

Usual Source of Care for Rural Medicare Fee-for-Service Beneficiaries in 2021

Sruthi Malavika Srinivasan, MPS; Melissa Sandahl, MS;
Kristie Thompson, MA; George Pink, PhD; Mark Holmes, PhD

INTRODUCTION

Access to health care is essential, and having a usual source of care (USC) significantly enhances access by ensuring timely and appropriate medical attention.¹ A USC is typically defined as a health care provider or facility that patients visit for consistent and ongoing primary care (e.g., private doctor’s office, community health center, or clinic).² Having a USC is associated with higher quality care, lower health care expenditures, reduced health care disparities,³ better management of chronic diseases, and fewer hospitalizations.⁴ USC is particularly important for maintaining individual health and preventing adverse health outcomes, especially among older people and people with disabilities.

Rural areas have higher proportions of Medicare Fee-for-Service (FFS) beneficiaries than urban areas. However, many rural beneficiaries may face barriers to accessing and using USC because of persistent primary care provider shortages, fewer health care facilities, limited specialty care services, and reduction of services following a hospital or practice merger or acquisition—factors that pose significant challenges to rural residents seeking regular care.⁵ The COVID-19 pandemic exacerbated these challenges by disrupting patterns of health care use,⁶ and the expansion of telehealth altered how Medicare FFS beneficiaries accessed care.⁷ A recent study found a decline in USC from 2018 to 2020 among those aged 50+, likely due to the impact of the COVID-19 pandemic.⁸ Conversely, recent policy changes, such as the increase in the Rural Health Clinic (RHC) per visit payment limit,⁹ may have improved health care access in rural regions.¹⁰

This brief describes the USC of rural Medicare FFS beneficiaries in 2021. It examines which types of facilities—private provider offices, Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Prospective Payment System (PPS) hospitals, and Critical Access Hospitals (CAHs)—serve as primary care providers for different demographic groups of rural Medicare FFS beneficiaries.

KEY FINDINGS

A Usual Source of Care (USC) is typically defined as a health care provider or facility that patients visit for consistent and ongoing primary care. This study found:

- Overall, 89.1 percent of rural Medicare Fee-for-Service (FFS) beneficiaries had a USC, 10.9 percent did not. Most beneficiaries used private provider offices as their USC, followed by RHCs, FQHCs, PPS hospitals, and CAHs.
- Beneficiaries more likely to lack a USC included males and those under age 65 who qualify based on disability.
- Beneficiaries using private provider offices were predominantly from large rural areas, while RHC use grew with increasing rurality.
- Regional patterns varied: the South had the highest use of private provider offices; the Midwest had the greatest reliance on RHCs; and the West had the highest percentage without a USC.

STUDY METHOD

Medicare FFS beneficiaries were identified using the Centers for Medicare & Medicaid Services (CMS) Master Beneficiary Summary File. The study included beneficiaries with 12 full months of Part A and Part B FFS coverage in 2021 and U.S. residence (including territories). We limited the study to rural Medicare FFS beneficiaries using the 2022 rural definition from the Federal Office of Rural Health Policy.¹¹ This study focuses on Medicare beneficiaries aged 18 and older, as they represent the vast majority of the Medicare population. While some children under 18 qualify for Medicare due to specific conditions, their numbers are small, and they were excluded to maintain focus on the primary Medicare population.

Claims data came from the 2021 Medicare Carrier and Outpatient Research Identifiable Files. This dataset included both the claims where Medicare acted as the primary payer (covering costs directly) and as the secondary payer (covering costs not paid by other insurance). The primary care service claims within the FFS claims data were identified according to the criteria outlined in the Shared Savings and Losses and Assignment Methodology obtained from the CMS Medicare Shared Savings Program.¹²

Beneficiaries with primary care service claims were attributed to a specific facility National Provider Identifier (NPI) from Medicare Carrier and Outpatient Research Identifiable Files in 2021, following the guidelines outlined in the Shared Savings and Losses and Assignment Methodology document.¹² Primary care service claims for beneficiaries were grouped by facility NPI and the date of service. Beneficiaries were then attributed to a single facility NPI based on the specialty codes of the rendering physicians listed on the claims. If one or more facility NPIs included primary care providers, the facility NPI with the plurality of visits was chosen. If no primary care provider specialties were identified, certain specialties were then used for assignment, followed by non-physicians. We did not attribute the beneficiary to a USC if none of the specified specialties or if no primary care service claims were found for the beneficiary.

We then classified facility NPIs into different types based on the information provided in their source files and the type of bill code associated with their claims. Claims submitted in the Carrier file were classified as private provider office. Claims submitted for outpatient services were further classified based on the type of bill code used: Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), Critical Access Hospitals (CAHs), and Prospective Payment System hospitals (PPS).

