



Rural Carve-out Funding

Authors: Michael Meit, MA, Crystal Barter, MSA, Sally Buck, MS, Mark Woodring, DrPH

I. Introduction

Federal funding to improve overall health and well-being distributed as grants to states can create inequities. Beginning with Congressional appropriations and directives to federal agencies, the path to rural communities requires attention. Moreover, the equitable impact of federal health improvement initiatives to all state residents is reliant on state, local, tribal, and territorial structure, and financial models to dedicate resources that overcome specific challenges in rural areas.

Rural residents have poorer access to essential health services than their urban counterparts, including primary and specialty care, acute care, behavioral and mental health, and emergency medical services. Moreover, many rural and frontier areas lack necessary public health infrastructure in the form of district, county, or city public health departments. Additionally, rural populations are older, have lower health status with lower life expectancy,¹ and experience higher rates of poverty than their urban counterparts. Of the 382 persistent poverty counties,² 365 (95 percent) are nonmetropolitan.³

While rural needs are more acute, funding initiatives are often directed at high population areas to meet grant objectives for the numbers served directly through campaigns, education, services, access, or research for efficiency or lack of representation. Policymakers are beginning to recognize the need to specifically invest in targeted, underserved communities through legislation, such as 2019's *Targeting Resources into Communities in Need Act* (S.1066), which was introduced in the 116th Congress. A focus on rural communities needs to be included in federally funded state health programs to improve community-level health behaviors, access through workforce, technology, and financial resources.

¹ Cross SH, Califf RM, Warraich HJ. Rural-Urban Disparity in Mortality in the US From 1999 to 2019. *JAMA*. 2021;325(22):2312–2314. doi:10.1001/jama.2021.5334.

² The Economic Research Service of the United States Department of Agriculture (USDA) defines a persistent poverty county as one that has had high poverty (at least 20 percent of the population) on each the last four censuses.

³ United States Department of Agriculture Economic Research Service. Economic Information Bulletin 171. April 2017



II. Supporting Data

Studies have assessed differences in public health and health care funding based on geography.^{4,5,6,7} Research conducted in 2008 on public health funding found that federal chronic disease funding from the CDC was often insufficient to distribute effectively to local and rural communities.⁴ Further, when allocated through a competitive grant process, rural communities faced greater barriers compared to non-rural communities.⁴ These challenges are particularly relevant to federal funding streams that allocate dollars to states with the expectation that states will equitably distribute funding to local entities.⁷ Examples of such funding streams include allocations made to states by federal agencies and state-level block grants.⁸ While states often favor these funding sources due to their flexibility, resources are often distributed in an inequitable manner based on geography, population density and other factors.^{4,7} Studies have found that states often feel pressure to demonstrate maximum impact of federal resources and may see investments in larger communities as a strategy to impact larger population groups.^{4,7} Similarly, funding available through these sources may be insufficient to meet all community needs, placing rural communities at a disadvantage in resource prioritization.

The lack of equity in rural health funding makes it difficult to ensure that federal funding effectively targets the needs of vulnerable rural populations. Rural residents experience significant health disparities across each of the five leading causes of death (heart disease, cancer, unintentional injury, chronic lower respiratory disease, stroke),⁹ which are the focus of much of the state-level funding allocated by CDC and block grant programs, such as the Preventive Health and Health Services Block Grant. Ensuring that federal funding allocated to states is equitably distributed to address the needs of rural communities will ultimately help to reduce long-standing rural health disparities.

Moreover, studies have also demonstrated that rural health funding inequities are compounded by other social determinants of health unmet needs, such as

⁴ Meit M, Ettaro L, Hamlin BN, Piya B. Rural public health financing: Implications for community health promotion initiatives. *J Public Health Manag Pract.* 2009;15(3):210-215.

⁵ Harris JK, Beatty K, Leider JP, Knudson A, Anderson BL, Meit M. The double disparity facing rural local health departments. *Annu Rev Public Health.* 2016;37:167-184.

⁶ Beatty K, Heffernan M, Hale N, Meit M. Funding and service delivery in rural and urban local US health departments in 2010 and 2016. *Am J Public Health.* 2020;110(9):1293-1299

⁷ Meit M, Knudson A, Dickman I, Brown A, Hernandez N, and Kronstadt, J. An Examination of Public Health Financing in the United States. (Prepared by NORC at the University of Chicago.) Washington, DC: The Office of the Assistant Secretary for Planning and Evaluation. March 2013.

⁸ Congressional Research Service. Block grants: Perspectives and controversies. 2020. <https://fas.org/sqp/crs/misc/R40486.pdf>. Accessed May 17, 2021.

