewed with great caution. Benefits available to rural Medicaid populations should not be less than those available to urban beneficiaries.

Some Medicaid policies, beneficial to rural communities, are already in place but are not consistently enforced by the Centers for Medicare and Medicaid Services (CMS). Examples include requirements for transportation for non-emergency conditions and requirements that payments are at sufficient rates to attract providers. CMS should more specifically address enforcement of these requirements.

The variation in delivery of Medicaid benefits (e.g., through managed care) may involve various administrative oversights or supplemental administrative support services, such as the use of case managers, lay providers, and primary care case management. Some of this variability may be appropriate and beneficial to rural beneficiaries. However, such may not always be the case. (For example, if richer benefits are limited to Medicaid managed care plans, rural populations may be disadvantaged. Medicaid managed care penetration is more limited in rural areas and local rural providers may be less likely to participate in Medicaid managed care.)

Other administrative systems requirements may be more difficult to implement, particularly those that rely on choice of providers or the access to the Internet (both unavailable to many rural Medicaid beneficiaries) with associated assumptions that patients and their families will be able to "price and quality shop." Some of the purported advantages of consumer-directed health plans are likely to be more difficult to achieve in rural communities where provider choice is less realistic than in non-rural communities.

In rural areas, patients who require specialty care (e.g., specialty consultations or chemotherapy management) must often travel long dis-

tances. The significant inadequacies in rural transportation systems can create additional mental and financial hardship for patients and their families. These can be insurmountable barriers to care, decreasing quality as well as leading to higher long-term costs. Telemedicine technology is one promising method for reducing this burden.

Other Considerations

It is essential to understand the community context of the Medicaid program and the potential impacts of changes on the broader community before implementing any kind of reform. The following points suggest just a few ways in which the rural context may provide important guidance as well as suggest caution:

- In most states, there are no requirements for meaningful consultation with rural populations and advocates before changes are made in Medicaid policies. As more states take advantage of options provided in the Deficit Reduction Act and/or the expansion of Medicaid waivers to change their Medicaid programs, this is of increasing importance. Meaningful consultation should be a federal as well as a state level requirement.²⁰
 - An important additional benefit of Medicaid is its contribution to community well-being through a stronger health care system and a more stable local economy. Medicaid contributes to rural economic development in four important ways. Medicaid: (1) provides opportunity for access to health care services, which in turn influences health status and therefore the productivity and quality of life of citizens; (2) provides patient revenue that helps retain the presence of health professionals; (3) supports the social services infrastructure; and (4) contributes to the economy through revenue and job generation.²¹ The availability of accessible health care is a critical component of meaningful rural community development, attracting and retaining employers, creating jobs, and expanding employer-offered health benefits. Changes (negative or positive) in Medicaid are likely to have associated disproportionate impacts on community economies, particularly in situations where providers operate with negative or close to negative operating margins.
- The impacts of cuts in Medicaid expenditures on local and state economies are inadequately appreciated. There are substantial positive, ripple effects on the economies of both, associated with Medicaid spending and the draw of federal funds into states. This is particularly true in states with high levels of federal Medicaid match payments. In some states, when Medicaid programs are cut, the combined effects of economic losses at the community level and the loss of associated state tax recoveries may result in much lower net savings to the state than anticipated.
 - The culture of some segments of rural America may reflect a higher level of independence and subsequent reluctance to accept Medicaid support to the extent that it is deemed a welfare program. Recasting Medicaid as an income support program may assist in diminishing any stigma.
 - Procedures for determining and redetermining eligibility that require multiple office visits, or other methods of eligibility determination requiring “in-person” interaction present very real barriers to access in rural communities given transportation barriers.
 - Farmers and commercial fishermen often use migrant and seasonal labor. There are challenges to providing access to care and any form of health insurance for both groups. The interface of this need with Medicaid eligibility options should be more substantively explored.
 - Asset transfer rules governing the disposition of farm assets in order to receive Medicaid coverage for long-term care can have significant implications for farm families. A better understanding of this issue is needed to adequately address any policy implications.
 - Some rural employers encourage their employees to seek Medicaid coverage rather than provide health insurance benefits. Opportunities to explore alternative funding options, particularly collaborative Medicaid—employee premium assistance models may be

difficult in rural communities because of the gaps in employer-sponsored insurance.

Nonetheless, in some rural communities this approach may have particular value.

