



**COVID-19 Policy Brief: Disparities Among Rural Communities in the United States**  
**Version: December 22, 2020**

The COVID-19 pandemic has resulted in close to 18 million cases and over 315,000 deaths in the United States as of Dec. 20, 2020.<sup>i</sup> While the pandemic has touched every community in our country, it has revealed striking socioeconomic and healthcare inequities across the U.S including individuals living in rural<sup>ii</sup> communities.

The Infectious Diseases Society of America and its HIV Medicine Association represent more than 12,000 infectious diseases and HIV physicians and other health care providers, public health practitioners and scientists committed to ending health disparities that been exacerbated by COVID-19. This brief is part of a series that examines [COVID-19 and health disparities in the U.S.](#) In this document, we call attention to the urgency to improve rural health infrastructure and bring awareness to a rural population demographic that is at significant risk for both contracting COVID-19 and experiencing adverse health outcomes due to the disease.

### **Background**

According to the Centers for Disease Control and Prevention, COVID-19 case rates per 100,000 persons in rural areas surpassed those in urban, suburban and other metro areas in the middle of September 2020 and continue to climb.<sup>iii</sup> Sixty million people, an estimated 19% of the U.S. population, live in rural areas that face unique challenges in responding to the COVID-19 pandemic.<sup>iv</sup> Within these rural communities, 80% of the population are designated as medically underserved.<sup>v</sup> Additionally, rural communities have higher disability rates and higher rates of residents without health care insurance or broadband internet services, limiting access to telemedicine.<sup>vi</sup>

Rural America has a significant population that is at high risk for severe illness if they contract COVID-19. While age is a significant risk for severe illness with COVID-19 and 80% of COVID-19-related deaths have been reported among adults aged greater than or equal to 65 years,<sup>vii</sup> rural communities have a higher proportion of older Americans compared with urban communities.<sup>viii</sup> Twenty-three percent of Americans aged 65 years or greater live in rural areas.<sup>ix</sup>

People of color, including [African American](#), [Latinx](#) and [Native American](#) communities, make up 22% of the rural population<sup>x</sup> and are also at higher risk for underlying health conditions that are known risk factors for severe COVID-19 disease. Rural healthcare systems face challenges in responding to the needs of rural populations during the pandemic, including fewer hospitals and physicians specializing in critical care and fewer intensive care (ICU) beds per capita<sup>xi</sup>, as well as fewer ID specialists.

### **CALL TO ACTION**

Lawmakers should focus policies on eliminating health inequalities to improve the health of rural communities. Increased vulnerability to infectious disease in any segment of the population increases the risk of spread to the rest of the population. COVID-19 is worsening in rural communities across the

U.S. We call on lawmakers to ensure rural communities have access to health care services by investing in robust rural health care infrastructures, providing adequate testing capacity to detect and control outbreaks and putting in place programs for contact tracing.

## **Rural Health Infrastructure**

### *Hospitals*

Deficient rural health infrastructure and limited access to health services make an effective public health response to COVID-19 difficult. The loss of health services in rural America is driven in part by the closure of hospitals due to higher rates of uninsured and lower-income residents, outdated payment models, aging populations and older infrastructure.<sup>xii</sup> Since 2010, at least 128 rural hospitals have closed, with at least 450 (21%) more being at risk for closure.<sup>xiii</sup> Studies have shown more hospital closures in states that have not expanded Medicaid.<sup>xiv</sup> These states do not provide expanded coverage to adults with incomes under 133% of the federal poverty level (around \$17,000 in 2020). In the 12 states that have not expanded Medicaid coverage,<sup>xv</sup> adults over 21 years of age are generally not eligible for Medicaid regardless of their ability to pay for health care, unless pregnant, raising a dependent child, elderly or living with a disability. Even more urgently, rural counties have a limited number of hospital beds, ventilators, and personal protective equipment. Importantly, 63%<sup>xvi</sup> of rural hospitals have no ICU beds, limiting their ability to treat patients with severe COVID-19. We recommend that:

- Congress provide substantial relief to state and local governments to close budget shortfalls for an extended period following the end of the COVID-19 public health emergency.
- The Centers for Medicare and Medicaid Services (CMS) consider flexibilities in allowing more rural hospitals to qualify as critical access hospitals, reducing the financial vulnerability of rural hospitals, and improving access to healthcare by keeping essential services in rural communities.
- The 12 states that have not expanded Medicaid be incentivized to do so.<sup>xvii</sup>
- Congress fund a national strategy to direct and support the scale-up of manufacturing and appropriate distribution of urgently needed medical supplies, including personal protective equipment and testing supplies.