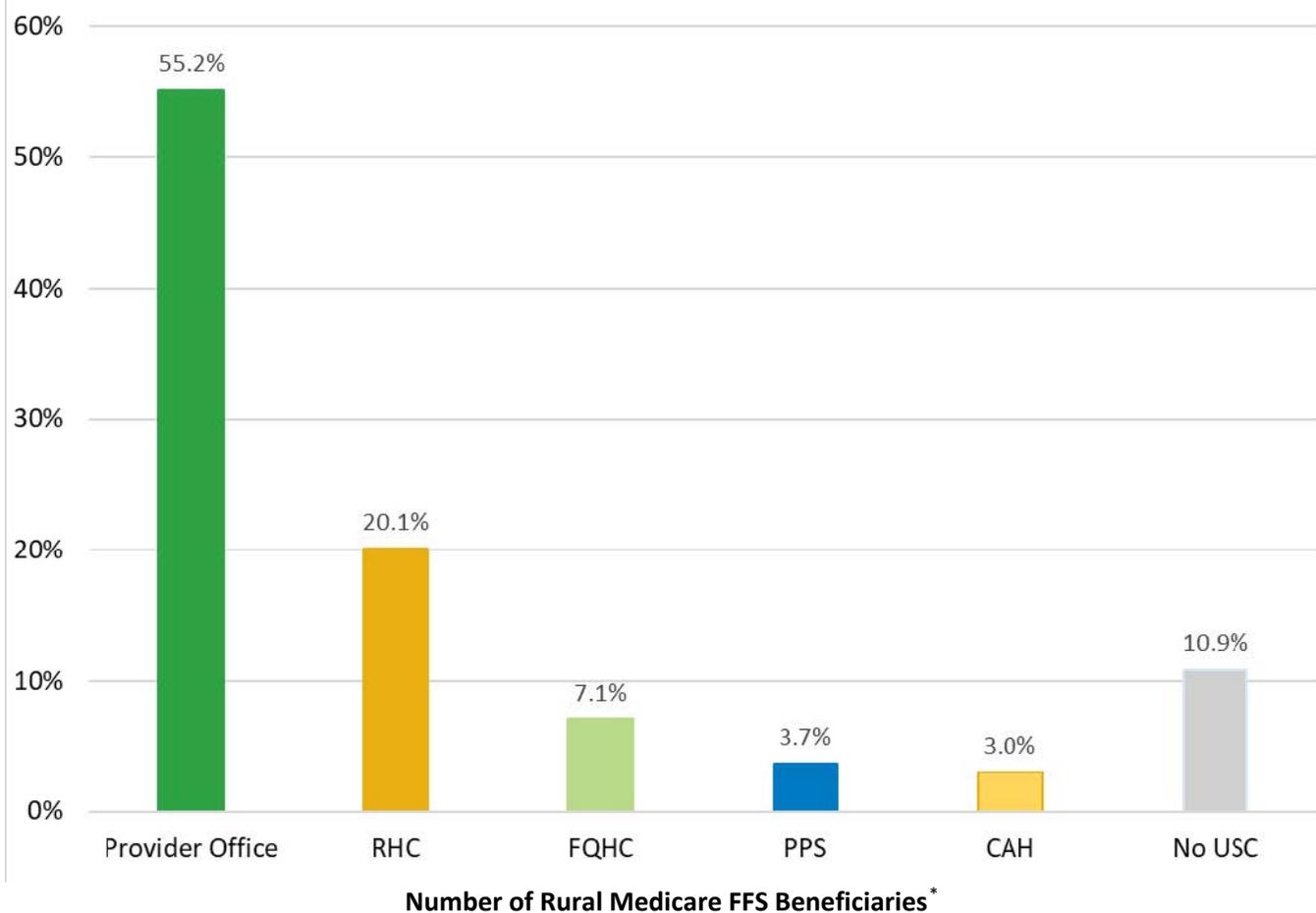
Note that this method assigns a USC to beneficiaries; this may be different than who the beneficiary considers their USC. For example, a beneficiary with one visit to a primary care provider would be assigned that provider as their USC, regardless of whether this was a “usual” source of care. Likewise, a beneficiary who received no care in a year would have no USC even if there was a provider they thought of as their “usual” source of care. Furthermore, note that a beneficiary who exclusively uses the Emergency Department would not be assigned a USC.

RESULTS

Usual Source of Care of Rural Medicare FFS Beneficiaries

Figure 1 shows the percent of rural Medicare FFS beneficiaries by USC in 2021. Overall, 89.1 percent of beneficiaries had a USC, and 10.9 percent did not have a USC. The USC of most beneficiaries was private provider office settings (55.2 percent), followed by RHCs (20.1 percent), FQHCs (7.1 percent), PPS hospitals (3.7 percent), and CAHs (3.0 percent).

Figure 1. Percent of Rural Medicare FFS Beneficiaries by Usual Source of Care in 2021



Total	Provider Office	RHC	FQHC	PPS	CAH	No USC
6,535,668	3,607,261	1,313,848	464,369	243,224	197,666	709,300

