Improving Health in Rural Communities

FY 2021 Year in Review

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From the Co-Chairs

On behalf of the Centers for Medicare & Medicaid Services (CMS) Rural Health Council, we are pleased to present the CMS Rural Health Fiscal Year 2021 Year in Review, reflecting on much of what has been accomplished as part of our collective efforts to serve rural communities.

As CMS moves to further embed health equity across Medicare, Medicaid, and the Marketplaces, we have made efforts to ensure our rural lens is as inclusive as possible. In this report, you will see a greater reflection of the work we are doing across rural, frontier, and tribal communities as well as the remote areas of the U.S. territories.

Approximately 20% of the U.S. population is spread across 97% of U.S. land area; this requires us to carefully consider how CMS approaches our rules and regulations, models, and outreach and education efforts. Therefore, we have stepped up our outreach efforts, ensuring we hear directly from those in rural communities, by hosting over 30 virtual town halls and listening sessions across all 10 regions.

CMS remains committed to all those we serve and to providing patients in rural communities with access to more affordable, equitable, and quality healthcare. All of us at CMS play a role in improving the lives of Americans. We look forward to the work ahead and our continued collaboration and partnership to further improve healthcare in rural, frontier, and tribal communities as well as U.S. territories.

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Executive Summary

Rural, frontier, tribal, and island communities face structural barriers to achieving equitable health outcomes, including practitioner shortages, hospital closures, and long travel distances to access care. The Centers for Medicare & Medicaid Services (CMS) is committed to working with rural communities to address these barriers and build on existing advancements to achieve optimal outcomes for all rural Americans.

Through its Rural Health Strategy, CMS is working with federal partners, community organizations, and Tribes to achieve equity in access to care, quality of care, and health outcomes for rural individuals. CMS works to improve the health and well-being of rural Americans by listening to community partners, and by developing and implementing innovative policy and payment solutions designed to meet the needs of rural communities and their most economically and socially marginalized populations. CMS facilitates transformation and improvement in the rural health system, integrating rural health equity within all Agency centers, programs, policies, and activities.

The activities and accomplishments outlined in this report represent CMS's commitment to designing programs and policies that affect rural, frontier, and tribal communities in fiscal year (FY) 2021. They are presented across 10 focus areas: the coronavirus disease 2019 (COVID-19); the Federally Facilitated and State Marketplaces; Medicare Payment and Policy; Practitioner Workforce; Medicaid and Children's Health Insurance Program Enrollment, Payment, and Policy; Long-Term Services and Supports; Maternal Health; Mental Health and Substance Use Disorders; Models and Demonstrations; and Quality and Equity.

CMS highlights include the following:

COVID-19 Vaccine Administration

Facilitated equitable access to the COVID-19 vaccines for rural, low-income, and underserved populations through regulations, payment policies, and targeted funding

Extended Postpartum Coverage

Provided states the option to extend postpartum coverage eligibility for 12 months and provide full benefits under Medicaid and the Children's Health Insurance Program

Rural Hospital Bypass Report

Published the first national analysis to explore the drivers behind why rural Americans bypass their local hospitals for inpatient services

These and other actions detailed in this annual report demonstrate CMS's commitment to improving the health and well-being of individuals living and working in rural areas. CMS actions span a wide breadth of the Agency's authorities and roles, including regulation, payment, coverage, partner tools and publications, community engagement, health system innovations, and regional coordination, as well as its ongoing response to the COVID-19 public health emergency (PHE). The CMS activities included in this report are summarized below.

COVID-19: The ongoing and evolving COVID-19 pandemic presented unprecedented challenges for rural communities in FY 2021. To continue supporting patients and providers, CMS released new resources and launched innovative programs, such as the Acute Hospital Care at Home program, to enable access to care and information during the PHE. CMS also took steps to facilitate equitable access to COVID-19 vaccines for rural and low-income populations, implementing statutory cost-sharing prohibitions that apply in Medicare, Medicaid, and most private insurance plans, and ensuring adequate Medicare payments for vaccine administration.

REGULATORY ACTIVITIES: Regulatory efforts to promote flexibilities for providers and other partners were a large part of CMS's actions to improve rural health in FY 2021. The final rule Establishing Minimum Standards in Medicaid State Drug Utilization Review and Supporting Value-Based Purchasing included regulatory changes that allowed states, payers, and manufacturers to better identify inappropriate prescribing of opioids. In addition, a December 2020 final rule modernized the physician self-referral law to, among other things, facilitate the ability of rural providers to more robustly engage in value-based healthcare delivery and payment.

PAYMENT POLICIES: Enhanced payment and other CMS policies paved the way for rural facilities and practitioners to implement innovative care practices. CMS increased Medicare payment rates to practitioners for face-to-face evaluation and management office visits, recognizing the time practitioners spend coordinating care for patients. CMS also added more than 60 services to Medicare's telehealth payment list, giving rural clinicians more opportunities to deliver person-centered care.

COVERAGE EXPANSION: Efforts to expand healthcare coverage and other CMS activities to facilitate access allowed rural individuals to obtain the care they needed. Coverage expansions included policies to give states the option to extend postpartum coverage for women enrolled in Medicaid and the Children's Health Insurance Program, guidance on legislative provisions to encourage states to expand Medicaid under the Patient Protection and Affordable Care Act (ACA, Pub. L. 111-148), and implementation of increased tax credits in the HealthCare.gov Marketplaces to lower health insurance costs. CMS also provided access on HealthCare.gov to a Special Enrollment Period, so consumers could enroll in the coverage they needed during and after the COVID-19 pandemic.

TOOLS AND PUBLICATIONS: The research and tools CMS published in FY 2021 sought to provide specific insights and guidance on rural health issues for patients, caregivers, providers, policymakers, researchers, and other partners. These tools and publications included the Long-Term Services and Supports Rebalancing Toolkit to support states in their efforts to expand and enhance home and community-based services equitably, and the Examining Rural Hospital Bypass for Inpatient Services Report, the first national analysis to explore the drivers behind why rural Americans bypass their local hospitals for inpatient care. CMS also launched the Nursing Home Resource Center, which serves as a centralized hub for the latest information, guidance, and data on nursing homes for patients, caregivers, and providers.

COMMUNITY ENGAGEMENT: Rural community engagement activities conducted during FY 2021 helped CMS identify opportunities and solutions to transform rural healthcare and improve health. Community engagement included issuing a Request for Information seeking feedback on effective methods for assessing whether Agency policies and actions are equitable, and hosting listening sessions to better understand access to diabetes self-management education in rural communities. Through the Rural Health Coordinators in the 10 CMS Regional Offices, CMS provided critical technical assistance to rural providers that was tailored to meet regional needs, while building new and maintaining existing bi-directional relationships with myriad rural health partners. In FY 2021, the Rural Health Coordinators organized more than 600 events and activities, promoting CMS initiatives, helping rural providers navigate the COVID-19 PHE waivers and flexibilities, and gathering and sharing feedback from rural partners. Additionally, the Coordinators worked daily to educate, inform, and assist internal and external partners on CMS's changing policies and programs through a variety of communications platforms.