### *Community Health Centers*

There have been 1,954 temporary Community Health Center (CHC) site closures due to financial losses resulting from reduced patient visits since May 8, 2020.<sup>xviii</sup> COVID-19 has led to widespread CHC staffing furloughs, reduced hours and decreased services. With the loss of services comes the loss of the revenue needed to keep clinics open. CHCs play a key role in providing health care services in rural communities. Of the CHC patient population, 68% have incomes under the poverty level, 63% identify as racial/ethnic minorities and 82% do not have health insurance.<sup>xix</sup> CHCs provide much-needed healthcare as well as translation, transportation, nutrition and pharmacy services. During the COVID-19 pandemic, CHCs are triaging patients, reducing the burden on hospitals, and attending to the increasing demand for behavioral health services. Notably, 90% of CHCs provide COVID-19 testing.<sup>xx</sup> We recommend that:

- Congress provide for a 5-year fully-funded reauthorization of the Community Health Center Fund and increase funding for workforce programs such as the National Health Service Corps.
- Congress provide sustainable funding for CHCs to respond to the COVID-19 pandemic and for emergency preparedness.

### *Telehealth*

The COVID-19 pandemic has accelerated the expansion of a broad range of telehealth services.<sup>xxi</sup> While telehealth is an important tool for expanding health care access in rural areas, rural areas are less likely to have access to reliable broadband internet and cellular connectivity, making telemedicine (real-time video conferencing) difficult.

With the support of legislation passed by Congress, the U.S. Department of Health and Human Services has been able to waive select telehealth restrictions temporarily.<sup>xxii</sup> Adequate and ongoing reimbursement from the Centers for Medicare and Medicaid Services (CMS) and all third-party payers must continue at rates similar to in-person visits for both video and telephone visits to make telemedicine sustainable and improve access for rural patients. Long-term policy and regulatory changes are needed to leverage telemedicine opportunities in rural areas, including taking action to reduce the digital divide.<sup>xxiii</sup> We recommend that:

- Congress permanently authorize continuation of telehealth waivers allowing parity for Evaluation and Management (E/M) audio-only visits and for the expansion of providers eligible for telehealth reimbursement, including across state lines; for services provided by advanced practice providers; and the expanded definition of distant sites to include community health centers and rural health clinics.
- Congress fund the Federal Communication Commission's Lifeline program at sufficient levels to ensure unlimited minutes for individuals with low incomes who count on the program for phone and Internet access.
- Congress invest in enhanced federal funding to expand broadband Internet services in rural and underserved communities across the U.S.

### *Health Professional Workforce*

The shortage of health professionals for both primary and specialty care is common in many rural areas. Infectious disease and HIV specialists manage care for patients with COVID-19 in both inpatient and outpatient settings, lead infection prevention and control programs at health care facilities, and work with public health administrators and stakeholders to lead community preparedness and response efforts. Nearly 80% of U.S. counties do not have any infectious diseases specialists.<sup>xxiv</sup> A concerted effort is needed to increase the public health workforce, including emergency medical technicians and paramedics, who are on the front lines of the COVID-19 response in addition to the deployment of community health workers in geographically maldistributed areas to allow for maximum flexibility for health care professionals to meet patients where they are. We recommend that:

- Congress swiftly enact COVID-19 relief legislation that addresses health workforce issues, including increased investment in the Provider Relief Fund, which supports American families, workers, and the healthcare providers in the battle against the COVID-19 outbreak and hazard pay for frontline health care workers.
- Congress pass the Student Loan Forgiveness for Frontline Health Workers Act to provide financial support for frontline healthcare workers, including infectious diseases/HIV physicians, through loan repayment.
- Congress address restrictions on the visa process, including the J-1 Visa Program to expand the physician workforce in rural communities.

- Congress increase funding for existing loan repayment programs including the National Health Service Corps (NHSC) program and explore opportunities to create a loan repayment program for public health workers.

### **Ensure Timely Access to High-Quality, Culturally Sensitive COVID-19 Testing, Care and Prevention**

According to a Surgo Foundation analysis,<sup>xxv</sup> close to 64% of all rural counties in the U.S. do not have a COVID-19 testing site. Policymakers should prioritize rural areas and populations disproportionately impacted by COVID-19 for testing, care and treatment and, when available, vaccines. We recommend that Congress:

- Provide resources and support to states to implement testing, treatment delivery, contact tracing programs and ensure that services are geographically and economically accessible.
- Congress provide the CDC with at least \$8.4 billion in funding for states to support COVID-19 vaccine distribution programs.
- Monitor COVID-19 vaccine uptake and coverage in critical populations and enhance strategies to reach populations with low vaccination uptake or coverage.

### **Agricultural and Food Processing Industries**

The Centers for Disease Control and Prevention documented large COVID-19 outbreaks in meat, poultry and food processing plants located mainly in rural areas.<sup>xxvi</sup> Factories and farms are not workplaces where people can physically distance and a large portion of the rural workforce cannot work remotely, thereby enabling the spread of the disease. In addition to employment challenges, farmworkers often are housed by employers in congregate housing, such as barracks-style facilities, making physical distancing impossible.