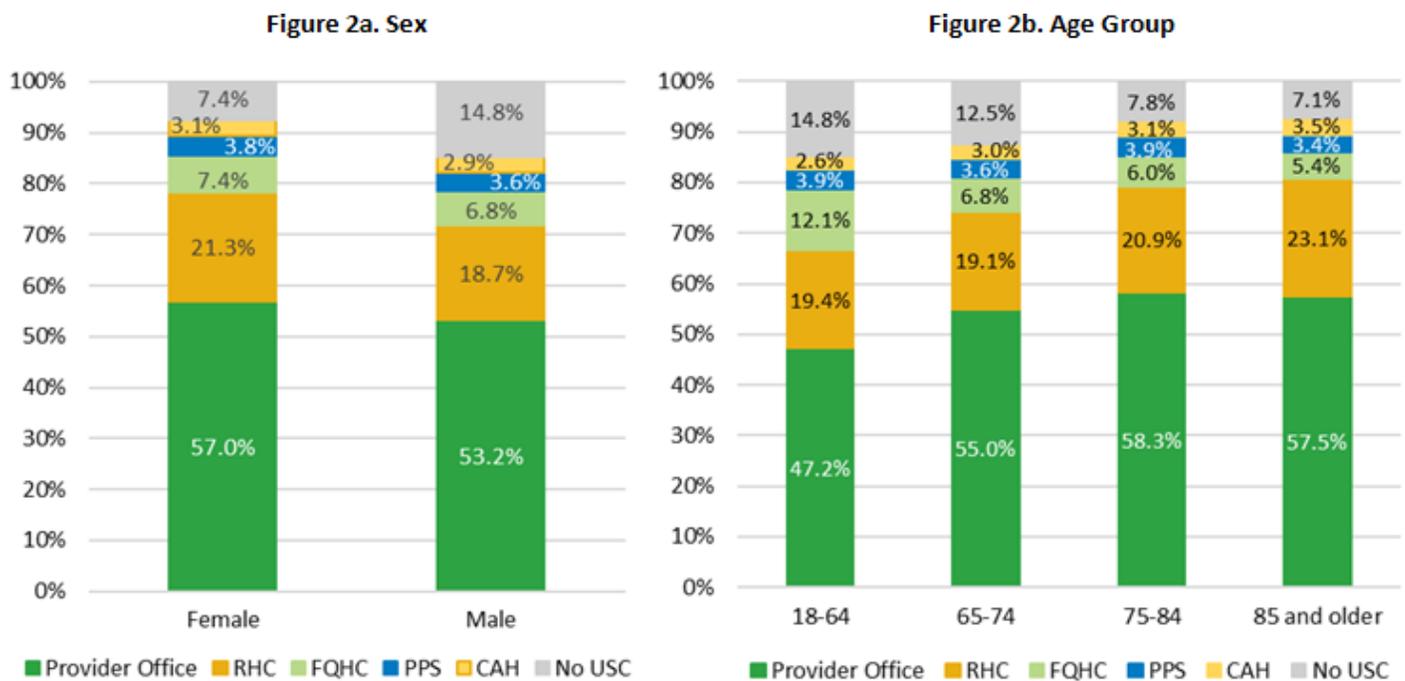
*Appendix 1 shows the number of rural Medicare FFS beneficiaries by USC in 2021, and Appendix 2 shows the percent of rural Medicare FFS beneficiaries by USC in 2021.

Usual Source of Care and Rural Medicare Beneficiary Demographics

Figure 2a shows the percent of rural Medicare FFS beneficiaries by USC and sex in 2021. A higher percentage of female beneficiaries (57.0 percent) had private provider offices as a USC in comparison with male beneficiaries (53.2 percent). In contrast, a higher percentage of male beneficiaries had no USC (14.8 percent) in comparison with female beneficiaries (7.4 percent).

Figure 2b shows the percent of rural Medicare FFS beneficiaries by USC and age group in 2021. A higher percentage of beneficiaries ages 65–74 (55.0 percent), 75–84 (58.3 percent), and ≥85 (57.5 percent) used private provider offices as their USC compared with beneficiaries ages 18–64 (47.2 percent), who typically qualify for Medicare due to disability, ALS, or ESRD. In contrast, a higher percentage of 18-64 year-old beneficiaries had a FQHC (12.1 percent) as a USC in comparison with 65-74 (6.8 percent), 75-84 (6.0 percent), and ≥85 (5.4 percent) year-old beneficiaries.

Figure 2. Percent of Rural Medicare FFS Beneficiaries by Usual Source of Care and Beneficiary Demographics in 2021



Number of Rural Medicare FFS Beneficiaries by Demographics

Total	Female	Male	18-64 years	65-74 years	75-84 years	≥85 years
6,535,668	3,485,269	3,050,399	857,653	3,090,595	1,875,333	712,087

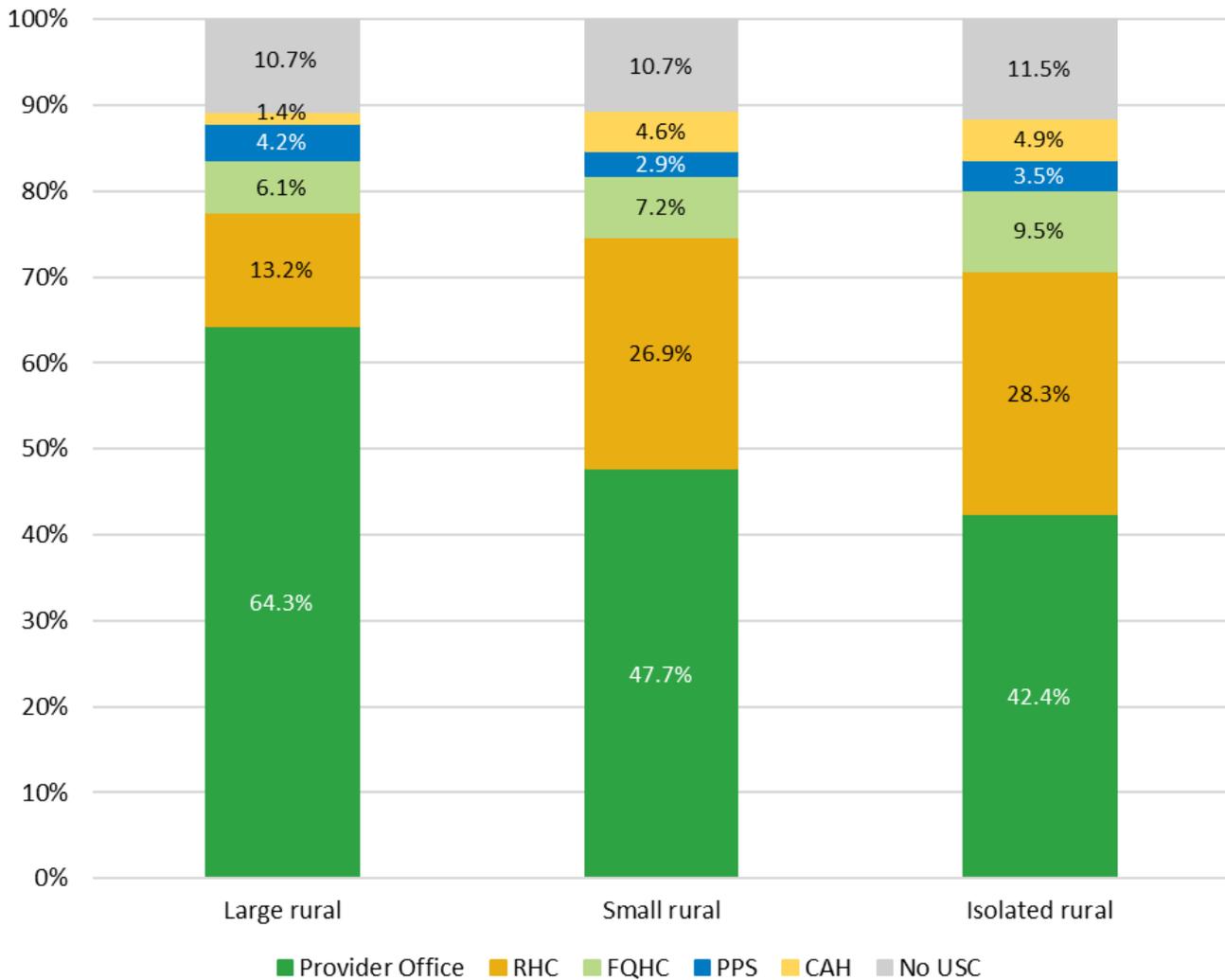
Appendix 1 shows the number of rural Medicare FFS beneficiaries by USC and demographics in 2021, and Appendix 2 shows the percent of rural Medicare FFS beneficiaries by USC and demographics in 2021. Other beneficiary demographic findings from the Appendices include:

- In comparison with other Medicare entitlement groups, beneficiaries under age 65 who qualify based on disability, ALS, or ESRD had a lower percentage of private provider offices, a higher percentage of FQHCs as a USC, and a higher percentage of beneficiaries with no USC.
- In comparison with beneficiaries who are not dually enrolled in Medicare and Medicaid, dual enrollees had a lower percentage of private provider offices and a higher percentage of FQHCs as a USC.

Usual Source of Care and Rurality

Figure 3 shows the percent of rural Medicare FFS beneficiaries by USC and Rural-Urban Commuting Area (RUCA) groups in 2021. A higher percentage of beneficiaries in large rural areas (64.3 percent) had private provider offices as a USC in comparison with beneficiaries in small rural areas (47.7 percent) and isolated rural areas (42.4 percent). The chart shows that RHCs as a USC increased with higher levels of rurality, from 13.2 percent in large rural areas to 28.3 percent in isolated rural areas. FQHCs as a USC also increased with higher levels of rurality, from 6.1 percent in large rural areas to 9.5 percent in isolated rural areas.

Figure 3. Percent of Rural Medicare FFS Beneficiaries by Usual Source of Care and RUCA Group in 2021



Number of Rural Medicare FFS Beneficiaries by RUCA Group*

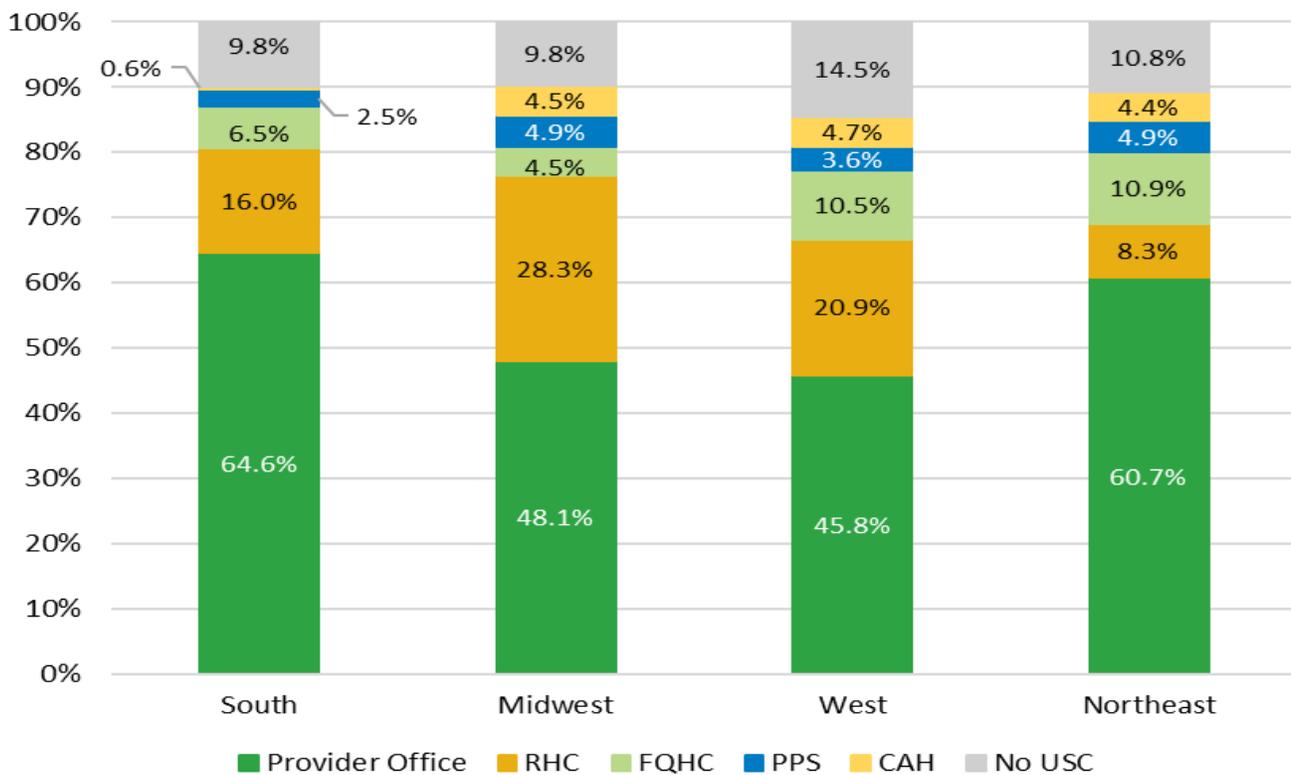
Total	Large Rural (RUCA 4-6)	Small Rural (RUCA 7-9)	Isolated Rural (RUCA 10)
6,535,668	3,367,567	1,825,005	1,343,096

*Appendix 1 shows the number of rural Medicare FFS beneficiaries by USC and RUCA group in 2021, and Appendix 2 shows the percent of rural Medicare FFS beneficiaries by USC and RUCA group in 2021.

