Rural Health Care Policy Solutions for California's Older Adults

CALIFORNIA POLICY BRIEF • NOVEMBER 2025

By UC Davis Health and The SCAN Foundation*
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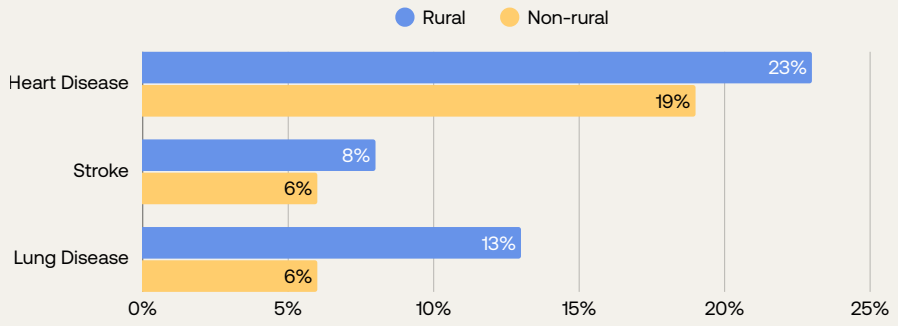
California's rural older adults, a growing, underserved population, face pronounced health care disparities driven by geographic isolation, chronic underinvestment in services and infrastructure, and systemic workforce shortages. Compared to urban areas, rural communities have:

- Greater proportion of adults ages 65 and older (1 in 4 vs. 1 in 6 statewide).[1]
- Higher rates of disability among older adults (40% vs. 34%).[2]
- Higher chronic disease burden including heart disease, stroke, and lung disease.[3]

These inequities are compounded by fewer health care resources, racial and ethnic inequities in access to care, the closure of rural clinics and hospitals, the aftermath of disasters such as wildfires, and the lingering effects of the pandemic, including workforce burnout, clinic closures, and delayed care for chronic conditions. The 2025 budget reconciliation act (H.R.1) cuts rural Medicaid funding by $155 billion nationally over a decade, with nearly two-thirds of the reductions hitting after 2030, precisely when the rural population ages 85+ is expected to surge. While a temporary $50 billion rural health fund (2026–2030) aims to offset losses, its adequacy is unclear.[4]

Higher Burden of Chronic Disease Among Rural Older Californians



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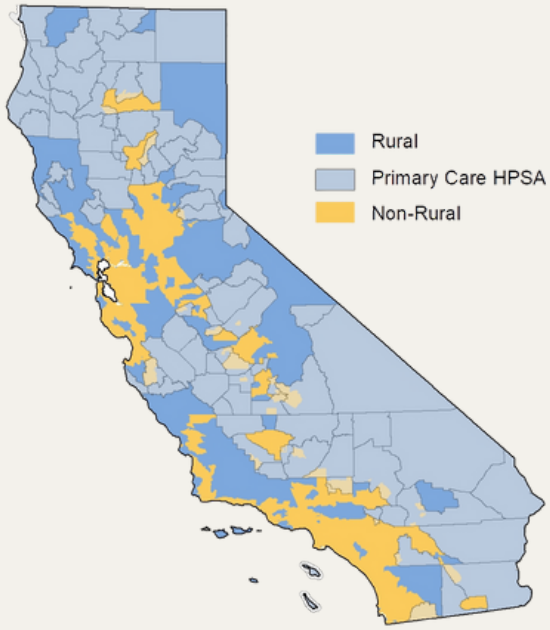
BARRIERS TO CARE

Workforce Shortages

- Wait times for new patients in many specialties can exceed six months.
- Severe shortages in primary care, geriatrics, specialty care, behavioral health, dental, and audiology require patients to secure transportation and travel long distances to find a provider, deterring necessary follow-ups or continued care.
- Rural counties average 6.8 primary care physicians per 10,000 residents, compared to 10.5 in non-rural areas.[5]
- Recruitment and retention are undermined by high turnover, uncompetitive salaries, and limited spousal employment opportunities.
- Providers often work in small or overburdened clinics (Community Health Clinics (CHCs), Federally Qualified Health Clinics (FQHCs), and Critical Access Hospitals (CAHs)), covering broad scopes of practice and taking on social service tasks for which they may not be trained.
- Training gaps persist in geriatrics, dementia, brain injury, disability, gender-affirming, transgender-specific, and culturally competent care.

Provider Shortages Are Concentrated in Rural California[6]



Health Professional Shortage Areas (HPSAs) guide key federal funding and workforce programs and show the greatest shortages in rural census tracts.