⁹ Moy E, Garcia MC, Bastian B, et al. Leading Causes of Death in Nonmetropolitan and Metropolitan Areas — United States, 1999–2014. *MMWR Surveill Summ* 2017;66(No. SS-1):1-8. DOI: [http://dx.doi.org/10.15585/mmwr.ss6601a1external icon](http://dx.doi.org/10.15585/mmwr.ss6601a1external_icon)



transportation, water, education, workforce development and broadband.¹⁰ As reported by USDA in 2017, low educational attainment in rural communities has been linked to higher rates of poverty and unemployment, which have profound impacts on overall health.³ Rural transportation must also be considered as a community asset to overall health outcomes and economic development, particularly for persistently impoverished counties.¹¹ As we prepare for post-pandemic care environments, it is clear that connecting patients, neighborhoods, and communities to broadband will play an important part of health care delivery to improve outcomes, as well.¹² Similarly, broadband deficits have contributed to other setbacks in education and workforce development,¹³ and generally, rural areas fall behind in broadband availability and adoption.¹⁴

Generally, a rural carve-out has not been designated in federal programs. However, the federal government recently identified a designated percentage of funding to go to rural providers in federal COVID-19 programs, due to the virus' disproportionate impact on health and economies in rural areas. In the months since the enactment of Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (P.L. 116-136), Consolidated Appropriations Act of 2021 (CCA) (P.L. 116-260), and Paycheck Protection Program and Health Care Enhancement (PPCHEA) (P.L. 116-139), there have been the following allotments of note. The following are examples of rural carve-outs of federal COVID-19 funding and programs:

- The U.S. Health and Human Services Department (HHS), Centers for Disease Control and Prevention (CDC) National Initiative to Address COVID-19 Health Disparities (CoAg OT21-2103): CDC made 108 awards with total funding of \$2.25 billion to support populations in high-risk and underserved communities, including racial and ethnic minority groups and people living in rural communities. Eligible recipients were state, local, and US territories and freely associated state

¹⁰ Long, Alexander S et al. "Socioeconomic variables explain rural disparities in US mortality rates: Implications for rural health research and policy." *SSM - population health* vol. 6 72-74. 31 Aug. 2018, doi:10.1016/j.ssmph.2018.08.009

¹¹ Kidder, Ben. "The Challenges of Rural Transportation." (2006). Utah State University. Western Rural Development Center.

¹² Bauerly, Brittney Crock et al. "Broadband Access as a Public Health Issue: The Role of Law in Expanding Broadband Access and Connecting Underserved Communities for Better Health Outcomes." *The Journal of law, medicine & ethics: a journal of the American Society of Law, Medicine & Ethics* vol. 47,2_suppl (2019): 39-42. doi:10.1177/1073110519857314

¹³ Hampton, K. N., Fernandez, L., Robertson, C. T., & Bauer, J. M. Broadband and Student Performance Gaps. James H. and Mary B. Quello Center, Michigan State University. <https://doi.org/10.25335/BZGY-3V91>

¹⁴ Whitacre, B., & Gallardo, R. (2020, October 1). *State Broadband Policy: What Impacts Availability?* Western Rural Development Center. <https://www.usu.edu/wrdc/files/WRDC-Rural-Broadband-Policy-OCT2020.pdf>.



health departments. Nineteen percent of the total available funds were awarded to state health departments to address the needs of rural communities. Each state health department recipient award includes funding that is specifically intended to support rural communities. This funding, referred to as the rural carve-out, was reflected in the notice of award for all state health departments. The size of each state health department's rural carve-out is based on the size of the rural population. This grant adopted the Federal Office of Rural Health Policy's (FORHP) fiscal year (FY) 2021 definition.

- CARES Act Provider Relief Fund (PRF): Allocated an approximately \$11 billion carve-out specifically for rural providers to address added COVID-19 challenges such as high need and vulnerable populations.
- Further, the Affordable Care Act (P.L. 111–148) CDC Community Transformation Grants state recipients were directed by Congress to allocate 20 percent to rural or the amount equal to the rural population in rural, whichever was greater.¹⁵

III. Recommendations

- Through Congressional appropriations and directives, encourage federal agencies to include a designated percentage, or “carve out” for rural residents in funding opportunities (see examples above). This ensures equitable distribution of resources to impact the over 57 million Americans living in rural areas.
- Encourage agencies to use the definitions of rural, as defined by the [HRSA's FORHP](#).
- Ensure that the designated rural funding has an adequate evaluation plan, potentially utilizing Rural Health Research Centers as technical assistance providers. A consistent approach to evaluation will demonstrate how effectively the funding is used, provide accountability for the rural carve out, and capture the impact on rural residents.
- Amplify the rural funding success stories to support rural health transformation and showcase best-practices.

¹⁵ National Center for Chronic Disease Prevention and Health Promotion. (2017, March 7). *Community Transformation Grants (2011–2014)*. NCCDPHP: Community Health. <https://www.cdc.gov/nccdphp/dch/programs/communitytransformation/index.htm>.



- Encourage agencies to partner with strong rural health resources in each state (i.e., State Offices of Rural Health or State Rural Health Associations) to assist in most equitable distribution of the funding at the state level. Ensure that federal agencies partner with a designated rural health agency will ensure that the funding reaches the most vulnerable rural residents. In addition, these state-level entities can ensure that funds are used to address disparities, including racial/ethnic disparities and persons living in poverty.