POLICY BRIEF
*January 2021*

UNIVERSITY OF MINNESOTA
RURAL HEALTH
RESEARCH CENTER

# Barriers to Health Care Access for Rural Medicare Beneficiaries: Recommendations from Rural Health Clinics

Megan Lahr, MPH
Carrie Henning-Smith, PhD, MPH, MSW
Adrita Rahman, MPH
Ashley M Hernandez, MSPH

## Key Findings

- In an online survey, Rural Health Clinic (RHC) staff identified barriers to accessing health care for Medicare beneficiaries.
- The most common barriers included transportation, cost/payers, workforce issues (e.g., provider shortages), distance/location, lack of health literacy, patient decisions, and lack of support (e.g., childcare, family support).
- To improve access, RHC staff recommended improvements to transportation, recruiting and retaining providers, expanding operations, changing provider payment policies, increasing patient education and awareness, expanding telemedicine, increasing provider communication, and lowering patient costs.

rhrc.umn.edu

## Purpose

Access to health care is essential for maintaining good health, but people in rural areas often face specific barriers to access, including in primary care. To date, there is limited information outlining specific barriers that are encountered by safety net providers in serving rural Medicare beneficiaries, including Rural Health Clinics (RHCs) that were designed to increase access for rural residents. This policy brief presents findings from an online survey of RHCs describing barriers for Medicare patients in accessing health care services, and recommendations for how to improve access to care for Medicare beneficiaries in rural areas.

## Background and Policy Context

Rural communities have struggled with access to health care services for decades.[1-4] Many known factors contribute to barriers to care in rural areas, including workforce shortages, transportation challenges, and lack of health insurance coverage.[5-7] The population in rural communities also tends to be older, on average, and has poorer health when compared to those living in urban areas,[8-9] which can lead to additional complications in being able to successfully access care in a timely manner.

In 1977, the federal government created Rural Health Clinics (RHCs) to fill a much-needed gap in primary health care services for Medicare beneficiaries in rural areas.[10] Today, roughly 4,500 RHCs provide primary care and preventive services to otherwise underserved rural communities.[10]

Although Medicare beneficiaries are insured, they still face many other challenges related to accessing timely, high-quality care, specifically in rural areas.[11] These include those barriers listed above and others, such as long distances between facilities, convenience and scheduling issues, physical accessibility of services, and financial constraints related to out-of-pocket expenses.[12-13] Access is particularly important to Medicare beneficiaries, as they tend to have more chronic health conditions and functional limitations compared to the general population.[14] For that reason, safety net providers, including RHCs, fulfill a vital role in improving access for rural Medicare beneficiaries.

## Approach

For this study, we surveyed 111 Rural Health Clinic (RHC) representatives across 27 states. The survey was administered in collaboration with the National Association of Rural Health Clinics (NARHC) through a link on the NARHC's online forum. The sur-

vey was fielded between March and April of 2019, and respondents included clinic managers, medical directors, practice supervisors, and CEOs. Survey participants answered questions about operations at their RHC, and provided input on barriers to health care access, as well as recommendations for improving access to care for Medicare beneficiaries. Participation was entirely voluntary, and as the survey included RHCs who chose to participate, data cannot be considered representative of all RHCs, but instead provides a perspective of RHCs willing and able to respond to a request for information on this topic.

The two survey questions examined for this analysis were: 1) What do you believe is the greatest barrier for Medicare beneficiaries in your area for accessing health care services?; and 2) What is your recommendation for improving how Medicare beneficiaries access health care in your rural area? For both questions, some respondents offered more than one response, so total responses do not reflect the exact number of individual respondents. Three members of the research team coded responses independently, and met to discuss the themes and arrived at consensus.

## Results

*Barriers*

Nearly all RHC respondents (95%; n=105) identified at least one barrier to accessing care for Medicare beneficiaries, while the remaining respondents reported that there were no barriers or that this question was not applicable. Overall, there were a total of 140 barriers mentioned (see Figure 1).

Seven themes (discussed below) were established for barriers to accessing care for Medicare beneficiaries: 1) Transportation; 2) Cost/Payers; 3) Workforce Issues; 4) Distance/Location; 5) Lack of Health Literacy; 6) Patient Decisions; and 7) Lack of Support. Additionally, there were responses that could not be collapsed into the above themes, and some respondents (n=6) noted that they did not perceive barriers to access for Medicare beneficiaries.