Complex and Fragmented Systems

- Navigating Medicare, Medi-Cal, and long-term services and supports (LTSS) is confusing for patients and families, especially without local, in-person support and amid fragmented communication between health care and social services.
- Medicare Advantage plans often have limited provider networks, lower hospital reimbursements (particularly for CAHs), and burdensome administrative requirements.
- Medicare reimbursement has not kept pace with inflation, and Medi-Cal rates remain among the lowest in the nation, leaving rural hospitals and primary care practices — which disproportionately serve Medicare, Medi-Cal, and dual-eligible patients — financially unstable and at higher risk of closure.

Care Coordination and Discharge Issues

- Rural clinics and hospitals have adopted electronic health records (EHRs) at increasing rates but persistent challenges including high costs, limited IT capacity, poor broadband connectivity, and interoperability barriers hinder full and effective use.
- Limited data sharing and shortages of post-acute facilities delay recovery.
- Administrative barriers restrict community-based organizations (CBOs) from participating in California Advancing and Innovating Medi-Cal (CalAIM) care coordination.
- Discharge planning is often inadequate, especially for those who are isolated, unstably housed, or lack reliable transportation or caregiving support.
- Hospice and long-term care settings face rising concerns about quality and accountability, with documented cases of unethical referrals and fraud in California.[7]

> "When I first got here, I had a hard time finding a doctor because they're closed, closed, closed. We're not accepting new patients… particularly for people that are low-income because the doctors aren't getting reimbursed like they should."
>
> *Latino older adult, North State*

Lack of Dementia Support

- Insufficient interprofessional dementia care and LTSS increase ER reliance and inappropriate hospitalizations for non-acute needs.
- Few dementia-trained providers result in poor chronic disease management, excess medication prescribing, and decreased focus on quality of life and functional capacity.
- Dementia often goes undiagnosed or is diagnosed late, leaving needs unmet.
- Many providers are unaware of community-based services (e.g., Alzheimer's Association, Caregiver Resource Centers (CRCs)), so families miss support.

> "Medications… get expensive. I have glaucoma and kidney trouble… The doctor says not to drive because of my eyes. I still drive, but not at night… to the grocery store, and to the senior center for meals."
>
> *85-year-old Hispanic older adult, Central Valley*

Transportation Barriers

- Rural residents travel twice as far for care, yet many older adults are unable to drive or access affordable, reliable, or safe transportation. Furthermore, travel often involves mountainous terrain or poorly maintained or unpaved roads.
- Reimbursement mechanisms are limited and do not cover common options like gas mileage or rides from friends.
- Paratransit is limited, unreliable, inaccessible, and requires advance reservations.
- Public transit is sparse or absent, with some regions lacking ambulance services.

Digital Health Limitations

- 12.7% of rural households lack broadband access in California.[8]
- Low digital and health literacy, lack of private spaces for telehealth, and skepticism about telehealth's ability to accurately diagnose certain conditions limits use.

Cultural and Language Barriers

- Patients with language or literacy barriers need advocacy support and materials in their own languages.
- Limited responsiveness to Spanish, Hmong, or Indigenous rural residents' health beliefs, preferences, and languages undermines communication, trust, and follow-through on care plans or recommendations.

> "I want another gay person to come and help me because you don't want to have to go through all that crap of 'Who are you? What are you?'"
>
> *LGBTQ+ older adult, North State*

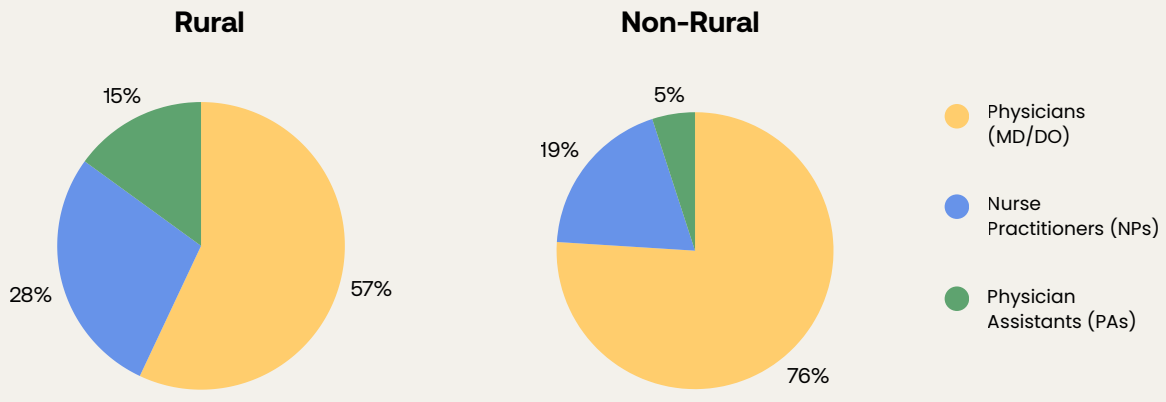
POLICY RECOMMENDATIONS

These recommendations build on the Rural Master Plan for Aging Initiative and ongoing input from coalitions in Northern California, the Central Valley, and the Inland Empire. They were further shaped by over 30 statewide advisors representing hospitals, health plans, advocacy organizations, academic experts, and rural providers. Together, this diverse input highlights practical solutions and potential state policy and investment opportunities to strengthen health care access for rural older adults.