Recommendations for NRHA Actions and Policy Positions

Understanding that any change in federal and state Medicaid policies will directly affect a state's ability to manage its budget and to provide quality care through Medicaid to rural populations, the NRHA offers the following recommendations for federal Medicaid reform and for consideration in the development of state Medicaid policies.²²

Improving Dialogue and Fostering Collaboration

- The challenges to rural health cannot be adequately addressed without more focused discussions of the impact of Medicaid. These discussions should be pursued, with the support of other organizations sharing NRHA interests, in the context of how Medicaid should be an influential partner (not just a payer) in advancing rural health. They should address how state and federal Medicaid programs can use their leverage as major payers to help build rural systems of care that will better meet the needs of 17 percent of the nation's rural population. "Partnership" discussions need to become more positive and to transcend many historic experiences.
- Although states play a large role in determining the scope and administration of their Medicaid programs, the federal government must not abdicate to the states its moral, legal, and financial responsibilities for rural, Medicaid eligible populations and the related development of sustainable rural health systems.
- Any changes in federal or state Medicaid policies should require a rural impact assessment. Requests by states for waivers of "state-wideness" should identify anticipated impacts on rural areas. Waivers should not be granted if anticipated state changes negatively and disproportionately affect rural populations.

Equity and Access

- There should be equity of Medicaid benefits across medical, oral health, and behavioral health benefits. Particular attention needs to be given to the disparities in health that affect rural populations and often Medicaid beneficiaries most specifically.
- Federal policies should continue to support advances in telemedicine as a tool to expand access and ensure adequate reimbursement for telemedicine services. While not a rural-Medicaid-specific recommendation, improved telemedicine will serve a significant number of rural Medicaid beneficiaries.
- In order to promote improvements in rural transportation for Medicaid beneficiaries, CMS should assess whether states are adequately addressing the requirements of the Medicaid program to provide non-emergency medical transportation benefits.

Eligibility and Enrollment

- Since rural recipients are more likely to rely on Medicaid as their source of insurance coverage, any changes in eligibility or in the application and recertification procedures which lead to reduced numbers of eligibles can have a disproportionate adverse impact in rural communities. Conversely, changes to expand eligibility or simplify the application process could positively affect rural communities. The federal and state governments should analyze the impact of eligibility changes on rural communities prior to implementation.
- Given the size and poverty level of the rural elderly and disabled populations, coordination of benefits and enrollment into available programs for dual-eligible beneficiaries should be given greater priority.
- Rural Medicaid recipients must be treated equitably by managed care and consumer-choice programs, as well as in the context of the development of Health Opportunity Accounts. Rural impacts need to be monitored.

Adequate Reimbursement for Providers

- Provider payments in rural areas must be adequate to assure Medicaid beneficiaries of financial access to services as well as to support recruitment and retention of providers.
- Protections should be implemented for rural providers, requiring state Medicaid plans to set payment rates that would reimburse the allowable cost appropriate to “economically and efficiently operated” rural providers, as defined by the states subject to approval by the Centers for Medicare and Medicaid Services. This approach should require that providers, receiving such cost-based reimbursement, receive no less when participating in managed Medicaid programs.
- This approach should also recognize that Medicaid programs should in some cases reimburse at a higher rate for services in rural areas than in non-rural settings to support the recruitment, operation, and retention of providers.

Improving the Utilization of Resources and Integration of Services

- Medicaid reimbursement should support chronic disease management and case management programs for Medicaid beneficiaries that improve quality and continuity of care while achieving cost savings. Issues that may be unique to rural populations need more focused assessment. Case management can be particularly beneficial to rural beneficiaries who may need additional assistance identifying providers and in obtaining medically necessary transportation.²³
- Adequate Medicaid access provided at sustainable state and federal costs will require reductions in waste, redundancies, and inadequate community level collaboration.
- To ensure improvements in rural systems of care for children, coordination should be improved between Medicaid and the State Children’s Health Insurance Program (SCHIP).
- Expanded multi-organizational collaboration should be encouraged, if not required, to advance the development of sustainable, integrated community health strategies for Medicaid populations.

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

Workforce Development

- The challenges of recruiting and retaining providers to rural communities will affect all rural residents. However, given the characteristics of rural Medicaid populations this is a disproportionately significant threat to Medicaid access. Support should continue for J-1, Conrad 30, and National Health Service Corps providers serving rural communities. These physicians should be required to treat Medicaid patients.
- Given the profound challenges of recruiting to rural communities, the definition of eligible providers should be expanded to cover all types of primary care, mental health, and oral health providers (not just physicians) and to include general surgery (an increasing critical shortage category).
- Given the need for more rural providers to ensure adequate Medicaid access, training programs for physicians, dentists, advanced practice nurses, registered dental hygienists, and pharmacists should be expanded. There should be particular attention to advocating for additional federal funding for educational programs that commit to expanding rural training in settings that provide care to Medicaid recipients and the uninsured, and that demonstrate success in achieving additional rural placements in proportion to funding. (This recommendation applies to access for all rural populations, not just Medicaid, but expanded training is critical to ensuring that fundamental services are available to rural Medicaid populations.)
- Support should be enhanced for Area Health Education Center (AHEC) programs specific to addressing the needs of rural populations, with focused attention on the needs of providers in caring for Medicaid beneficiaries.