Usual Source of Care and Census Region

Figure 4 shows the percent of rural Medicare FFS beneficiaries by USC and Census region in 2021. A higher percentage of beneficiaries in the South (64.6 percent) and Northeast (60.7 percent) had private provider offices as a USC in comparison with beneficiaries in the Midwest (48.1 percent) and West (45.8 percent). In contrast, a higher percentage of beneficiaries in the Midwest (28.3 percent) and West (20.9 percent) had an RHC as a USC in comparison with the South (16.0 percent) and Northeast (8.3 percent). A higher percentage of beneficiaries in the Northeast (10.9 percent) and West (10.5 percent) had an FQHC as a USC in comparison with the South (6.5 percent) and West (4.5 percent). A higher percentage of beneficiaries in the West (14.5 percent) had no USC in comparison with beneficiaries in the Northeast (10.8 percent), South (9.8 percent), and Midwest (9.8 percent).

Figure 4. Percent of Rural Medicare FFS Beneficiaries by Usual Source of Care and Census Region in 2021



Number of Rural Medicare FFS Beneficiaries by Census Region *

Total	South	Midwest	West	Northeast
6,535,668	2,498,026	2,070,054	1,309,848	656,742

DISCUSSION

Most rural Medicare beneficiaries used private provider offices as their USC, followed by RHCs, FQHCs, PPS hospitals, and CAHs. This finding is consistent with a previous study that found most Medicare FFS beneficiaries consider a private doctor's office or doctor's clinic as their primary source of care.¹³ This preference for private provider office settings suggests that they could be a more accessible and convenient primary care source for many beneficiaries. Their widespread availability and established patient-provider relationships likely contribute to their popularity, especially during challenging times such as the COVID-19 pandemic.

RHCs were the second most common USC of rural beneficiaries, possibly due to proximity to rural communities, acceptance of walk-in appointments, accommodation of language interpretation needs, and other factors contributing to their accessibility.¹⁴ Additionally, RHCs may have sliding-fee scales that ensure health care affordability.¹⁵

*Appendix 1 shows the number of rural Medicare FFS beneficiaries by USC and census region in 2021, and Appendix 2 shows the percent of rural Medicare FFS beneficiaries by USC and census region in 2021

Males and beneficiaries under 65 qualifying due to disability were more likely to lack a USC. This study found that a higher percentage of male beneficiaries (14.8 percent) compared to female beneficiaries (7.4 percent) had no USC. These findings are similar to other study reports showing a higher percentage of males than females lack a USC. The National Center for Health Statistics reports that in 2023, 84.4 percent of adult males and 90.7 percent of adult females had a usual source of care.¹⁶ Another study of Emergency Department patients found that in 2022, 87 percent of women compared to 77 percent of insured men aged 18-64 reported having a usual source of care.¹⁷ Other studies suggest that men may be less likely to have a USC for a number of reasons, including: fear, avoidance, discomfort;¹⁸ societal stigma, judgment by others;¹⁹ mistrust of the medical profession;²⁰ less likely to prioritize self-care;²¹ and men are more likely to visit a general practitioner later in the course of a condition compared to women.²²

Research also suggests Medicare beneficiaries with disabilities, typically those under age 65 who qualify due to disabilities, might lack a USC for several reasons: many have complex health needs and multiple chronic conditions, which can make it challenging to find consistent care; those with lower incomes or without supplemental coverage may face financial barriers that prevent them from accessing regular care; many rural areas have a shortage of providers, making it difficult for beneficiaries who are disabled to find a regular doctor; and navigating the health care system can be particularly difficult for those with disabilities, leading to gaps in care.²³

Some studies have also noted that individuals with disabilities may encounter ableist attitudes and a lack of understanding of disability realities among some primary care providers,^{24,25} which can discourage them from seeking consistent care. Some people with disabilities may visit specialists so frequently that these providers effectively serve as both primary care and specialist providers. The physical and mental effort required to visit a provider, along with the potential income loss,²⁶ can also deter individuals with disabilities from maintaining a regular source of care. Finally, after the COVID-19 pandemic, shifting policies around mask requirements in many health care settings may have made some people with disabilities apprehensive about exposure to unmasked individuals in care settings,²⁷ further reducing their likelihood of having a USC.

Rural Medicare FFS beneficiaries using private provider offices were predominantly from large rural areas, while isolated rural areas showed a larger proportion lacking a USC. A higher percentage of rural Medicare FFS beneficiaries who visit private provider office settings are from large rural areas, which could indicate greater availability of offices. Additionally, large rural areas are more connected to nearby urban clusters,²⁸ suggesting that beneficiaries in these areas may experience better health care access due to higher provider density²⁹ and proximity to health care facilities,³⁰ compared to people in more remote areas.