Of the barriers identified by respondents, the most common theme was related to transportation, with 41% of responses (n=57) reporting this as a barrier to serving rural Medicare beneficiaries. Most responses were simply "transportation", though some specified general difficulties for older patients and people with mobility limitations, or challenges due to the lack of public transportation in small towns.

Barriers related to issues with cost of care and with payers were included in 22% (n=31) of respondents' comments. These obstacles included deductibles and copays, cost of services and medications, Medicare reimbursement rates, and poverty rates among their patient populations.

Mentions of workforce issues, including provider shortages, limited appointment availability, and difficulties accessing specialty services were mentioned in 13% (n=18) of responses.

In 10% (n=14) of responses, barriers linked to geographic distance, long travel times, and/or rural location were identified. These included comments about patients having to travel 50-200 miles to receive care, particularly for specialists, as well as the long amount of time it takes to travel from rural areas to necessary providers.

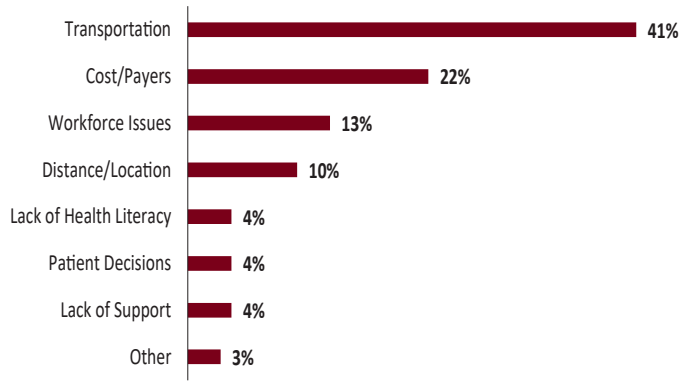
Issues associated with lack of health literacy among the patient population were noted in 4% (n=6) of responses, including "not knowing how to navigate the health care system" and "confusion on services covered."

Barriers related to patient decisions made up 4% (n=5) of responses. These also included responses that mentioned lack of patient compliance with treatment recommendations, and not wanting to go to the doctor or use benefits.

The final theme for barriers identified in 4% (n=5) of responses was a lack of support surrounding rural Medicare beneficiaries that prevented their accessing care in a timely manner. This included responses related to lack of formal/informal support systems, limited family support to guide care, lack of childcare (for beneficiaries with children), as well as limited support in the form of health literacy education among the patient population.

There were some additional responses that could not be collapsed into the above themes, and these made up 3% (n=4) of all responses.

**Figure 1. Barriers for Medicare Beneficiaries to Accessing Care in Rural Communities**



*Recommendations*

Overall, 88% (n=98) of 111 respondents named at least one recommendation for improving access to care for rural Medicare beneficiaries, and there were a total of 113 recommendations identified from RHC respondents. Responses of recommendations for improving access to care for Medicare beneficiaries were categorized into eight themes: 1) Improve Transportation; 2) Recruit & Retain Providers; 3) Expand Operations; 4) Change Provider Payment Policies; 5) Increase Patient Education & Awareness; 6) Expand Telemedicine; 7) Increase Provider Communication; and 8) Lower Patient Costs (see Table 1).

The most common recommendation was to improve transportation in rural areas, with 27% (n=31) of responses (see Figure 2). Suggestions included making transportation available as a benefit, increasing availability of public transportation or transit systems, and making existing transportation options more affordable in rural areas.

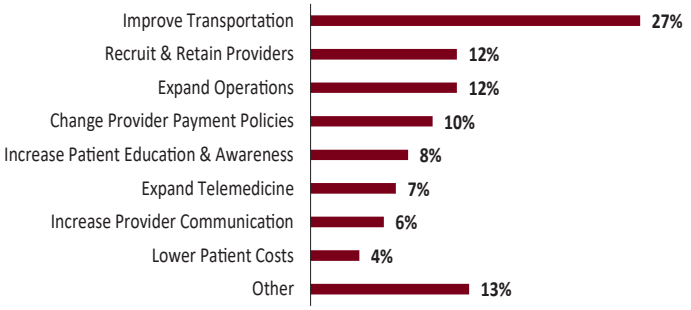
Recruiting and retaining providers was the second most common theme with 12% (n=14) of responses, and these included mentions of incentivizing providers to care for patients in rural areas. Recommendations also included additional funding to strengthen recruiting and bring more providers to rural areas.