1. Strengthen the Rural Health Workforce

- Enable team-based, interdisciplinary care by updating scope-of-practice guidelines and aligning Medi-Cal reimbursement and workforce grants with collaborative models that integrate nursing, pharmacy, medicine, oral health, behavioral health, and social work.
- Expand NP and PA residency programs in rural regions to strengthen advanced training and prepare providers for independent practice. NPs and PAs already deliver 43% of rural primary care compared to 24% in non-rural communities.[9]
- Invest in rural health education pipelines — from early exposure programs (Area Health Education Centers and rural-serving community college/university partnerships that engage high school and undergraduate students) to advanced medical education collaboratives (e.g., UC Davis Rural PRIME, California Oregon Medical Education & Training [formerly COMPADRE]) focused on medical school and residencies — to prepare physicians to practice in rural communities.
- Expand state-supported rural residency training programs in specialties including emergency medicine, general surgery, neurology, cardiology, psychiatry, and internal medicine.
- Attract, retain, and support rural providers through state-funded incentives (scholarships, loan forgiveness, housing stipends, tax credits), paired with leadership and operations training for rural health care administrators and physicians, and succession planning to stabilize rural health systems.
- Advocate for sustainable Medicare and Medi-Cal reimbursement, while using state levers (e.g., targeted Medi-Cal rate adjustments, supplemental payments for CAHs and Rural Health Clinics) to help rural providers bridge gaps until federal policies are addressed.

Nurse Practitioners and Physician Assistants Deliver Almost Half (43%) of Primary Care in Rural Communities[9]



2. Promote Provider Training in Geriatrics and Dementia

- Fund and expand geriatric training opportunities in primary care residency programs and postgraduate medical education, prioritizing rural placements.
- Develop and fund statewide continuing education programs on geriatrics, dementia, disability, and LGBTQ+ care (e.g., webinars, seminars, accredited CME/CEU courses, and non-formal tools), with targeted outreach to rural providers.
- Expand California's Dementia Care Aware model in rural regions, equipping primary care providers with dementia detection tools and training.

> "They forget that you may not know the medical terms... also, if it's a different language for you... Or if you're hard of hearing, or you can't see well, all those things..."
>
> *Latina older adult, North State*

3. Orient Clinical Services Toward Age-Friendly Care

- Incentivize FQHCs, CHCs, and rural clinics to pursue Patient-Centered Medical Home (PCMH) or age friendly certification to strengthen workflows, policies, and procedures for older adults.
- Promote development of Geriatric Emergency Departments in regional hub hospitals (e.g., Chico, Redding, Eureka) to improve emergency care for surrounding rural areas.

4. Expand Dementia Support

- Bring CMS's Guiding an Improved Dementia Experience (GUIDE) Model to rural California, which funds person-centered dementia care, care coordination, caregiver education, and 24/7 support.
- Invest in the CRCs to fund rural-focused outreach campaigns and dedicated staff to build awareness among local providers, medical schools, and community hubs.
- Provide targeted outreach and education in partnership with health plans to help rural providers and care teams integrate dementia services into care coordination, in alignment with existing dementia-specific standards in Dual Eligible Special Needs Plans (DSNPs) and CalAIM Enhanced Care Management.

5. Simplify Navigation of Services

- Expand Aging and Disability Resource Centers (ADRCs) as single points of entry for information, counseling, and help applying for health and long-term care programs, improving care transitions and connecting older adults to services.
- Increase funding for the Health Insurance Counseling and Advocacy Program (HICAP), which offers free, one-on-one assistance with Medicare, long-term care insurance, and related issues.

6. Improve Care Coordination and Discharge Planning

- Fund upgrades to EHR systems in rural safety-net clinics and hospitals to improve interoperability and enable care coordination for older adults with complex conditions, including dementia, through participation in California's statewide Data Exchange Framework (DxF).
- Encourage hospital-community partnerships in discharge planning by incentivizing coordination with Area Agencies on Aging (AAAs) and Independent Living Centers (ILCs), and by increasing state funding to expand AAA/ILC capacity to meet growing demand.
- Expand Medi-Cal coverage and increase reimbursement for rural home health services, including medical equipment and post-discharge wellness checks, to strengthen recovery and reduce avoidable readmissions (see companion policy brief on the LTSS workforce).
- Develop statewide discharge protocols for unhoused older adults that address transportation, shelter, and follow-up care.