In isolated rural areas, a higher percentage of rural Medicare FFS beneficiaries had RHCs as their USC, and a higher percentage had no USC. A higher percentage of rural Medicare FFS beneficiaries in isolated rural areas rely on RHCs as their USC due to limited availability of private providers and specialists, as well as proximity of RHCs to underserved areas.¹⁴ For isolated rural areas, RHCs offer lower-cost, comprehensive primary care services and are a vital health care resource. A larger percentage of those with no USC are from isolated rural areas. Many isolated rural areas are far from health care facilities, making it difficult for residents to access care quickly, especially in emergencies. There are fewer health care providers in isolated rural areas, which can lead to longer wait times and travel distances for patients. Rural residents may have lower incomes and less access to health insurance, making it harder to afford care. Limited public transportation options can also make it difficult for residents in isolated rural areas to travel to health care facilities.³¹

The South had a higher prevalence of rural beneficiaries using private provider office settings, the Midwest favored RHCs, and the West had the highest number of rural beneficiaries without a USC. These findings may be influenced by factors such as distribution of health care facilities, patient preferences, and population movement in recent years.³² Beneficiaries in the Midwest, where a relatively larger percentage of the population resides in rural areas, tended to use RHCs, which may be partly due to the higher number of RHCs available in the region.³³ The West region had the highest percentage of beneficiaries without a USC, possibly due to several factors unique to rural communities in the area, such as a higher poverty rates, remote locations contributing to challenges in accessing care,³⁴ and a higher prevalence of health professional shortage areas.³⁵

Our study highlights key patterns in 2021 health care utilization of rural Medicare FFS beneficiaries. The COVID-19 pandemic may also have influenced USCs for rural Medicare FFS beneficiaries by disrupting care, including causing clinic

closures and reducing in-person visits. In a separate comparative study, we examine this issue by analyzing changes in USCs before and after the pandemic.³⁶ Understanding these impacts is essential for shaping responsive policies and interventions that address existing disparities and guide future health care strategies.

LIMITATIONS

This study is limited to Medicare FFS (Part A and Part B) beneficiaries, who comprise about half of all Medicare beneficiaries.³⁷ The exclusion of Medicare Advantage enrollees is due to differences in coverage benefits and utilization patterns between the two groups. Medicare Advantage enrollees may have different health care experiences and utilization compared to those with traditional Medicare, which could influence their USC.³⁸ Moreover, the study excluded the Emergency Department (ED) from USC and did not account for other types of care such as Indian Health Service (IHS) and Veterans Affairs (VA) care.

REFERENCES AND NOTES

1. Liaw W, Jetty A, Petterson S, Bazemore A, Green L. Trends in the types of usual sources of care: A shift from people to places or nothing at all. *Health Services Research*. 2018;53(4):2346-2367. <https://doi.org/10.1111/1475-6773.12753>
2. MEPS Topics: Usual Source of Care. Medical Expenditure Panel Survey. Accessed September 6, 2024. https://meps.ahrq.gov/mepsweb/data_stats/MEPS_topics.jsp?topicid=44Z-1#:~:text=Description%3A%20Usual%20source%20of%20care
3. Lee DC, Shi L, Wang J, Sun G. Usual source of care and access to care in the US: 2005 vs. 2015. *PLOS ONE*. 2023;18(1):e0278015. <https://doi.org/10.1371/journal.pone.0278015>
4. Kim MY, Kim JH, Choi IK, Hwang IH, Kim SY. Effects of having usual source of care on preventive services and chronic disease control: A systematic review. *Korean Journal of Family Medicine*. 2012;33(6):336-336. <https://doi.org/10.4082/kjfm.2012.33.6.336>
5. Orgera K, Senn S, Grover A. *Rethinking Rural Health*. AAMC Research and Action Institute. Published September 27, 2023. Accessed September 6, 2024. <https://www.aamcresearchinstitute.org/our-work/issue-brief/rethinking-rural-health>
6. Hirko KA, Kerver JM, Ford S, et al. Telehealth in response to the COVID-19 pandemic: Implications for rural health disparities. *Journal of the American Medical Informatics Association*. 2020;27(11):1816-1818. <https://doi.org/10.1093/jamia/ocaa156>
7. Saharkhiz M, Rao T, Parker-Lue S, Borelli S, Johnson K, Cataife G. Telehealth expansion and Medicare beneficiaries' care quality and access. *JAMA Network Open*. 2024;7(5):e2411006. <https://doi.org/10.1001/jamanetworkopen.2024.11006>
8. Tavares JL, Cohen MA. *Becoming Less Usual: Understanding the Decline in the Number of People with a Usual Source of Care*. Milbank Memorial Fund. Published September 2023. Accessed September 6, 2024. <https://www.milbank.org/wp-content/uploads/2023/09/USC-Milbank.pdf>
9. CMS, Medicare Learning Network. *Update to Rural Health Clinic (RHC) Payment Limits*. Published May 4, 2021. Accessed September 6, 2024. <https://www.cms.gov/files/document/mm12185.pdf>
10. Guth M, Ammula M. *Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021*. KFF. Published May 6, 2021. Accessed September 6, 2024. <https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicare-expansion-february-2020-to-march-2021/>
11. Health Resources and Services Administration. *How We Define Rural*. Accessed September 6, 2024. <https://www.hrsa.gov/rural-health/about-us/what-is-rural>
12. CMS, Medicare Shared Savings Program. *Shared Savings and Losses and Assignment Methodology Specifications*. Published January 2022. Accessed September 6, 2024. <https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-1>
13. Boccuti C, Swoope C, Damico A, Neuman T. *Medicare Patients' Access to Physicians: A Synthesis of the Evidence*. KFF. Published December 10, 2013. Accessed September 6, 2024. <https://www.kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence/>