HEALTH SYSTEMS INNOVATION: Several payment and practice innovations moved forward in FY 2021 to test and bolster improvements to the rural health system. These innovations included ongoing implementation, evaluations, and updates to CMS models that focus on rural populations, and models designed to address the needs of economically and socially marginalized beneficiaries and enrollees, such as Medicare and dually eligible beneficiaries affected by opioid use disorders.

This annual report describes CMS's FY 2021 actions across its various roles in improving rural health and healthcare. These actions provide a snapshot of CMS's ongoing commitment to rural communities, building on previous years' achievements, and laying the groundwork for future years' work. CMS is committed to continuing its progress in helping to achieve rural health equity in collaboration with its federal and community partners.

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Introduction

Why Rural Health?

Rural communities are diverse, encompassing people from micropolitan, frontier, and tribal areas, as well as U.S. territories.[1] Approximately one in five Americans lives in a rural area, where populations are more widely dispersed across geographic expanses. More than 97% of land area in the U.S. is considered rural.[2]

Americans living in rural, frontier, tribal, and geographically isolated areas tend to be older than those in urban areas, and rural communities are often less racially and ethnically diverse, with nearly 78% of their populations identifying as non-Hispanic White.[3] Yet, rural communities have experienced demographic shifts in recent years, including an increase in racial and ethnic diversity, increased urban-to-rural migration for recreation and retirement, and an aging population.[4]

Rural residents often face socioeconomic and structural barriers to healthcare access that result in disparate outcomes compared to urban residents. Rural areas generally have higher rates of poverty and unemployment than urban areas and tend to also have higher rates of uninsurance or underinsurance.[5] Rural Americans often experience longer travel times to reach their healthcare practitioners and frequently lack access to public transportation, which can impede timely access to necessary care.[6, 7] Rural residents may also have limited access to high-speed internet and modern technology, hindering their ability to leverage online healthcare information and participate in remote visits with their healthcare practitioners.[8]

Practitioner shortages and facility closures in rural areas further limit access to care. Rural areas account for approximately 60% of federally designated Health Professional Shortage Areas, which include shortages of primary care, dental health, and behavioral health practitioners.[9] Between 2008 and 2018, an estimated 500 out of more than 4,500 rural nursing homes closed or merged, leaving approximately 10% of rural counties without a nursing home and impeding access to nursing home care for aging rural Americans.[10] Since 2010, more than 137 rural hospitals have closed, limiting rural residents' ability to receive hospital care near their homes.[11] Many other rural hospitals are at risk of closure, with nearly 47% of the country's rural hospitals operating with negative operating margins, and many closing specific care units, such as obstetric units.[12] Rural hospitals with thin operating margins have been particularly vulnerable to the impacts of the coronavirus disease 2019 (COVID-19), which has led to lower

revenues due to cancelled or deferred elective services and higher spending on personal protective equipment.[13]

Compared to urban residents, rural residents generally experience poorer health outcomes. An estimated one in three rural adults lives with a disability, impacting their hearing, vision, cognition, mobility, self-care, or independent living.[14] Compared with their urban counterparts, residents of rural counties have a higher prevalence of chronic conditions such as diabetes, chronic obstructive pulmonary disease, and obesity; higher rates of substance use, including opioids, tobacco, and alcohol use; and higher rates of preventable death, including from suicide.[15, 16, 17] People in rural areas also have a higher prevalence of serious mental illness, which is often associated with chronic conditions and can lead to shortened lifespans.[18] Women in rural areas experience increased maternal morbidity and mortality compared to women in urban areas, and infant mortality is higher in rural areas.[19, 20] In general, all-cause mortality rates are higher in rural than in urban counties.[21]

Within rural areas, people from underserved racial and ethnic groups experience greater access barriers and disparities in health outcomes.[22] Compared to non-Hispanic Whites, people from racial and ethnic minority groups living in rural areas are more likely to report not having primary care practitioners, not having accessed healthcare appointments due to cost, and having fair or poor health status. In general, Black, American Indian, and Alaska Native women experience worse maternal health outcomes compared to non-Hispanic White women, and these disparities are compounded by limited access to high-quality obstetric care in rural communities.[23]

In response to these challenges, many rural and frontier communities have designed and implemented creative solutions to address local health problems. They are well-positioned to test and advance innovative models to improve the health and well-being of their rural residents. The Centers for Medicare & Medicaid Services (CMS) strives to be both a partner and a leader in this work, amplifying and building on existing rural innovations, and advancing rural healthcare solutions to help achieve health equity for all Americans.

The Rural Health Strategy and Advancing Health Equity

To address the challenges described above and build on the successes of rural communities, CMS has prioritized improving the health of rural Americans through its Rural Health Strategy. This strategy applies a rural lens to CMS's many programs and policies, resulting in Agency-wide efforts to empower rural patients and consumers, support rural providers, launch rural health innovations, and advance rural health equity. The Rural Health Strategy supports CMS in better serving individuals in rural areas, and in developing policies and programs that address unique rural healthcare needs.

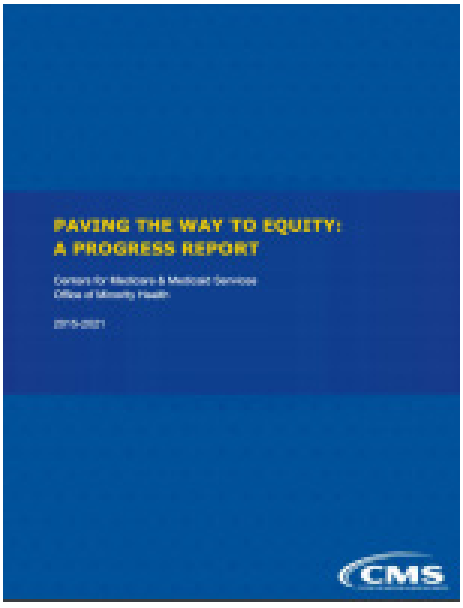
The Rural Health Strategy is a vital part of CMS's effort to transform the healthcare delivery system into a model that delivers high-quality, affordable, and accessible healthcare for every American. The specific objectives of the Rural Health Strategy are to:

- Apply a rural lens to CMS programs and policies.
- Improve access to care through provider engagement and support.
- Advance telehealth and telemedicine.
- Empower patients in rural communities to make decisions about their healthcare.
- Leverage partnerships to achieve the goals of the CMS Rural Health Strategy.