7. Improve Transportation Access

- Fund accessible transit for non-Medi-Cal older adults (e.g., vans, vetted volunteer driver networks, mileage reimbursement regardless of who is driving).
- Ensure ambulance coverage in rural "ambulance deserts" through targeted state subsidies, prioritizing areas with 25+ minute response times or no local provider, using flexible models suited to local needs.
- Fund and incentivize mobile and community-based care delivery in trusted rural hubs (e.g., food distribution sites, senior centers, caregiver programs) through Medi-Cal reimbursement, state grants, and reducing regulatory barriers.

> "Being so overwhelmed with what is going on [caregiving] and then trying to get resources—even if they are there—they are hard to navigate."
>
> *Caregiver, Inland Empire*

8. Expand Digital Health

- Invest in broadband infrastructure in underserved rural regions and ensure affordability programs reach older adults who face cost barriers.
- Fund digital literacy training and outreach through CBOs and libraries.
- Reimburse "telehealth navigators" under Medi-Cal.
- Protect rural telehealth access regardless of federal changes by codifying Medi-Cal payment parity (including clinically appropriate audio-only), designating the home as an originating site, and allowing FQHCs, RHCs, and Tribal Health to serve as distant sites. Direct Department of Health Care Services (DHCS) to seek federal approvals, such as State Plan Amendments (SPAs) or waivers, and provide state bridge funding if Medicare flexibilities expire.

9. Increase Community-Based Patient Education and Support

- Strengthen state-Tribal collaboration on health initiatives by funding Tribal-led approaches and programs.
- Expand state-supported health care programs tailored to LGBTQ+ older adults and adults with disabilities in rural regions.
- Fund and deploy multilingual navigators and community health workers (CHWs) through Medi-Cal and state grant programs to assist with appointments, insurance enrollment, and care coordination.
- Support partnerships with senior centers, libraries, faith-based organizations, and cultural community hubs to deliver multilingual, culturally tailored education on chronic disease management, preventive care, and resource navigation.

Footnotes

1. Authors' analysis of 2023 American Community Survey (ACS) 5-year estimates. Share of residents ages 65+ calculated for rural (non-metro) vs. non-rural (metro) counties, using 2023 National Center for Health Statistics (NCHS) county classification. Results are a county average (unweighted).
2. Authors' analysis of 2023 ACS 5-year estimates. Percent of older adults (65+) reporting any disability, averaged across counties (unweighted). Rural vs. non-rural defined by 2023 NCHS county classification.
3. UCLA Center for Health Policy Research, AskCHIS (2023 for heart disease and stroke; 2005 for lung disease). Rural defined by 2023 NCHS county classification. Results are population-weighted. "Lung disease" includes COPD, emphysema, and chronic bronchitis, excludes asthma.
4. Kaiser Family Foundation. A closer look at the $50 billion rural health fund in the new reconciliation law. 2025. https://www.kff.org/medicaid/issue-brief/a-closer-look-at-the-50-billion-rural-health-fund-in-the-new-reconciliation-law/
5. Authors' analysis of 2022 HRSA Area Health Resources Files (AHRF). Ratios reflect providers per 10,000 residents, including (a) primary care physicians (MD/DO in family medicine, general practice, internal medicine, pediatrics, OB/GYN), (b) nurse practitioners with an NPI, and (c) physician assistants. Rural vs. non-rural defined by 2023 NCHS county classification. Results are county averages (unweighted).
6. Health Professional Shortage Area (HPSA) designations from the California Health and Human Services Open Data Portal (2024), overlaid with HRSA 2025 rural/non-rural census tracts.
7. Qualitative findings from the Rural MPA Initiative. See also: California Department of Justice. Consumer Alert: Hospice Fraud. https://oag.ca.gov/system/files/attachments/press-docs/DMFEA%20Hospice%20Fraud%20Consumer%20Alert.pdf
8. Johnson, H., & Cuellar Mejia, M. (2024). Rural California. Public Policy Institute of California. https://www.ppic.org/publication/rural-california/
9. Authors' analysis of 2022–2023 HRSA Area Health Resource Files (AHRF). Rural vs. non-rural defined using 2023 NCHS county classification. Results are population-weighted.

About The SCAN Foundation

The SCAN Foundation (TSF) envisions a society where all of us can age well with purpose. We pursue this vision by igniting bold and equitable changes in how older adults age in both home and community. Our grants and impact investments prioritize communities that have been historically marginalized with an emphasis on: older people of color, older adults with lower incomes, and older residents in rural communities. Learn more at **https://www.thescanfoundation.org/**

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The Family Caregiving Institute at the Betty Irene Moore School of Nursing at UC Davis advances the health and wellbeing of family caregivers through research, education and policy. Its work centers on developing systems of support for the millions of caregivers who provide the majority of long-term care for older adults, elevating their role within health care and communities. Learn more at **https://health.ucdavis.edu/family-caregiving/**