**Table 1. Representative Quotes from Each Recommendation Theme.**

| Theme | Quote(s) |
|---|---|
| 1) Improve Transportation | *'Developing a short notice transportation system.'* – Practice Manager, MI<br><br>*'Medicare patients are so appreciative of being able to see a doctor without driving an hour or more to a city.'* – Clinic Manager, NE |
| 2) Recruit & Retain Providers | *'Specialists scheduled at hospital at least once a month.'* – Billing Specialist, KS<br><br>*'Offer additional dollars to drive new providers to practice in rural areas.'* – Practice Manager, MI |
| 3) Expand Operations | *'Expanded hours of operation to accommodate these populations.'* – Marketing Coordinator, TX<br><br>*'Home visits for more than just homebound patients.'* – CFO, IA |
| 4) Change Provider Payment Policies | *'Better reimbursement for independent rural clinics.'* – Administrator, OR<br><br>*'For Medicare to pay for telehealth visits at the RHC rate.'* – Administrator, LA* |
| 5) Increase Patient Education & Awareness | *'Provide better education of resources available.'* – Operations Specialist, MI<br><br>*'Educate them on what is covered and who to contact with questions. So many of our Medicare patients have no idea if they are covered by traditional Medicare or an Advantage plan. There are so many scams out there it is disheartening, but our patients get taken advantage of often.'* – Administrator, IL |
| 6) Expand Telemedicine* | *'Provide an alternative technology (virtual) visit option.'* – Administrator, TN<br><br>*'Telemedicine specialist networks.'* – CEO, LA |
| 7) Increase Provider Communication | *'Improved coordination between all healthcare providers.'* – Director, IN<br><br>*'Better communications about access and need to establish a PCP.'* – Physician Assistant, FL |
| 8) Lower Patient Costs | *'Paying for the labs that these older people need to have done.'* – Office Manager, LA<br><br>*'Increase coverage of medications.'* – Director of Clinic Operations, KS |

**This survey was completed prior to the COVID-19 pandemic and the associated availability of changes to telehealth and billing for telehealth services.*

**Figure 2. Recommendations for Improving Access to Care for Medicare Beneficiaries in Rural Communities.**




Expanding clinic operations was mentioned in 12% (n=13) of responses. These recommendations included home visits, extended hours of operation, and general increased availability of services and service times.

Recommendations of changes to provider payment policies were included in 10% (n=11) of responses, with increases to Medicare reimbursement and changes to coverage under Medicare, including coverage of an annual physical (above and beyond the annual wellness visit), the most commonly mentioned.

Enhanced education and awareness were cited 8% (n=9) of the time as ideas for improving access to care. These responses included suggestions for education for patients on health issues, improvement of health insurance literacy, and knowledge of resources available in rural areas.

The use of telemedicine was reported in 7% (n=8) of responses, including suggestions for expanding the use of telemedicine for in-home visits and specialty care appointments.

Recommendations related to provider communication made up 6% (n=7) of responses. These included suggestions to improve basic communication to patients from clinics and providers, such as proactive contact from clinics to patients, but also coordination between providers to improve patient access to care.

Lowering the cost of care to individual patients as a means to increase access was mentioned in 4% (n=5) of responses. Specific solutions included waiving deductibles, lowering the cost of medications, and covering the cost of labs and medications.

There were also many responses (13%, n=15) that could not otherwise be categorized into themes, so those were left ungrouped. For example, these responses included mentions of "more community help" and "old-fashioned personal service."

## Discussion and Implications

This study identified considerable barriers for rural Medicare beneficiaries in accessing health care services from the perspective of representatives of Rural Health Clinics (RHCs), an important source of safety net care in rural areas. RHC staff also provided recommendations for policy solutions that would improve access to care for their Medicare patient population by enabling beneficiaries to have an easier time accessing care, as well as allowing RHCs to more easily provide optimal care in their rural communities. Not all of the recommendations identified fall under the purview of changes that can be made in Medicare policy, but instead some require broad solutions that may include actions that RHCs can act on themselves and/or with the support of other funding or policy changes.