These rural health objectives are strengthened and amplified through new efforts to embed health equity across all CMS programs and policies. The Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, released in January 2021, seeks to adopt a comprehensive approach to advancing equity for all Americans, including individuals living in rural and geographically isolated communities who have historically been denied equitable opportunity and treatment. The Executive Order tasks executive departments and agencies within the federal government to work to redress inequities in their policies and programs. In September 2021, the Administrator of CMS, Chiquita Brooks-Lasure, outlined six strategic pillars to guide CMS's work, the first of which is to "advance health equity by addressing the health disparities that underlie our health system."

These new efforts allow CMS to build on existing work to advance rural health equity, such as CMS's Equity Plan for Improving Quality in Medicare. The CMS Equity Plan lays out approaches for CMS to reduce health disparities among the populations it serves through Medicare, including racial and ethnic minority groups, sexual and gender minority groups, people with disabilities, and individuals living in rural areas. The CMS Equity Plan includes six priorities for reducing health disparities at the individual, interpersonal, organizational, community, and policy levels of the health system. These priorities are to:

- Expand the collection, reporting, and analysis of standardized data.
- Evaluate the impacts of disparities, and integrate equity solutions across CMS programs.
- Develop and disseminate promising approaches to reduce health disparities.
- Increase the ability of the healthcare workforce to meet the needs of vulnerable populations.
- Improve communication and language access for individuals with limited English proficiency and persons with disabilities.
- Increase physical accessibility of healthcare facilities.



In February 2021, CMS released an updated progress report on its past five years of work on the CMS Equity Plan. The report describes CMS's progress on the Path to Equity since 2015, including increasing understanding and awareness of disparities, and developing, disseminating, and implementing sustainable solutions to achieve health equity.

Purpose of this Report

This report compiles an account of CMS programs, policies, and outreach that have impacted rural health in fiscal year (FY) 2021. These activities either specifically prioritize rural populations, or they are designed for all CMS beneficiaries and enrollees, but rural populations in particular may stand to benefit.

The activities and accomplishments outlined in this report underscore CMS's commitment to improving rural health. They represent steps to realize the visions of the Rural Health Strategy and CMS Equity Plan: the achievement of high-quality, affordable care that improves health outcomes and promotes health equity for people in rural areas. Each of the report sections below details CMS activities relevant to areas of particular importance to rural health. These focus areas are: COVID-19; the Federally Facilitated and State Marketplaces; Medicare Payment and Policy; Practitioner Workforce; Medicaid and Children's Health Insurance Program (CHIP) Enrollment, Payment, and Policy; Long-Term Services and Supports; Maternal Health; Mental Health and Substance Use Disorders; Models and Demonstrations; and Quality and Equity. Although some CMS activities may span multiple focus areas, each activity is only included once in this report, under one focus area.

Throughout this report, under section 1101 of the Social Security Act, the term "state" will include the District of Columbia and the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

COVID-19

The ongoing COVID-19 public health emergency (PHE) has presented significant challenges for rural Americans who have weathered the social, economic, and health impacts of an enduring pandemic. In response, CMS provided support for the rural health workforce, created flexibility for the healthcare system, and protected the nation's health.

Facilitating Access to Care, Resources, and Information During the PHE

CMS acted to ensure Americans had access to the care they needed during the PHE, including issuing guidance together with the Departments of Labor and the Treasury that removed barriers to COVID-19 diagnostic testing,[24] providing Medicare coverage of monoclonal antibodies to treat COVID-19 with no cost-sharing,[25] and launching the Acute Hospital Care at Home program, a novel program that provides eligible hospitals with regulatory flexibilities to treat eligible patients in their homes throughout the course of the PHE.[26]

CMS took further steps to expand access to telehealth and other virtual services during the PHE, temporarily adding new services to the Medicare telehealth services list, publishing From Coverage to Care resources to support providers and patients to leverage virtual care,[27] and

releasing a new supplement to the State Medicaid & CHIP Telehealth Toolkit that provides examples and insights into lessons learned from states that have implemented telehealth changes.[28] Recognizing the benefit of expanded access to telehealth beyond the COVID-19 PHE, CMS permanently added more than 60 services to the Medicare telehealth list in the Calendar Year (CY) 2021 Physician Fee Schedule final rule. These will allow rural beneficiaries to maintain access to telehealth services, including certain emergency department visits, therapy services, and critical care services, and will allow teaching physicians to provide supervision through real-time audio and video communications technologies to residents located in rural settings after the PHE has ended.[29] CMS will continue to review and make permanent telehealth flexibilities where appropriate, soliciting feedback from rural communities to inform its decisions.

CMS supported rural providers during the PHE by developing a new web-based platform for providers and suppliers to submit 1135 waiver requests, and through payments for hospitals, including Critical Access Hospitals (CAHs), to incentivize the use of new products authorized to treat COVID-19.[30, 31] For Indian Health Service and tribal hospitals, CMS modified Medicare payment policies to allow COVID-19 diagnostic testing to be reimbursed at the Medicare outpatient Indian Health Service encounter rate.[32] Throughout the PHE, CMS has also regularly updated a variety of resources to keep rural providers and the public informed, including the CMS Rural Crosswalk to highlight COVID-19 flexibilities relevant to rural facilities, and the CMS Coronavirus Partner Toolkit, which has a specific section for rural areas. Recognizing the evolving needs of Americans during the pandemic, CMS also released new resources, like the Nursing Home Resource Center, an online platform to serve as a centralized hub for the latest information, guidance, and data on nursing homes.[33] CMS also issued guidance clarifying that existing COVID-19 Medicare flexibilities apply to Indian Health Service and tribal hospitals, and allowed them to bill Medicare for hospital outpatient services furnished remotely during the PHE.[34]

In January 2021, CMS invited the public to participate in three listening sessions to discuss the continued impact of COVID-19 on underserved populations, including racial and ethnic minorities, people with disabilities, sexual and gender minorities, people with limited English proficiency, and people living in rural areas.[35] Locally, CMS's Rural Health Coordinators partnered with rural providers and community organizations in their regions to support geographically isolated Americans. For example, in January 2021, CMS Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin) hosted a meeting with the State Offices of Rural Health and the Rural Health Associations from all six states to discuss the most effective ways to engage with and provide information to rural partners during the PHE. Region V's partnership with these organizations has been a powerful tool in designing messaging to reach rural and other marginalized populations who were significantly impacted by the COVID-19 pandemic. Similarly, in response to feedback from CAHs and Rural Health Clinics (RHCs) trying to navigate the economic and environmental changes of the COVID-19 PHE, CMS Region X (Washington, Oregon, Idaho, Alaska) coordinated with its State Hospital Associations and State Offices of Rural Health in Washington and Oregon, and with the Health Resources & Services Administration (HRSA), to explore creative solutions to rural providers' challenges, including facility integration and new collaborative relationships between rural providers.

