Closing the Distance in Rural Primary Care

Evidence, Stories and Solutions

Prepared by

pcc primary care collaborative

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Primary Care Collaborative
2025 Evidence Report

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Dear Colleagues,

Most of the increasingly prolific headlines about rural health care focus on hospital closures.

And while these are unfortunate and will create gaps in care, policymakers need to broaden their aperture and also consider how strengthening primary care in rural communities could be a lower cost, more effective solution to improving health in the heartland.

And we absolutely do need to improve the health of our rural neighbors, who constitute about 20% of the US population.

Rural residents have higher rates of chronic conditions, poorer behavioral health and higher mortality, along with a greater risk of opioid overdoses. This is due to economic and social factors and less access to care — driven, in part, by 15% fewer primary care clinicians on a population basis than other geographies.

On the positive side of the ledger, the way primary care is practiced in rural America already reflects many of the assets that the National Academy of Science Engineering and Medicine (NASEM) describe as high quality, whole-person primary care. These include a team-based care delivery model, offering a comprehensive set of services in an array of settings and, in many cases, tackling social drivers of health. Rural practices also know their patients — outside of clinical encounters and even across generations — and have rich connections within their communities.

Yet, these effective rural primary care practice models are not adequately financed. In fact, they rely on serial re-invention, cash-pay services and even incorporation of 340B pharmacies to keep their doors open. And many value-based models providing more flexibility and resources for primary care in urban settings do not translate into rural communities.

Federal and state policymakers committed to improving health in the heartland have some clear policy levers to pull.

At the state level, policymakers should participate in efforts to measure and increase primary care spending, with a focus on more investment in "rural friendly" value-based models. State legislators must also refrain from making cuts to primary care in Medicaid, a pressure they will encounter in light of reductions in spending due to the passage of H.R. 1.

At the federal level, policymakers should prioritize applications for the Rural Health Transformation Program (RHTP) that provide enhanced financial support for the team-based, whole-person primary care practices that already exist in the community and channel more funding to proven delivery models (CHCs, RHCs, independent primary care) and training programs (THCGME).

Our rural neighbors — who are fortunate to reside in some of the most physically striking environments that exist across our expansive country — also deserve to enjoy better health and longer lives in those amazing communities.

Best,

Ann Greiner
President and CEO
Primary Care Collaborative

Executive Summary

I might be in the grocery store in the produce aisle, and we'll talk about your [chronic conditions]. I mean we're touchable. They see us in the community, so it's not just this person in the background that wears the white coat and you have that every three-month visit or whatever. They see us active within the community and are very comfortable in coming up and talking to us."

– Nurse practitioner in Tucumcari, NM

Rural health care in the U.S. is struggling with headwinds, including aging populations, a shrinking physician workforce and consolidation of health care services. Some rural communities can access major health systems by interstate travel, while others are isolated by many miles, mountains and rough terrain, and lack adequate broadband and emergency services.[1,2] When a rural hospital closes, it is an economic blow to a community as well as a blow to local health care access.

The 2025 passage of H.R. 1 — a large federal tax and reconciliation legislative package — creates more challenges for rural communities by reducing Medicaid coverage and spending. A KFF analysis suggests that federal Medicaid spending could fall by $137 billion in rural areas over the next decade.[3]