Perhaps not surprisingly, transportation emerged as both the most common barrier to care and as the issue that RHCs would most like to see addressed in policy and programmatic interventions. The issue of rural transportation is a long-standing challenge, involving constraints in resources, especially for public transportation and non-emergency medical transportation; long distances; aging infrastructure; and distinct boundaries between state, regional, and municipal transportation systems that make travel inconvenient or even impossible.[16]

These transportation issues are particularly salient for rural Medicare beneficiaries, who are more likely than their younger counterparts to have travel-limiting health conditions. Prior research shows that rural residents are less likely to stop driving in the face of a travel-limiting medical condition, likely because there are no other viable options.[16] This can put individuals and populations at risk of poor outcomes. Routine access to primary care is essential for Medicare beneficiaries, and addressing transportation barriers is one important step in doing so. While some Medicare Advantage plans may include supplemental transportation benefits, additional policy changes might include expanded reimbursement for non-emergency medical transportation, better coordination between transportation systems, and programs to increase the availability of volunteer drivers.

Despite having health insurance coverage through Medicare, RHC staff noted that cost was still a significant barrier for Medicare beneficiaries. These costs extend beyond premiums, and consist of co-pays, medications, and other non-covered items, including certain

providers, procedures, medical equipment, or types of care (i.e., telemedicine from home). Prescription drugs make up over 20% of out-of-pocket expenses for Medicare beneficiaries (not including premiums),[17] and the increases in costs for prescription drugs has become a national issue. Policies addressing the high and growing costs of prescription drugs, as well as policies that would lower the out-of-pocket costs for Medicare beneficiaries across all areas of care are important to improving their full access to care in rural areas. One example of such policies is the Medicare Part D Senior Savings Model implemented in January 2021, that caps seniors' insulin costs at $35 per month for participating health plans.[18]

Related to the cost of care for beneficiaries is the cost for RHCs to provide care. Respondents commonly expressed the need for changes to reimbursement policies for RHCs, noting that increased funding would help their clinics to improve access for individuals in their rural communities. These policy changes could include changing the reimbursement rate for telemedicine, or increasing the Medicare reimbursement rates in general. These recommendations for changes in reimbursement would allow RHCs to have additional financial flexibility to make improvements such as covering the cost of bringing specialty care on-site, or hiring additional providers at their clinics. On the patient side, respondents noted a need to improve health literacy and increase awareness of benefits. Some of this could be done by building on already-existing State Health Insurance Assistance Programs (SHIPs), although education should be done with the unique rural context in mind.

Concerns with the barrier created by a lack of available trained health care professionals, and the solution of increasing this workforce in rural areas were additional themes derived from this analysis. By improving recruitment and retention among the workforce in rural communities, by both employing additional health care professionals in RHCs as well as improving the access to specialists outside of RHCs, several improvements could be made. RHCs would be able to improve access by serving a larger patient population or serving their current populations more efficiently without patients having to travel longer distances or endure long waiting periods to see providers. Additionally, their patients would be able to access specialty services within their communities, or via telehealth, to improve the overall access for Medicare beneficiaries. Strategies to bolster the rural health care workforce might include additional recruitment or incentives for those who relocate to rural areas, but can also include providers and/or health systems willing and able to provide telemedicine services to rural areas. The latter includes investment in technological equipment, sufficient broadband Internet or telephone connectivity, and equitable reimbursement policies for telehealth services.

In the wake of the COVID-19 pandemic, considerable flexibility has been introduced to telehealth reimbursement for Medicare beneficiaries;[19] maintaining this flexibility post-COVID may address some of the access barriers around both transportation and workforce identified in this study, though additional education and patient support may also be necessary. The CARES Act, passed in response to the COVID-19 pandemic, allows RHCs to be telehealth distance sites under Medicare for the first time since that benefit was introduced, though the reimbursement amount is limited for RHC encounters.[20] If RHCs could hire and retain the additional health care professionals they need, RHCs may be able to implement expanded clinic operations to further improve access to care for Medicare beneficiaries. RHCs could offer additional appointments on evenings or weekends, or expand alternative appointment types (i.e., telemedicine or home visits), which would in turn improve access to care for some patients.

As the Medicare population grows, the issues raised in this study will only become more important for rural beneficiaries and should be used to influence policy solutions designed to improve access to health care services in rural communities.

## Acknowledgements

The authors would like to thank the National Association of Rural Health Clinics for their collaboration in fielding the online survey of Rural Health Clinics, as well as the Rural Health Clinic staff who participated in the survey for sharing their experiences and ideas.