Promoting COVID-19 Vaccine Administration

As COVID-19 vaccines were developed, authorized for emergency use, and approved by the U.S. Food & Drug Administration (FDA), CMS took several steps to facilitate equitable access to the vaccines for rural, low-income, and underserved populations. Compared to urban areas, rural communities have had lower COVID-19 vaccination rates, and rural residents who have received a vaccine have traveled farther for it.[36]

In October 2020, the Departments of Health and Human Services (HHS), Labor, and the Treasury issued an Interim Final Rule with Comment Period (IFC) requiring that most private health insurance plans cover, without cost-sharing, any COVID-19 vaccine that has a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), regardless of whether the immunization is recommended for routine use. The IFC also established that the vaccines would be covered under Medicare as a preventive service at no cost to beneficiaries.[37] Recognizing the costs involved in administering these new vaccines during the COVID-19 PHE, CMS in March increased the Medicare COVID-19 vaccine administration payment rate. CMS also allowed Medicare-enrolled immunizers, including pharmacies, to bill and receive direct reimbursement from Medicare for vaccinating Medicare skilled nursing facility residents, facilitating crucial access to the COVID-19 vaccines for a particularly high-risk population.[38]

Under the American Rescue Plan Act of 2021 (ARP, Pub. L. 117-2), state Medicaid and CHIP programs are temporarily required to cover COVID-19 vaccines and their administration, without cost sharing, for all CHIP enrollees and nearly all Medicaid enrollees. Under the ARP, state Medicaid and CHIP programs are also temporarily required to cover COVID-19 testing and COVID-19 related treatment without cost-sharing for all CHIP enrollees and a broad range of Medicaid enrollees.[39, 40, 41, 42] To further facilitate vaccine administration, CMS issued another IFC in May 2021 to ensure that long-term care facilities and residential facilities serving individuals with intellectual disabilities educate and offer the COVID-19 vaccines to residents, clients, and staff, and report COVID-19 vaccination status data weekly.[43] In June 2021, CMS announced an additional $35 Medicare payment for administering in-home COVID-19 vaccinations to bring the vaccines to Medicare beneficiaries who may have difficulty leaving their homes or who face clinical, socioeconomic, or geographical barriers to getting a COVID-19 vaccine in settings other than their home.[44]

Rural providers have shared with CMS the challenges in administering the vaccines in rural areas. In May 2021, CMS held a COVID-19 vaccine listening session with rural partners, at which attendees highlighted many barriers for rural residents, including long travel distances and not knowing where to get the vaccines. In June 2021, CMS Region IX (Arizona, California, Hawaii, Nevada, Pacific Territories) hosted a virtual rural town hall in Nevada, at which healthcare organizations from the state supported CMS strategies to encourage rural Americans to receive the COVID-19 vaccine.

To continue to build confidence in COVID-19 vaccinations, CMS raised public awareness and understanding of the vaccines in rural and tribal areas. CMS participated in the HHS We Can

Do This campaign, a national initiative designed to increase COVID-19 vaccination rates, which offers tailored vaccine resources and toolkits for a diverse set of users. In June 2021, CMS hosted a webinar to walk through the Rural Community Toolkit and is committed to training community organizations, local voices, and trusted leaders to use the campaign tools for vaccine outreach efforts.[45] CMS also worked with the Indian Health Service and tribal elders to raise public awareness and promote the vaccines in tribal communities. In FY 2021, more than 1.6 million COVID-19 vaccine doses were administered through the 352 Indian Health Service–operated healthcare facilities, tribal health programs, and urban Indian organizations, and over 55% of American Indians and Alaska Natives have received at least one vaccine dose.[46]

The Federally Facilitated and State Marketplaces

Access to health insurance is critical to rural Americans' ability to obtain needed care. Rural residents are more likely to be uninsured, and they often face higher health plan premiums and fewer plan options in the Federally Facilitated and State Marketplaces than their urban counterparts.[47, 48] In FY 2021, CMS sought to reduce costs for consumers in the Federally Facilitated and State Marketplaces, decreasing inequities in access to coverage for individuals in rural communities.

In February 2021, determining that the COVID-19 PHE presented exceptional circumstances for consumers in accessing health insurance, CMS provided access to a Special Enrollment Period through the HealthCare.gov platform, so individuals and families could apply for and enroll in the coverage they needed.[49] To support outreach, education, and enrollment efforts with underserved populations, including rural populations, CMS made approximately $2.3 million in additional funding available to current Navigator grantees for the Special Enrollment Period.[50] CMS Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming) hosted meetings throughout the region with HHS staff, Navigators, and certified application counselors to discuss the Special Enrollment Period, providing an opportunity for staff to share timely updates and creating a forum for Navigators and certified application counselors to share best practices and discuss regional issues.

CMS hosted listening sessions with rural partners across the country to ensure that promotional materials for the Special Enrollment Period were reaching rural communities and to gather feedback to inform future Open Enrollment campaigns. In July 2021, as part of the Summer Sprint to Coverage initiative, CMS held a Tribal Week of Action to encourage American Indian and Alaska Native enrollment during the Special Enrollment Period. CMS also hosted a series of panel discussions focused on best practices for agents and brokers

to connect with consumers from specific underserved or underinsured communities, which included discussions on rural, American Indian, and Alaska Native communities. More than 2.8 million Americans signed up for new health insurance coverage through HealthCare.gov and State Marketplaces during the Special Enrollment Period, including 9,400 American Indians and Alaska Natives.[51]

The ARP allowed CMS to make health coverage more affordable by increasing premium subsidies for many Americans to purchase health plans available through the Federally Facilitated and State Marketplaces.[52] These changes resulted in a 39% increase in the availability of zero-premium plans after advance payments of premium tax credits for uninsured non-elderly rural adults, and a 27% increase in the availability of low-premium plans after advance payments of premium tax credits, improving access to health insurance and lowering premiums for thousands of rural Americans.[53] Building on these efforts, CMS issued the Notice of Benefit and Payment Parameters for 2022 final rule part two, lowering the annual limit on consumers' maximum out-of-pocket costs by $400 from the proposed limit, and enhancing consumers' experience on the HealthCare.gov platform.[54]

In August 2021, CMS awarded $80 million in grant funding to 60 Navigator awardee organizations to support approximately 1,500 Navigators in states with a Federally Facilitated Marketplace for the 2022 plan year.[55] This is the largest funding allocation CMS has made available for Navigator grants to date, and will assist with education, outreach, and enrollment efforts in underserved and diverse communities. Of the 60 Navigator awardee organizations, 45 specifically mention rural and/or tribal communities as populations of focus.[56] CMS also announced $20 million in funding to support State Marketplaces to modernize or update their systems, programs, and technology to improve access to health insurance coverage in their states.[57]

Additionally, under the ARP, CMS provided $452 million to 13 states to implement section 1332 state-based reinsurance waivers. These waivers are designed to improve health insurance affordability, market stability, and access to care by reimbursing issuers for a portion of healthcare provider claims that could otherwise be paid by consumers through higher premiums.[58] In plan year 2021, states that have implemented section 1332 state-based reinsurance waivers for the individual market have seen statewide average premium reductions ranging from 4.92% to 41.17%. For example, Colorado's reinsurance waiver program targets higher premium reductions in rural areas of the state and encourages carriers to enter parts of the state with less carrier participation, which are largely rural and mountain areas.