These industries often pay low wages and employ a disproportionate number of people who already face economic opportunity barriers. These frontline employees face heightened risks for COVID-19 exposure and acquisition, lack of personal protective equipment, little to no physical distancing, and the threat of losing the ability to file for unemployment benefits if the employee determines it is unsafe to return to the job.

In addition to agricultural and food processing industries contributing to the spread of COVID-19 in rural communities, over half of [correctional facilities](#) are located in rural areas. These facilities urgently need interventions to prevent and respond to outbreaks, including resources to ensure masks and hand cleaners are universally available in addition to actions such as reducing population size to allow for physical distancing.

Mask mandates have been shown to reduce the spread of COVID-19 and should be coupled with policies promoting physical distancing.<sup>xxvii</sup> With daily case rates in the U.S. reaching nearly 200,000 in November 2020,<sup>xxviii</sup> these public health measures are critical to prevent hospitals from becoming overwhelmed, resulting in shortages of ICU beds, ventilators and other essential life-saving equipment.

We recommend that:

- Congress pass the Frontline At-Risk Manual Laborers Protection Act that provides farmworkers paid sick leave, pandemic premium pay, and funding for agriculture providers to implement recommended sanitation and physical distancing, safe housing and transportation.

- Congress expand rural healthcare by increasing funding to CHCs that serve farmworker populations.
- States implement masking and physical distancing requirements combined with public education about the importance of these prevention measures as the most effective tools we have to contain the spread of COVID-19.
- Require employers to furnish recommended personal protective equipment and provide access to COVID-19 testing resources and supplies at no charge to employees.

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<sup>i</sup> Centers for Disease Control and Prevention. Case Report in the U.S. Visited on September 1, 2020. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>.

<sup>ii</sup> The Census Bureau defines rural as any population, housing, or territory not in an urban area. The Census Bureau identifies two types of urban areas: Urbanized Areas (UAs) of 50,000 or more people, Urban Clusters (UCs) of at least 2,500 and less than 50,000 people.

<sup>iii</sup> Centers for Disease Control and Prevention. Trends in COVID-19 Cases and Deaths in the United States, by County-level Population Factors. Online at: [https://covid.cdc.gov/covid-data-tracker/#pop-factors\\_newcases](https://covid.cdc.gov/covid-data-tracker/#pop-factors_newcases). Accessed 10/27/20.

<sup>iv</sup> United States Census. Rural America. Available at: <https://gis-portal.data.census.gov/arcgis/apps/MapSeries/index.html?appid=7a41374f6b03456e9d138cb014711e01>.

<sup>v</sup> Health Resources & Services Administration, Medically Underserved Areas and Populations (MUA/Ps). Available at: <https://bhw.hrsa.gov/shortage-designation/muap>.

<sup>vi</sup> Peters, D., Community Journal of Rural Health, May 19, 2020. Available at:

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<sup>vii</sup> Centers for Disease Control and Prevention. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html>.

<sup>viii</sup> Smith A., Trevelyan E., The Older Population in Rural America: 2012-2016, American Community Survey Reports, September 2019. Available at: <https://www.census.gov/content/dam/Census/library/publications/2019/acs/acs-41.pdf>.

<sup>ix</sup> United States Census Bureau, Older Population in Rural America, October 22, 2019. Available at:

<https://www.census.gov/library/stories/2019/10/older-population-in-rural-america.html>.

<sup>x</sup> United States Department of Agriculture, Economic Research Service, Economic Information Bulletin 200, November 2018. Available at: <https://www.ers.usda.gov/webdocs/publications/90556/eib-200.pdf>.

<sup>xi</sup> Boren S., Journalist's Resource, Rural health care and COVID-19: A research roundup, June 10, 2020. Available at: <https://journalistsresource.org/studies/government/health-care/rural-health-care-covid-19-research/>.

<sup>xii</sup> Wishner, J et al. A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies. Kaiser Family Foundation. July 2016. Online at: <https://www.kff.org/medicaid/issue-brief/a-look-at-rural-hospital-closures-and-implications-for-access-to-care/>.

<sup>xiii</sup> Diaz, A, [Karan R. Chhabra](#), KR, Scott JW. The COVID-19 Pandemic and Rural Hospitals – Adding Insult to Injury. Health Affairs. May, 3, 2020.

<sup>xiv</sup> Ibid.

<sup>xv</sup> Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision. Online at: [www.kff.org](http://www.kff.org). Accessed 11/24/2020/

<sup>xvi</sup> The Chartis Group, The Rural Health Safety Net Under Pressure: Understanding the Potential Impact of COVID-19, April 2020. Available at: [https://www.chartis.com/resources/files/CCRH\\_Research\\_Update-Covid-19.pdf](https://www.chartis.com/resources/files/CCRH_Research_Update-Covid-19.pdf).

<sup>xvii</sup> Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision. Oct. 21, 2020.

<sup>xviii</sup> Corallo B., Tolbert J., Impact of Coronavirus on Community Health Centers, May 20, 2020. Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/impact-of-coronavirus-on-community-health-centers/>.

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