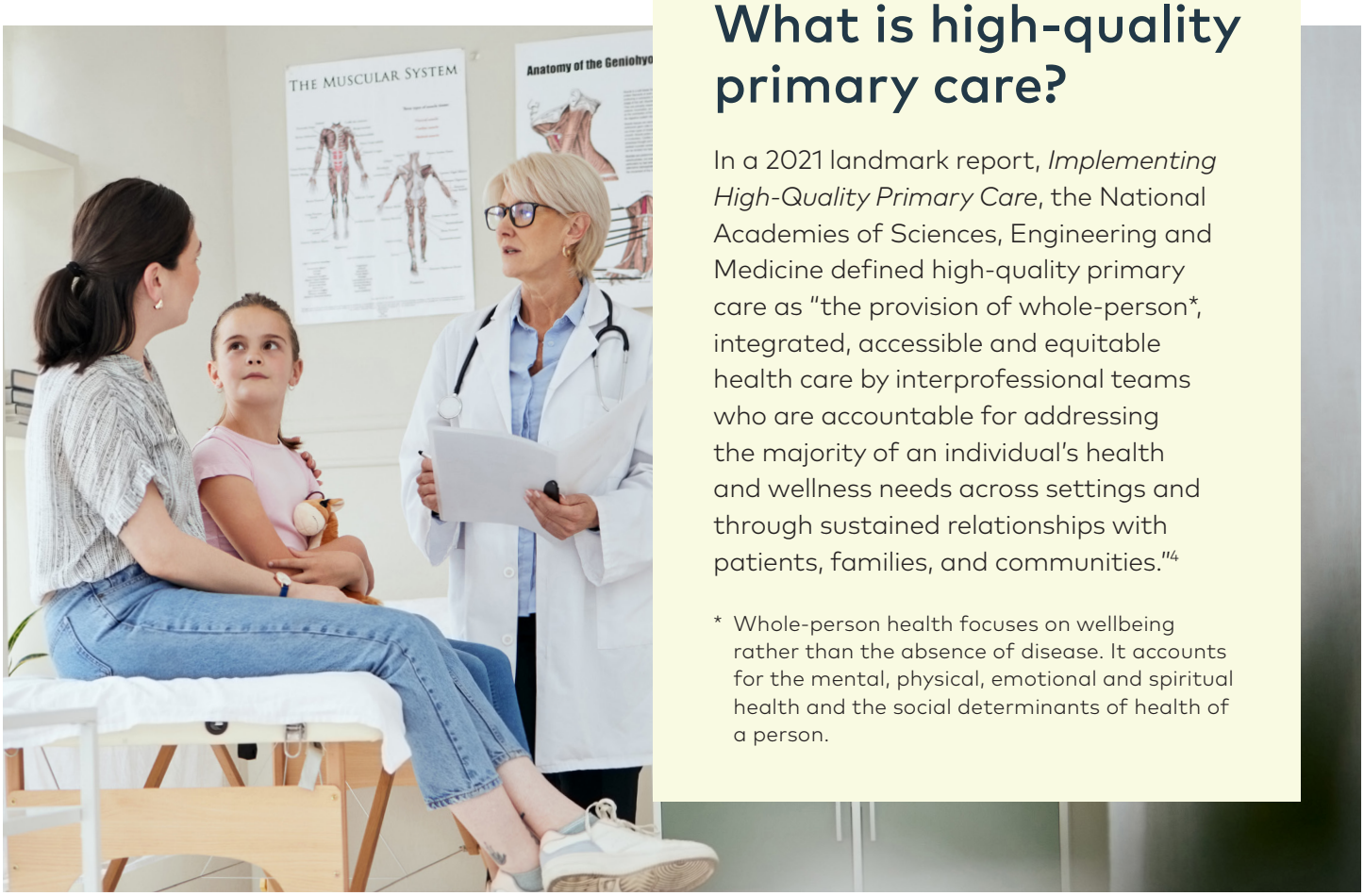
Researchers and policymakers have generally not focused on factors that sustain rural primary care, with most attention focused on the availability of rural hospitals. Strengthening access to whole-person primary care — that supports chronic care, behavioral health, maternal and women's health, and oral health, and connects residents to healthy food, self-care options and other resources — is a more attainable goal for many rural communities than sustaining a full-service hospital. Access to whole-person primary care, together with access to a pharmacy and integration with hospital care in larger rural communities, is likely to be the most cost-effective path to improving lagging rural health outcomes.

This report is a snapshot of the state of rural primary care in the U.S. It includes a literature review, a description of federal legislative trends affecting rural primary care, a quantitative analysis of primary care trends (comprehensiveness, primary care spending, and primary care workforce) and five case studies that describe current rural practice models. The report concludes with policy recommendations to strengthen and sustain rural primary care so that all types of rural communities can thrive with better health.

The report's five case studies highlight rural primary care practices in a range of geographies and practice models, including federally qualified health centers (FQHCs), a Direct Primary Care (DPC) private practice supported financially by patient membership fees, a private practice led by nurse practitioners (NPs) and a rural hospital perspective.