FY 2021 also saw a continued expansion of coverage options for rural Marketplace consumers. The percentage of rural consumers who have a choice between two or more issuers rose from 73% in FY 2020 to 91% in FY 2021. Reporting by county, this represents a reduction from 629 rural counties that had only a single issuer offering coverage on the Marketplaces in FY 2020 to just 234 single issuer rural counties remaining in FY 2021.

Medicare Payment and Policy

Medicare provides critical coverage to millions of older and disabled adults, approximately one fourth of whom live in rural areas.[59] In FY 2021, CMS adopted policies under Medicare to improve the financial sustainability of rural providers and facilitate access to care for beneficiaries.

Supporting Providers through Medicare Fee-for-Service

CMS provides reimbursement and guidance to more than one million providers annually through its Medicare Fee-for-Service program.[60] Each year, CMS updates its Medicare payments and policies to better support its healthcare facilities and practitioners. In the CY 2021 Medicare Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System final rule with comment period, CMS adopted certain changes to the payment policies under the OPPS, which CMS estimates will result in a 2.9% payment increase to rural hospitals.[61] Additionally, in the CY 2022 Medicare Physician Fee Schedule proposed rule, CMS is seeking comments on whether to amend Medicare regulations to make all Indian Health Service and tribally operated outpatient facilities eligible for payment at the Medicare outpatient per visit rates.[62]

Locally, CMS has communicated with rural providers and beneficiaries as Medicare policies have been updated and revised. For example, CMS Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, Texas) partnered with TexLa Telehealth Resource Center to provide technical assistance and resources throughout Texas and Louisiana to rural practices with telehealth programs for Medicare beneficiaries. This partnership has allowed for swift dissemination of information amidst rapidly changing Medicare telehealth policies and has helped to promote the use of telehealth in more rural practices. Looking forward, CMS has proposed to further expand access to telehealth in rural and underserved communities in the CY 2022 Medicare Physician Fee Schedule proposed rule by allowing Medicare to pay for mental health services furnished through interactive telecommunications technology provided in RHCs and Federally Qualified Health Centers.[63] This rule also proposes provisions that, if finalized, would allow payment to eligible practitioners for providing behavioral health services via audio-only telephone calls, facilitating access to care for those in areas with poor broadband infrastructure.

Expanding Access for Beneficiaries through Medicare Advantage and Part D

Medicare Advantage plans and Medicare Part D plans provide important coverage options for many Medicare beneficiaries. Medicare Advantage plans cover all items and services under Medicare Parts A and B, and may choose to offer supplemental health benefits and/

or prescription drug coverage.[64] Approximately one quarter of Medicare beneficiaries in rural areas are enrolled in Medicare Advantage plans, and more than one half are enrolled in some type of Part D plan, with enrollment increasing in recent years for both.[65, 66]

The average deductibles for Medicare Advantage and Part D plans are higher for rural than urban beneficiaries, in part due to smaller risk pools and greater healthcare facility and practitioner shortages in rural areas.[67, 68] In FY 2021, CMS equipped beneficiaries, including those in rural areas and territories, with more information about the cost of Medicare Advantage and Part D plans and services. In January 2021, CMS posted the CY 2022 Medicare Advantage and Part D final rule, which requires Part D plans to offer a real-time benefit comparison tool, so beneficiaries can obtain information about lower-cost alternative therapies under their prescription drug benefit.[69] The rule also codifies existing policies around Medicare Advantage supplemental benefits, such as reductions in cost-sharing as an allowable supplemental health benefit.

Practitioner Workforce

CMS proposed and issued several policies that address persistent practitioner shortages and other workforce limitations in rural, frontier, and island communities.

Throughout FY 2021, the CMS Rural Health Coordinators strove to better understand and respond to workforce challenges in their regions. CMS Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont) experiences large population influxes during "ski season" and "water season" each year, exacerbating workforce shortages in rural facilities. In June 2021, CMS Region I staff conducted a virtual rural listening session with several New England state associations and rural partners, providing an opportunity for the Regional Office to better understand rural communities' largest workforce concerns and for staff to highlight CMS's current work and upcoming policies to improve workforce capacity.

CMS sought to reduce clinician burden and invest in primary care and care coordination in the CY 2021 Medicare Physician Fee Schedule by increasing payments to physicians and other practitioners for the additional time they spend with patients, especially those with chronic conditions.[70] In the same rule, CMS finalized changes allowing non-physician practitioners, who are vital members of the rural health workforce, to practice at the top of their licenses. This includes changes that allow physician assistants and nurse practitioners to supervise the performance of diagnostic tests, within their scope of practice and state law, as they maintain required relationships with supervising or collaborating physicians. In a separate final rule amending regulations governing the physician self-referral prohibition (commonly referred to as the "Stark law"), CMS created new exceptions to the prohibition that will permit physicians and other healthcare practitioners, providers, and suppliers to enter into certain financial relationships that support value-based care and improved patient care coordination.[71]

Looking forward, in the CY 2022 Physician Fee Schedule proposed rule, CMS proposes to allow physician assistants, who comprise a greater proportion of the healthcare workforce in rural than in urban areas, to bill Medicare directly for the services they furnish.[72, 73] In this proposed rule, CMS also proposes to revise eligibility requirements in the Quality Payment Program Merit-based Incentive Payment System (MIPS) to allow clinical social workers and certified nurse-midwives to be MIPS-eligible clinicians, recognizing that these professionals are often at the forefront of serving rural communities with acute healthcare needs.

Medicaid and CHIP Enrollment, Payment, and Policy

Implemented through partnerships between CMS and states, Medicaid and CHIP are vital resources for many Americans, including infants and children, pregnant and postpartum women, low-income enrollees, people with disabilities, and Medicare-Medicaid enrollees (individuals eligible for both Medicare and Medicaid). Approximately 25% of non-elderly rural individuals nationwide have Medicaid or CHIP coverage.[74] In FY 2021, CMS took steps to help ensure that state Medicaid and CHIP programs facilitate access to more comprehensive, equitable care for their enrollees.

Recognizing that social determinants of health (SDOH), such as lack of access to nutritious food or convenient, reliable transportation, can exacerbate health disparities for rural and other underserved populations, CMS published a State Health Official letter describing opportunities under Medicaid and CHIP for states to address SDOH.[75] The letter provides guidance to states interested in designing programs, benefits, and services to more effectively improve population health, reduce disability, and lower overall healthcare costs in the Medicaid and CHIP programs through addressing SDOH.