Long-Term Strategies

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

A Suggested Research Agenda

- The importance of Medicaid to rural communities' economies and to sustaining rural development needs to be better understood, as do the relationships between rural spending, direct and indirect impacts on rural communities, states budgets, and federal matching payments. More specific research should be encouraged.
- Further research is required related to models of care most suitable for delivering more cost effective integrated packages of services to Medicaid beneficiaries, e.g., through CAHs,

FQHCs, and school-based health programs in rural areas.

- Additional study is needed to clarify barriers to rural Medicaid enrollment, including the implications for new citizenship documentation requirements.
- Federal and state provisions related to the transfer of assets should be carefully monitored to see if there is a differential impact on rural areas (e.g., on farm families).
- Expanded research should be supported for chronic disease management and case management for Medicaid beneficiaries.
- There should be an assessment of the appropriateness of Medicaid reimbursement at a higher rate for services in rural areas than in non-rural settings in order to support the recruitment, operation, and retention of providers.

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Endnotes

- ¹Rural Policy Research Institute (RUPRI) Issues Brief, Medicaid and Its Importance to Rural Health, 2006
- ²Kaiser Commission on Medicaid and the Uninsured. (March, 2007). Medicaid: A Primer, Washington, DC: The Henry J. Kaiser Family Foundation.
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- ⁴Understanding Recent Changes in Medicaid Spending and Enrollment Growth between 2000-2004. Kaiser Commission on Medicaid and the Uninsured. Spending grew annually on average: 11.9% (2000-2002), 6.9% (2002-03), 7.6% (2003-04)
- ⁵The exception to state spending is when Medicaid services are provided by the Indian Health Service or a federally recognized Indian tribe or tribal organization. These services are reimbursed with 100 percent federal dollars and passed through the respective state Medicaid offices. There is currently no state dollars matched for these services.
- ⁶Rural Policy Research Institute (RUPRI) Issues Brief, Medicaid and Its Importance to Rural Health, 2006
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- ¹¹U.S. Bureau of Labor Statistics & U.S. Bureau of the Census. (2005). Current Population Survey, March 2005.
- ¹²Rogers, C. (2002). The Older Population in 21st Century Rural America. Rural America, 17(3), 2-10.
- ¹³Institute for Health Policy, Muskie School of Public Service University of Southern Maine with The Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage In Rural America," September 2003
- ¹⁴US Census, Annual Social and Economic Supplement. Current Population Survey, 2006
- ¹⁵APHA Medicaid, Prevention and Public Health: Invest Today for a Healthier Tomorrow
- ¹⁶Rural Policy Research Institute (RUPRI) Issues Brief, Medicaid and Its Importance to Rural Health, 2006
- ¹⁷Center for Studying Health System Change. (2000/2001). Community Tracking Survey - Physician Survey. Washington, DC: Center for Studying Health System Change.
- ¹⁸APHA Medicaid, Prevention and Public Health: Invest Today for a Healthier Tomorrow
- ¹⁹APHA Medicaid, Prevention and Public Health: Invest Today for a Healthier Tomorrow
- ²⁰Meaningful consultation is taking place in Indian Country, but only after years of advocating by elected tribal leaders. The consultation is under the directive of various Executive Orders, starting with the Clinton administration, continuing with President Bush's administration. The process ended when On January 14, 2005, shortly before departing the office of Secretary, Tommy G. Thompson signed a new Consultation Policy for the Department of HHS, thus culminating nearly two years of extensive work with tribal representatives through which the text of the Policy was developed. This comprehensive 23- page Policy spells out in great detail the basis for an Indian-specific Policy and the manner in which departmental officials must relate to tribes and consult with them before any action is taken that will significantly affect them. This example could be adapted to ensure that rural residents where offered an opportunity to respond to actions then by states that would have an effect on their health.
- ²¹Rural Policy Research Institute (RUPRI) Issues Brief, Medicaid and Its Importance to Rural Health, 2006.
- ²²Note: Recommendations are characterized into a primary category but may have characteristics that would fit under several headings. For example, adequate reimbursement for providers in also an access issue.
- ²³Silberman, P, Poley, S, Slifkin, R. Innovative Primary Care Case Management Programs Operating in Rural Communities: Case Studies of Three States. 2003. (Rural Medicaid Policy Paper NRHA Policy Board May 17, 2007)

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