By using a mixed-methods approach — quantitative and qualitative — that includes in-depth interviews of practice leaders and other rural health leaders, the report provides insights for stakeholders and policymakers as they consider strategies for strengthening rural health and the key role played by primary care.

Unfortunately, although also critical to rural health, we could not capture the full richness of rural communities and unique role of the Indian Health Services, nor many innovative, home-grown primary care solutions that leverage schools, emergency medical services, tribal traditions, and pastors and congregations to expand the opportunities for providing prevention and primary care in rural America.



What is high-quality primary care?

In a 2021 landmark report, *Implementing High-Quality Primary Care*, the National Academies of Sciences, Engineering and Medicine defined high-quality primary care as "the provision of whole-person*, integrated, accessible and equitable health care by interprofessional teams who are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities."[4]

* Whole-person health focuses on wellbeing rather than the absence of disease. It accounts for the mental, physical, emotional and spiritual health and the social determinants of health of a person.

Key Findings

Rural primary care services are more comprehensive than non-rural primary care services

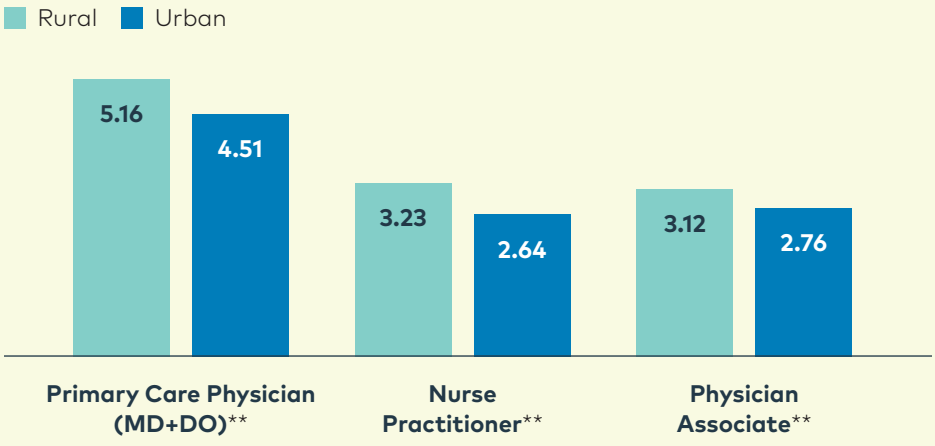
An analysis of the mix of services delivered by primary care in rural and urban areas finds that, on average, rural primary care physicians (PCPs) provide more comprehensive services than urban primary care (see Figure ES1), and those differences carry over to NPs and physician associates (PAs), albeit to a smaller degree. The comprehensive measure is limited to Medicare fee-for-service claims and captures the complexity and breadth of care delivered in rural primary care practices. For example, rural primary care clinicians (PCCs) are more likely to perform minor skin procedures and endoscopies. Those practicing in FQHCs are more likely to deliver behavioral health services, including treating substance-use disorders, addressing social determinants including nutrition, and coordinating care with specialists and facilities. It also reflects that rural primary care is available in a broader array of settings, including nursing facilities and hospitals. However, the comprehensiveness of rural primary care services has been declining recently.

On a population basis, the analysis finds there are 15% more primary care clinicians in cities and surrounding suburbs than in rural communities.

Although the more robust set of services rural primary care delivers is a positive, rural residents have less access to all health care services — including primary care — than their urban counterparts. On a population basis, the analysis finds there are 15% more PCCs in cities and surrounding suburbs than in rural communities.