## References

1. Casey, M. M., Thiede Call, K., & Klingner, J. M. (2001). Are rural residents less likely to obtain recommended preventive healthcare services? American Journal of Preventive Medicine, 21(3), 182–188.
2. Chan, L., Hart, L. G., & Goodman, D. C. (2006). Geographic access to health care for rural Medicare beneficiaries. The Journal of Rural Health, 22(2), 140–146.
3. Douthit, N., Kiv, S., Dwolatzky, T., & Biswas, S. (2015). Exposing some important barriers to health care access in the rural USA. Public Health, 129(6), 611–620.
4. Nayar, P., Yu, F., & Apenteng, B. A. (2013). Frontier America's health system challenges and population health outcomes. The Journal of Rural Health, 29(3), 258–265.
5. Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services. (2019). Third quarter of fiscal year 2019 designated HPSA quarterly summary. Retrieved from https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport
6. Henning-Smith, C., Evenson, A., Corbett, A., Kozhimannil, K., & Moscovice, I. (2017). Rural transportation: challenges and opportunities. Retrieved from https://rhrc.umn.edu/publication/rural-transportation-challenges-and-opportunities/
7. United States Census Bureau. (2018). Uninsured rates in urban and rural America. Retrieved from https://www.census.gov/library/visualizations/interactive/rural-urban-uninsured.html
8. Moy, E., Garcia, M., Bastian, B., Rossen, L., Ingram, D., Faul., M., …Iademarco, M. (2017). Leading causes of death in nonmetropolitan and metropolitan areas— United States, 1999–2014. MMWR Surveill Summ. 66(1):1-8.
9. United States Department of Agriculture (2018). Rural America at a glance, 2018 edition. Retrieved from https://www.ers.usda.gov/webdocs/publications/90556/eib-200.pdf?v=5899.2
10. Centers for Medicare and Medicaid Services. (2019). Rural Health Clinic. Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctsht.pdf
11. Centers for Medicare and Medicaid Services Office of Minority Health and RAND Corporation. (2018). Rural-urban disparities in health care in Medicare. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Urban-Disparities-in-Health-Care-in-Medicare-Report.pdf
12. Medicare Payment Advisory Commission. (2012). Serving rural Medicare beneficiaries. Report to the Congress: Medicare and the health care delivery system, 115-168. Retrieved from http://www.medpac.gov/docs/default-source/reports/chapter-5-serving-rural-medicare-beneficiaries-june-2012-report-.pdf
13. Ziller, E., Lenardson, J., & Coburn, A. (2015). Rural disabled Medicare beneficiaries spend more out-of-pocket than their urban counterparts. Retrieved from http://muskie.usm.maine.edu/Publications/rural/PB-60-Medicare-out-of-pocket.pdf
14. Kaiser Family Foundation. (2019). An Overview of Medicare. Retrieved from https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/
15. Hsieh, H., & Shannon, S. (2005). Three approaches to qualitative content analysis. Qualitative health research, 15(9), 1277-1288.
16. Henning-Smith, C., Evenson, A., Kozhimannil, K., & Moscovice, I. (2018). Geographic variation in transportation concerns and adaptations to travel-limiting health conditions in the United States. Journal of Transport and Health, 8, 137-145.
17. Kaiser Family Foundation. (2019). 10 essential facts about Medicare and prescription drug spending. Retrieved from https://www.kff.org/infographic/10-essential-facts-about-medicare-and-prescription-drug-spending/
18. Centers for Medicare and Medicaid Services. Part D Senior Savings Model. Available at: https://innovation.cms.gov/innovation-models/part-d-savings-model.
19. Hollander, J & Carr, B. (2020). Virtually Perfect? Telemedicine for Covid-19. The New England Journal of Medicine, 328(18), 1679-1681.
20. Centers for Medicare and Medicaid Services. Rural Health Clinics Center: COVID-19 Public Health Emergency (PHE) – Updates for RHCs. Available at: https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center

RHRC
Rural Health Research & Policy Centers
Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org

Support for this study was provided by the Federal Office of Rural Health Policy, Health Resources and Services Administration, Cooperative Agreement U1CRH03717-13-00. The information, conclusions, and opinions expressed are those of the authors, and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.

For more information, contact Megan Lahr (lahrx074@umn.edu)

University of Minnesota Rural Health Research Center
Division of Health Policy and Management, School of Public Health,
2221 University Avenue SE, #350 Minneapolis, MN, 55414