In a further commitment to improving access to Medicaid coverage, section 9814 of the ARP encourages the remaining states that have not yet expanded their Medicaid eligibility under the Patient Protection and Affordable Care Act (ACA, Pub. L. 111-148) to do so by temporarily increasing the Federal Medical Assistance Percentage (FMAP) for certain state expenditures by five percentage points.[76] Rural residents in states that have not expanded Medicaid are more likely to be uninsured than those in states that have, and rural hospitals in non-expansion states are at greater risk of having to manage high levels of uncompensated care; if these ARP provisions result in Medicaid coverage expansions, they should help facilitate access to care, support providers, and bolster health systems in rural communities.[77, 78] In July 2021, Oklahoma expanded Medicaid, improving access to coverage for primary and preventive care, emergency and substance use disorder services, and prescription drug benefits for approximately 190,000 adults aged 19-64 and at or below 133% of the federal poverty line. Under the ARP, Oklahoma is eligible to receive the temporary five percentage point FMAP increase, estimated to be nearly $500 million over two years.[79]

Long-Term Services and Supports

Millions of Americans, including children, adults, and seniors, need long-term care services due to disabling conditions and chronic illnesses. Long-term services and supports (LTSS) encompass a wide range of medical and nonmedical supportive services. These services include institutional care, like care provided in nursing and mental health facilities, and home and community-based services (HCBS), such as personal care and home health.

LTSS are becoming increasingly important as rural Americans grow older, and most rural Americans prefer to remain in their own homes and communities as they age.[80] Thus, HCBS that deliver person-centered care to individuals in their homes and the community are critical in rural and frontier communities. However, rural residents are less likely to use HCBS than their urban counterparts, partly due to limited program availability in rural areas.[81]

Medicaid is the primary payer of LTSS in the U.S., accounting for about 52% of all LTSS spending.[82] In November 2020, CMS published the LTSS Rebalancing Toolkit to support states in their efforts to expand and enhance HCBS equitably and to rebalance, or recalibrate, LTSS from institutional to community-based systems.[83] The report highlights specific rural considerations, including rural nursing facility closures, changing rural demographics, and barriers to accessing HCBS in rural communities.

To further support efforts to enhance, expand, and strengthen HCBS through the Medicaid program, states are eligible for a temporary 10 percentage point increase in federal funding through Medicaid's FMAP for HCBS under section 9817 of the ARP.[84, 85] Moreover, CMS announced a supplemental funding opportunity for the 33 states operating Money Follows the Person demonstrations, a program that supports state efforts to redesign their LTSS systems so Medicaid enrollees have a choice of where they live and receive services.[86] The opportunity makes available up to $5 million in grant funds for each eligible state to accelerate LTSS system transformation design and implementation and to expand HCBS capacity. The Consolidated Appropriations Act of 2021 (Pub. L. 116-260) extended funding for the Money Follows the Person demonstration through 2023.[87]

In addition to promoting adequate access to HCBS in rural communities, CMS is committed to improving the quality of HCBS. CMS issued a Request for Information (RFI) on a recommended quality measure set for Medicaid-funded HCBS, requesting comments by November 2020.[88] The draft measure set includes recommendations for analysis of one or more measures by race, ethnicity, primary language, and rural/urban status, and the RFI sought feedback on the potential benefits and challenges that could result from a national set of quality measures for voluntary use.

Additionally, through its LTSS Technical Assistance Center, CMS distributed monthly newsletters with information related to planning and implementing LTSS programs in tribal

communities, and hosted monthly webinars on LTSS topics, including the Native Aging in Place Project, the Alaska Native Traditional Foods Movement, Fall Prevention for Native Elders, HomeFit and Caregiving, and Staffing Shortages in Tribal Facilities.[89] With approximately 40% of American Indians and Alaska Natives living in rural areas, long-term care planning tailored to meet the specific needs of tribal populations is imperative for rural communities.[90]

Maternal Health

Inequities in maternal health outcomes are a concern for rural communities, as pregnant women in rural areas face barriers to accessing maternal health services, including hospital and obstetric unit closures, workforce shortages, and lack of comprehensive health coverage.[91] Therefore, CMS has made it a priority to collaborate across the Agency and HHS, as well as engage with rural partners, to reduce rural maternal health disparities.

In December 2020, CMS launched the second phase of the Maternal and Infant Health Initiative to support state Medicaid and CHIP agencies through targeted technical assistance in their efforts to improve maternal and infant health outcomes.[92] As part of the second phase, CMS created the Postpartum Care Learning Collaborative to provide strategies for states and their partners to improve postpartum care.[93] This phase builds on the first phase of the Maternal and Infant Health Initiative that focused on improving the rate and quality of postpartum visits and increasing the use of effective methods of contraception among women in Medicaid and CHIP.

In May 2021, the CMS Rural Maternal Health Workgroup, an internal multidisciplinary group of Agency experts, launched to identify actions that CMS can undertake to advance rural maternal health equity. This work expands upon previous CMS efforts to engage national, regional, and local partners to improve maternal health outcomes in rural communities, including assembling a Rural Obstetric Readiness workgroup of 26 rural health, maternal health, pediatric, emergency services, and public health experts from June to November 2020 to draft considerations to help rural hospitals without obstetric services and rural emergency medical services prepare for obstetric emergencies, and soliciting feedback through the 2020 RFI on rural and infant healthcare.

In addition, the ARP included sections 9812 and 9822 to support pregnant and postpartum women through Medicaid, which pays for approximately 43% of births in rural areas, and CHIP.[94] The provisions offer an option for states, beginning in April 2022, to provide 12 months of continuous, postpartum coverage for pregnant women enrolled in Medicaid and CHIP. Beneficiaries eligible for the continuous postpartum coverage must be provided full benefits under the state plan.[95] States opting to extend postpartum coverage for pregnant women in Medicaid must generally also opt to similarly extend postpartum coverage under their separate CHIP plan. Soon after the ARP passed, CMS approved a Medicaid demonstration under

section 1115 in Illinois to allow the state to extend postpartum coverage to Medicaid-eligible women beyond the required 60 day postpartum period to 12 months, making it the first state to extend postpartum coverage to all pregnant women under Medicaid for 12 months.[96] This approval will help ensure access to vital healthcare services, promote better health outcomes, and positively impact maternal morbidity and mortality in Illinois.