FIGURE ES1

Comprehensiveness Among Primary Care Clinicians by Specialty, Rural vs. Urban, 2016–2022*



* As defined by Mean Berenson-Eggers. ** p<.001

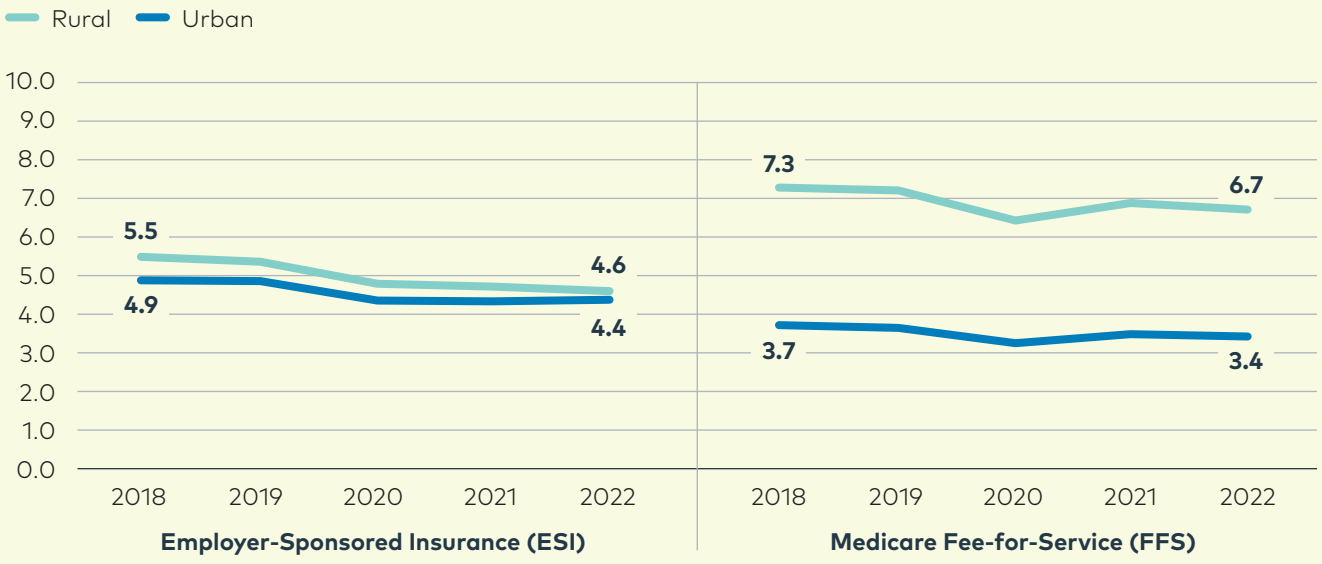
Spending on primary care is falling in rural and urban areas

When primary care spending is measured separately as a share of total spending in rural and urban areas, primary care's share of total spending in rural areas in the aggregate is higher than primary care's share of total spending in urban areas.

Disturbingly, primary care spending is falling in rural and urban areas (see Figure ES2). The declines are seen in commercially insured populations enrolled in employer-sponsored plans and those enrolled in traditional Medicare. In addition, the decline is observed when analyzing primary care services delivered by physicians only and when using a broader measure of the primary care workforce that includes NPs and PAs.

FIGURE ES2

National Share of Primary Care Spending to Total Medical Spending, Rural vs. Urban, 2018–2022 — Narrow Definition



Excludes lump payments for federal health centers, such as HRSA-funded CHCs.