14. Lahr M, Henning-Smith C, Hernandez AM, Neprash H. *Access and Capacity to Care for Medicare Beneficiaries in Rural Health Clinics*. University of Minnesota Rural Health Research Center. Published December 2019. Accessed September 6, 2023. <https://rhrc.umn.edu/wp-content/uploads/2019/12/UMN-access-to-care-RHCS-policy-brief-12.10.19.pdf>
15. Rural Health Information Hub. *Rural Health Clinics (RHCs) Introduction*. Accessed January 22, 2025. <https://www.ruralhealthinfo.org/topics/rural-health-clinics>
16. National Center for Health Statistics. *Has a usual place of care among adults*. NCHS Data Query System. Accessed March 17, 2025. https://nchsdata.cdc.gov/DQS/#nchs-home_has-a-usual-place-of-care/-/sex/all-time-periods/2
17. Long M, Frederiksen B, Ranji U, Salganicoff A, Deip K. *Experiences with Health Care Access, Cost, and Coverage: Findings from the 2022 KFF Women’s Health Survey*. KFF. Published December 20, 2022. Accessed Feb 28, 2025. <https://www.kff.org/womens-health-policy/report/experiences-with-health-care-access-cost-and-coverage-findings-from-the-2022-kff-womens-health-survey/>
18. Reddy Medical Group. *Breaking the Silence: Unraveling the Mystery of Men’s Reluctance to Seek Medical Care*. Published March 7, 2024. Accessed September 8, 2024. <https://reddymedicalgroup.com/news/breaking-the-silence-unraveling-the-mystery-of-mens-reluctance-to-seek-medical-care>
19. Griffith D, Ogunbiyi A, Jaeger, E. *Men and Mental Health: What are we Missing?* AAMC. Published April 2, 2024. Accessed September 8, 2024. <https://www.aamc.org/news/men-and-mental-health-what-are-we-missing>
20. Novak JR, Peak T, Gast J, Arnell M. Associations between masculine norms and health-care utilization in highly religious, heterosexual men. *American Journal of Men’s Health*. 2019;13(3):155798831985673. <https://doi.org/10.1177/1557988319856739>
21. Slegel J. 6 Things that keep men from taking better care of themselves. *Psychology Today*. Published July 20, 2022. Accessed September 8, 2024. <https://www.psychologytoday.com/us/blog/self-care-for-men/202207/6-things-that-keep-men-from-taking-better-care-of-themselves>
22. Banks I. No man’s land: men, illness, and the NHS. *BMJ: British Medical Journal*. 2001;323(7320), 1058–1060. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1121551/>
23. Boccuti C, Swoope C, Damico A, Neuman T. *Medicare Patients’ Access to Physicians: A Synthesis of the Evidence*. KFF. Published December 10, 2013. Accessed September 6, 2024. <https://www.kff.org/medicare/issue-brief/medicare-patients-access-to-physicians-a-synthesis-of-the-evidence/>
24. VanPuymbrouck L, Friedman C, Feldner H. Explicit and implicit disability attitudes of healthcare providers. *Rehabilitation Psychology*. 2020;65(2). <https://doi.org/10.1037/rep0000317>
25. World Health Organization. *Disability*. Published March 7, 2023. Accessed September 10, 2024. <https://www.who.int/news-room/fact-sheets/detail/disability-and-health>
26. Vallas R, Fremstad S, Ekman L. *A Fair Shot for Workers with Disabilities*. Center for American Progress. Published January 28, 2015. Accessed March 6, 2025. <https://www.americanprogress.org/article/a-fair-shot-for-workers-with-disabilities/>
27. McCluskey PD. With masks off in hospitals, people with disabilities weigh the risk of care. *WBUR*. Published June 1, 2023. Accessed September 10, 2024. <https://www.wbur.org/news/2023/06/01/covid-masks-disability-immunocompromised>
28. U.S. Department of Agriculture, Economic Research Service. *Rural-Urban Commuting Area Codes—Documentation*. Published January 6, 2025. Accessed March 5, 2025. <https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/documentation>
29. Chen X, Orom H, Hay JL, et al. Differences in rural and urban health information access and use. *J Rural Health*. 2018 Nov 16;35(3):405–417. <https://pubmed.ncbi.nlm.nih.gov/articles/PMC6522336/>
30. Lam O, Broderick B, Toor S. *How Far Americans Live from the Closest Hospital Differs by Community Type*. Pew Research Center. Published Dec 12, 2018. Accessed March 5, 2025. <https://www.pewresearch.org/short-reads/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/>
31. Rural Health Information Hub. *Healthcare Access in Rural Communities*. Accessed September 8, 2024. <https://www.ruralhealthinfo.org/topics/healthcare-access>
32. U.S. Census Bureau. *United States Population Growth by Region*. Accessed September 8, 2024. https://www.census.gov/popclock/data_tables.php?component=growth
33. Rural Health Information Hub. *Rural Health Clinics*. Published May, 2024. Accessed September 8, 2024. <https://www.ruralhealthinfo.org/rural-maps/mapfiles/rural-health-clinics.jpg?v=383>

34. Warshaw R. *Health Disparities Affect Millions in Rural U.S. Communities*. AAMC. Published October 31, 2017. Accessed September 8, 2024. <https://www.aamc.org/news/health-disparities-affect-millions-rural-us-communities>
35. Rural Health Information Hub. *Health Professional Shortage Areas Primary Care*. Published July, 2024. Accessed September 8, 2024. <https://www.ruralhealthinfo.org/rural-maps/mapfiles/hpsa-primary-care.jpg?v=387>
36. Srinivasan SM, Sandahl MA, Thompson KW, Pink GH, Holmes M. *Changes in Usual Sources of Care After Covid-19: A Comparative Analysis of 2019 and 2021*. NC Rural Health Research Program, UNC Sheps Center. 2025.
37. Ochieng N, Cubanski J, Neuman, T. *A Snapshot of Sources of Coverage Among Medicare Beneficiaries*. KFF. September 23, 2024. <https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/>
38. Lee C. *A Review of 62 Studies Finds Few Big Differences between Traditional Medicare and Medicare Advantage on a Variety of Measures*. KFF. Published September 16, 2022. Accessed September 8, 2024. <https://www.kff.org/medicare/press-release/a-review-of-62-studies-finds-few-big-differences-between-traditional-medicare-and-medicare-advantage-on-a-variety-of-measures/>