To further support efforts focused on improving maternal and perinatal health, CMS regularly collects and reports key maternal health metrics, leveraging those insights to address maternal health outcomes and advance maternal health equity. CMS identified a core set of 11 measures for voluntary reporting by state Medicaid and CHIP agencies in the 2021 Maternity Core Set, which CMS will use to measure and evaluate progress toward improving maternal and perinatal health in Medicaid and CHIP.[97] CMS also published the Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health, which provides an overview of the demographics, health status, health outcomes, risk factors, and healthcare utilization among reproductive age women, women with a recent live birth, and infants covered by Medicaid and CHIP.[98] Additionally, in the FY 2022 Hospital Inpatient Prospective Payment System and Long-Term Care Prospective Payment System final rule, CMS added a maternal morbidity structural measure to the Hospital Inpatient Quality Reporting Program that will assess hospital participation in state and national perinatal quality improvement initiatives, as well as their implementation of safety practices or bundles to improve maternal health outcomes.[99]

Mental Health and Substance Use Disorders

Rural, frontier, and tribal communities suffer from high rates of opioid overdoses and drug-related deaths, and rural residents face barriers to accessing mental health and substance use disorder treatment.[100, 101] Mental health conditions and feelings of social isolation have worsened during the COVID-19 PHE, as individuals have forgone millions of primary, preventive, and mental healthcare visits, and mental health services have been slow to rebound.[102, 103] In FY 2021, CMS explored innovative models and issued policies to improve access to substance use disorder treatment and mental health services and make opioid prescribing patterns safer.

In December 2020, CMS issued a final rule to modernize Medicaid prescription drug purchasing and encourage payment innovation by providing states, private payers, and manufacturers more flexibility to enter into value-based purchasing arrangements for prescription drugs.[104] Additional changes in this final rule are designed to promote safe prescribing of opioids through state Medicaid Drug Utilization Review programs, which is essential to prevent and reduce opioid misuse and abuse. CMS also released guidance

about provisions in the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, Pub. L. 115-271) requiring state Medicaid programs to cover all drugs and biologics approved by the FDA to treat opioid use disorder, including methadone, along with related counseling services and behavioral therapies.[105] Moreover, the ARP offers an option for states to receive certain flexibilities under the Medicaid program to provide qualifying community-based mobile crisis intervention services for individuals experiencing a mental health or substance use disorder crisis and receive an initial 85% FMAP rate for services furnished through this initiative.[106] CMS subsequently awarded $15 million to 20 state Medicaid agencies to develop and implement programs that provide community-based mobile crisis intervention services.[107]

CMS also explored innovative methods to improve access to substance use disorder treatment. In April 2021, CMS announced the selected applicants for the Value in Opioid Use Disorder Treatment Demonstration, a new four-year demonstration that aims to increase access to opioid use disorder treatment services to eligible Medicare Fee-for-Service beneficiaries, including those dually eligible for Medicare and Medicaid.[108] Eligible participants include RHCs, CAHs, and Federally Qualified Health Centers. In December 2020, CMS also announced the approval of both the Oklahoma and Maine section 1115 demonstrations to expand treatment for substance use disorders in their states, which represented the 30th and 31st approvals to states to broaden treatment services available to Medicaid beneficiaries diagnosed with substance use disorders.[109]

The CMS Rural Health Coordinators leveraged local partnerships to expand community awareness of mental health and substance use disorder treatment, services, and education opportunities in their regions. For example, CMS Region VII (Iowa, Kansas, Missouri, Nebraska) worked with grassroots organizations and regional partners at the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish a robust behavioral health network to actively serve rural communities. The CMS Regional Office conducted outreach around treatment and services for mental health and substance use disorders, including sharing information from the Missouri Opioid Task Force with local partners and meeting with regional behavioral health organizations to discuss opioid outreach in their communities.

Models and Demonstrations

CMS is designing and testing new models of care to advance rural health equity, improve the rural healthcare delivery system, and lower costs. In FY 2021, CMS administered and evaluated several national models in rural, frontier, and geographically isolated areas, publishing evaluation reports for models that encourage and support rural participation.

Through the Community Health Access and Rural Transformation (CHART) Model, CMS aims to continue addressing disparities, providing a way for rural communities to

transform their healthcare delivery systems by leveraging innovative financial arrangements as well as operational and regulatory flexibilities through two tracks: the Community Transformation Track, and the Accountable Care Organization (ACO) Transformation Track. The Community Transformation Track will test whether predictable capitated payments combined with community-specific strategies to redesign healthcare delivery facilitate improved access to high-quality care while reducing healthcare costs. This track includes upfront funding for Lead Organizations—single entities that represent rural communities—that will coordinate with key model partners (e.g., participating hospitals, payers) to lead the development and implementation of transformation plans. This year, CMS awarded funding to four Lead Organizations that collectively represent approximately 300,000 Medicare Fee-for-Service beneficiaries in rural and tribal communities across four states. CMS plans to release a Request for Application for the ACO Transformation Track in 2022.[110]

Through the Frontier Community Health Integration Project Demonstration, CMS tested new models of integrated, coordinated healthcare at low-volume, frontier CAHs in Montana, Nevada, and North Dakota. The model enhanced payments for Medicare Part B ambulance services, increased bed capacity for skilled nursing facility or nursing facility level of care, and increased originating site payments for telehealth services.[111] In November 2020, CMS published the demonstration's final evaluation report, showing that some participating CAHs used the expanded cost-based payments to bolster the emergency medical technician workforce, and that all CAHs reported high patient satisfaction with telehealth because care could be received locally without extensive travel.[112] In August 2021, CMS announced the extension of this demonstration for an additional five-year period.

The Accountable Health Communities Model, which addresses whether identifying health-related social needs such as food insecurity, housing instability, and lack of access to transportation can, through enhanced clinical-community linkages, improve health outcomes and reduce costs, has shown promising results for participating rural organizations.[113, 114] Participants use the Accountable Health Communities Social Needs Screening Tool to identify health-related social needs among Medicare and Medicaid beneficiaries, enabling staff to better connect beneficiaries with community resources that can address their needs.[115] In June 2021, CMS released a new user guide that leverages the experiences of organizations participating in the Accountable Health Communities Model to provide key insights for implementing universal screening for health-related social needs.[116] The guide is designed to help healthcare and social services providers apply the Screening Tool in a wide range of clinical settings.