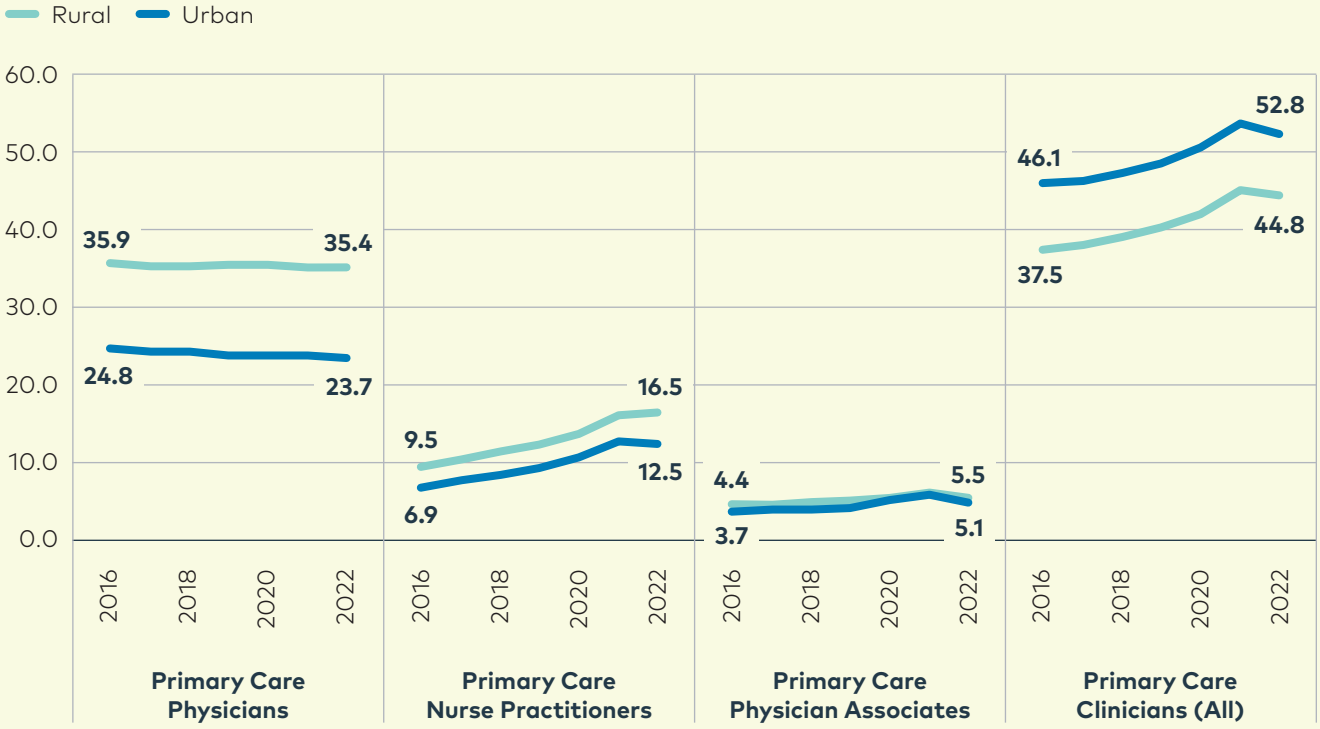
The rural primary care workforce is changing; the share of physicians is declining

An analysis of workforce trends between 2016 and 2022 generated similar findings to the primary care spending analysis. A longstanding gap remains in the number of PCPs relative to population in rural areas compared to urban areas — with measures for both indicating declines — and the gap growing slightly over this period.

Over the same period, while the number of rural PCPs has declined, a broader definition of the primary care workforce that includes NPs and PAs suggests the total number of PCCs as a share of the population in urban and rural areas has grown over this six-year period (see Figure ES3). This is due primarily to a marked increase in NPs practicing primary care in urban and rural areas. While positive, the rise of NPs needs to be seen in light of growing chronic care needs in rural communities. Team-based inter-professional models are needed to deliver comprehensive primary care.

FIGURE ES3

Number of Primary Care Clinicians per 50,000 People, Rural vs. Urban, 2016–2022



Primary care makes care more affordable

When a rural primary care physician leaves practice, patients experience an economic loss as well as a loss of regular care from a trusted, local professional who knows them and their community. The report estimates that a family of four could experience almost $5,600 more in annual costs due to utilizing care in higher-cost settings if its primary care physician is not replaced after leaving practice in the local community.

Key takeaways from the case studies and literature and legislative reviews

- Two federal programs — rural health clinics (RHCs) and FQHCs — are key enablers for sustaining the finances of rural primary care: 90% of rural counties have either an RHC or FQHC, with 41% having both.
- Rural primary care practices face challenges to participating in value-based payment (VBP) models, including lower volumes and slim financial margins.
- Broad-scope, comprehensive primary care builds trust with patients and is cost effective and convenient for the community.
- Financial sustainability requires support from public payers such as Medicare and Medicaid, team-based delivery models and diversified revenue streams, including the 340B Drug Pricing Program.
- Workforce development and retention require local rural training pathways, nontraditional pathways, scholarships and academic partnerships.
- Continued investment in rural training and education tracks that focus on broad-scope and whole-person primary care and embed trainees in rural settings and communities is necessary.
- Access to many specialties is limited in rural areas, with specific shortages of psychiatrists and behavioral health professionals.