APPENDICES

APPENDIX 1. Number of Rural Medicare FFS Beneficiaries by Usual Source of Care and Demographics in 2021

Demographic	Total	Provider Office	RHC	FQHC	PPS	CAH	No USC
All FFS beneficiaries	6,535,668	3,607,261	1,313,848	464,369	243,224	197,666	709,300
Sex							
Female	3,485,269	1,984,870	742,334	258,124	133,033	107,861	259,047
Male	3,050,399	1,622,391	571,514	206,245	110,191	89,805	450,253
Age Group							
18-64	857,653	404,940	166,150	103,390	33,200	22,676	127,297
65-74	3,090,595	1,699,594	591,577	210,651	112,561	91,309	384,903
75-84	1,875,333	1,093,187	391,436	111,915	73,502	58,736	146,557
≥85	712,087	409,540	164,685	38,413	23,961	24,945	50,543
Current Entitlement							
Age	5,677,149	3,201,880	1,147,571	360,931	209,961	174,968	581,838
Disability	847,833	399,835	164,591	102,469	32,037	22,413	126,488
ESRD	7,274	3,791	1,065	646	825	189	758
Disability and ESRD	3,412	1,755	621	323	401	96	216
Dually Enrolled Status							
Non-Dual	5,473,861	3,116,478	1,076,686	316,112	205,239	168,917	590,429
Dual	1,061,807	490,783	237,162	148,257	37,985	28,749	118,871
Region							
South	2,498,026	1,613,188	399,254	162,662	62,862	14,178	245,882
Midwest	2,070,054	994,935	585,555	92,973	100,582	93,754	202,255
West	1,309,848	599,739	274,328	137,003	47,747	60,911	190,120
Northeast	656,742	398,806	54,667	71,665	32,019	28,818	70,767
RUCA 2010							
Large rural (RUCA 4-6)	3,367,567	2,166,533	443,894	206,366	142,672	47,483	360,619
Small rural (RUCA 7-9)	1,825,005	871,055	490,111	130,751	53,720	84,598	194,770
Isolated rural (RUCA 10)	1,343,096	569,673	379,843	127,252	46,832	65,585	153,911

APPENDIX 2. Percent of Rural Medicare FFS Beneficiaries by Usual Source of Care and Demographics in 2021

Demographic	Total	Provider Office	RHC	FQHC	PPS	CAH	No USC
All FFS beneficiaries	6,535,668	55.19%	20.10%	7.11%	3.72%	3.02%	10.85%
Sex							
Female	3,485,269	56.95%	21.30%	7.41%	3.82%	3.09%	7.43%
Male	3,050,399	53.19%	18.74%	6.76%	3.61%	2.94%	14.76%
Age Group							
18-64	857,653	47.21%	19.37%	12.05%	3.87%	2.64%	14.84%
65-74	3,090,595	54.99%	19.14%	6.82%	3.64%	2.95%	12.45%
75-84	1,875,333	58.29%	20.87%	5.97%	3.92%	3.13%	7.81%
≥85	712,087	57.51%	23.13%	5.39%	3.36%	3.50%	7.10%
Current Entitlement							
Age	5,677,149	56.40%	20.21%	6.36%	3.70%	3.08%	10.25%
Disability	847,833	47.16%	19.41%	12.09%	3.78%	2.64%	14.92%
ESRD	7,274	52.12%	14.64%	8.88%	11.34%	2.60%	10.42%
Disability and ESRD	3,412	51.44%	18.20%	9.47%	11.75%	2.81%	6.33%
Dually Enrolled Status							
Non-Dual	5,473,861	56.93%	19.67%	5.77%	3.75%	3.09%	10.79%
Dual	1,061,807	46.22%	22.34%	13.96%	3.58%	2.71%	11.20%
Region							
South	2,498,026	64.58%	15.98%	6.51%	2.52%	0.57%	9.84%
Midwest	2,070,054	48.06%	28.29%	4.49%	4.86%	4.53%	9.77%
West	1,309,848	45.79%	20.94%	10.46%	3.65%	4.65%	14.51%
Northeast	656,742	60.72%	8.32%	10.91%	4.88%	4.39%	10.78%
RUCA 2010							
Large rural (RUCA 4-6)	3,367,567	64.34%	13.18%	6.13%	4.24%	1.41%	10.71%
Small rural (RUCA 7-9)	1,825,005	47.73%	26.86%	7.16%	2.94%	4.64%	10.67%
Isolated rural (RUCA 10)	1,343,096	42.41%	28.28%	9.47%	3.49%	4.88%	11.46%

Suggested Brief Citation

Srinivasan SM, Sandahl M, Thompson K, Pink G, Holmes M. *Usual Source of Care for Rural Medicare Fee-for-Service Beneficiaries in 2021*. NC Rural Health Research Program, UNC Sheps Center, February 2026.

This study was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement # U1CRH03714. The information, conclusions and opinions expressed in this brief are those of the authors and no endorsement by FORHP, HRSA, HHS, or The University of North Carolina is intended or should be inferred.



UNC
THE CECIL G. SHEPS CENTER
FOR HEALTH SERVICES RESEARCH

North Carolina Rural Health Research Program
The Cecil G. Sheps Center for Health Services Research
The University of North Carolina at Chapel Hill
www.shepscenter.unc.edu/programs-projects/rural-health