“There’s so many problems in value-based care, one being the 12-month financial cycle. I mean, in primary care we do things in a 2-year old’s life. You know, educating parents or vaccination to help them live beyond sixty... And so the measuring savings feels foolish because we’re not doing the work in order to glean one year savings or glean one-year outcomes. We’re doing the work because we want that person to live to a good, long, rich, thriving life...innovation, social determinants of health is an area that we’ve taken pride in.”

– Primary care physician at a FQHC in Waco, TX

Policy recommendations

The policy recommendations below reflect the findings from the entire report. The timeliness of the case studies reflects uncertainty and concern across rural primary care practices with expected loss of Medicaid coverage in their communities due to the 2025 federal legislation, H.R. 1.

Federal and state policymakers should measure primary care spending regularly and establish benchmarks and targets for increasing primary care investment. Specifically, benchmarking and trending within and across states, subpopulations, and payers can ensure accountability for Medicaid and Medicare resources. Measuring spending in rural areas separately from urban geographies can provide important feedback to policymakers and be used to also hold private sector partners accountable for prioritizing spending to produce improved health outcomes at lower costs.

Federal policymakers should immediately increase investment in the proven programs that sustain rural primary care. These include RHCs and rural FQHCs. At the time this report went to press, the federal government was shut down and funding had expired for critical programs funded by the Public Health Service Act that benefit rural health, including Section 330 grant funding and mandatory funding from the Community Health Center Fund for CHCs, the National Health Service Corps, and Teaching Health Centers Graduate Medical Education.

Despite facing federal Medicaid reductions, states should refrain from reducing primary care reimbursement rates and ensure Medicaid managed care plans are incentivized to strengthen primary care services delivered by the range of primary care practices serving rural areas of their states.

Federal and state policymakers should ensure that programs and resources intended for rural health are supporting care and training in and for people in rural communities. Special federal designations for rural providers and Medicare-funded residency and training programs intended to expand primary care and the rural workforce must benefit these communities. Programs that emphasize interprofessional training, particularly for teams of physicians, NPs, behavioral health professionals and community health workers, are needed to deliver comprehensive whole-person primary care in rural communities.

Federal and state policymakers should put comprehensive, whole-person primary care at the foundation of rural health transformation when launching initiatives funded by the $50 billion Rural Health Transformation Program (RHTP) included in the 2025 H.R. 1 legislation. The Centers for Medicare and Medicaid Services (CMS) leaders should select state RHTP proposals that will ensure whole-person primary care plays the foundational role that a large body of evidence supports.

Federal and state policymakers should ensure VBP models are "rural friendly" and consider the unique characteristics of rural primary care, which include lack of capital and capacity to fund infrastructure for population health, while at the same time demonstrating a more comprehensive approach to care delivery. A new option, known as Primary Care Flex, became available in 2024 to support rural and safety-net practices that want to form or join Medicare accountable care organizations (ACOs). Many rural primary care practices prioritize their independence and responsiveness to their communities. ACOs, clinically integrated networks and other entities that support VBP should have incentives to integrate independent practices and FQHCs in rural communities.

The report reveals that a brighter future for rural primary care is possible. However, policymakers must take bold steps to accelerate the capacity of rural primary care to deliver whole-person primary care in order to deliver that future. This is especially important in the wake of Medicaid spending reductions and coverage restrictions that rural communities will face in the wake of H.R. 1. Ensuring that rural residents have a convenient usual source of comprehensive primary care who also knows their community will contribute to better health outcomes.

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About the Primary Care Collaborative

The Primary Care Collaborative (PCC) is the leading national, nonpartisan and multi-stakeholder voice advocating for better health and wellbeing for all Americans by strengthening primary care. The PCC unifies and engages diverse stakeholders in promoting policies and sharing best practices that encourage the growth of comprehensive, whole-person primary care.

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About the American Academy of Family Physicians (AAFP) Robert Graham Center

The AAFP's Robert Graham Center aims to improve individual and population healthcare delivery through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international levels. The information and opinions contained in research from the AAFP's Robert Graham Center do not necessarily reflect the views or policies of the American Academy of Family Physicians.

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