Two other national models, the Million Hearts® Cardiovascular Disease Risk Reduction Model and the Comprehensive Primary Care Plus Model, released evaluation reports in FY 2021. The Million Hearts® Model is a randomized controlled trial that seeks to bridge the gap in cardiovascular care by providing targeted incentives for healthcare practitioners to engage in individual cardiovascular disease risk calculation and population-level risk management.[117] This

year, the Million Hearts® Model released its third annual evaluation report, showing reductions in cardiovascular disease risk scores and the all-cause death rate for the intervention group, 28% of whom were from rural areas.[118] The Comprehensive Primary Care Plus Model, a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation, also released its third annual evaluation report, the results of which show promising improvements for service use and quality of care in both rural and urban areas.[119] In FY 2021, CMS also proposed changes to the End-Stage Renal Disease Treatment Choices Model to encourage dialysis providers to decrease disparities in rates of home dialysis and kidney transplants, and to the Medicare Diabetes Prevention Program expanded model to make it easier for local suppliers to participate.[120, 121]

In addition to testing national models, CMS provided states with the flexibility to transform rural healthcare delivery through tailored interventions. The Maryland Total Cost of Care Model, the first CMS model to hold a state fully at risk for the total cost of care for Medicare beneficiaries, entered its third program year.[122] Building upon CMS's Maryland All-Payer Model, this model seeks to ensure that all Maryland residents have access to quality healthcare in every corner of the state, whether rural or urban. Additionally, five new hospitals joined the Pennsylvania Rural Health Model beginning in 2021, bringing the total number of participating hospitals to 18 for its third year. The Pennsylvania Rural Health Model seeks to test whether care delivery transformation coupled with hospital global budgets can increase rural Pennsylvanians' access to high-quality care and improve their health, while also reducing the growth of hospital expenditures across payers and improving the financial viability of rural hospitals.[123] Lastly, the Vermont All-Payer ACO Model released its first evaluation report in FY 2021. The model includes a Medicare ACO initiative, tailored to meet the specific needs of Vermont's residents and providers, 65% of whom are rural.[124] The report highlighted findings showing that the model was associated with decreases in acute care stays and unplanned 30-day readmissions.[125]

Quality and Equity

CMS applies quality and equity lenses to all its programs, initiatives, and resources. To further improve the quality of care provided in rural communities and advance equitable outcomes, CMS has proposed policies, conducted research, and engaged with rural communities across the country. In May 2021, CMS, in partnership with the Office of Management and Budget, released an RFI on Methods in Leading Practices for Advancing Equity in Support for Underserved Communities through Government, seeking feedback on effective methods for assessing whether Agency policies and actions equitably serve all eligible individuals and communities, particularly those that are currently and historically underserved, including rural populations.[126]

CMS also partnered with the CMS Alliance to Modernize Healthcare Federally Funded Research and Development Center (Health FFRDC) to release the Examining Rural Hospital Bypass for Inpatient Services Report, the first national analysis to explore why rural Medicare beneficiaries choose to bypass their closest rural hospitals for inpatient care that is available locally.[127] This report expands upon a previous data highlight describing the extent to which rural Medicare Fee-for-Service beneficiaries bypass their local rural hospital for inpatient care. CMS further engaged the Health FFRDC to better understand access to diabetes self-management education services in rural communities, hosting a series of listening sessions with a variety of rural partners, including rural providers, patients, and tribal organizations, in May and June 2021. Feedback from these public meetings will help inform CMS's strategies to improve rural residents' access to diabetes self-management education services.

The CMS Rural Health Coordinators engage rural communities regionally through listening sessions, partner meetings, conferences, and myriad other events, collecting and disseminating information from CMS and other federal agencies. For example, CMS Region II (New Jersey, New York, Puerto Rico, Virgin Islands) hosted an event in May 2021 that showcased presentations from the Regional Administrator of SAMHSA and the New York state Lead for HRSA. The event also featured the COVID-19 Recovery Coordinator for the Regional Office of the Assistant Secretary for Preparedness and Response, who discussed preparations for the upcoming tropical storm season in rural island communities. The CMS Rural Health Coordinators from CMS Regions III (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia) and IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee) were invited to speak at prominent rural partner meetings on topics that included ground ambulance waivers, COVID-19 vaccine updates, and CMS proposed rules, underscoring the ongoing commitment of the Regional Offices to foster bi-directional relationships with rural providers and community organizations.

CMS strives to constantly improve the quality of care provided to its beneficiaries and enrollees through annual regulatory activity. In April 2021, CMS issued four proposed rules for FY 2022 that included RFIs on the use of Fast Healthcare Interoperability Resources in support of Digital Quality Measurement and Closing the Health Equity Gap.[128, 129, 130, 131] In July 2021, CMS issued the CY 2022 Home Health Prospective Payment System proposed rule, with proposals aimed at incentivizing payment for home health services based on value and quality for older adults and people with disabilities.[132] The rule seeks feedback on ways to achieve health equity for all beneficiaries, including enhancing reports on people who live in rural areas. Moreover, CMS is committed to collecting comprehensive, standardized data to identify disparities in healthcare delivery outcomes. Thus, in the CY 2022 Physician Fee Schedule proposed rule, CMS is soliciting feedback on the collection of demographic data to advance equity for all Medicare beneficiaries, including rural and tribal populations.[133]

The Way Forward

The activities and initiatives described in this report are part of an ongoing commitment to improving the health and well-being of CMS beneficiaries and healthcare consumers living in rural, frontier, tribal, and geographically isolated communities, including U.S. territories. Going forward, CMS plans to develop and implement programs and policies that foster access to high-quality care for rural patients, support rural providers, address unique rural healthcare economics, and reduce unnecessary burdens in the rural health system. CMS will continue to leverage its Rural Health Coordinators in the 10 CMS Regional Offices to build stronger partnerships with local organizations and support the unique and diverse needs of rural providers and communities. CMS is dedicated to supporting advancements and transformations of the rural health system to improve outcomes for Americans living in rural areas and advance rural health equity.

As in previous years, CMS is committed to continuing its ongoing work to improve access to care and quality in rural and tribal areas through initiatives that will build on the developments and achievements of FY 2021. CMS anticipates expanding promising programs, finalizing proposed rules based on public comment and feedback, and leveraging current research and community engagement activities to inform work across the Agency. CMS will also act, as feasible, to implement existing and new legislation and policies. For example, CMS looks forward to crafting policies surrounding the Rural Emergency Hospital designation and new Medicare-funded residency positions in rural and underserved communities. CMS will also support rural payers, providers, and communities as policies evolve.

CMS will continue this important work in collaboration with its rural partners to ensure that all individuals in rural communities have access to quality, affordable, and equitable healthcare.

Appendix: Acronym List

(Acronyms listed in alphabetical order)

Acronym	Full Term
ACA	The Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
ARP	The American Rescue Plan Act of 2021
CAH	Critical Access Hospital
CDC	Centers for Disease Control and Prevention
CHART	Community Health Access and Rural Transformation
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CY	Calendar Year
FDA	Food & Drug Administration
FFRDC	Federally Funded Research and Development Center
FMAP	Federal Medical Assistance Percentage
FY	Fiscal Year
HCBS	Home and Community Based Services
HHS	U.S. Department of Health & Human Services
HRSA	Health Resources & Services Administration
IFC	Interim Final Rule with Comment Period
LTSS	Long-Term Services and Supports
MIPS	Merit-based Incentive Payment System
OPPS	Outpatient Prospective Payment System
PHE	Public Health Emergency
RFI	Request for Information
RHC	Rural Health Clinic
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health

References

1 Rural Health Information Hub. (2019, April 8). What is rural? Retrieved from https://www.ruralhealthinfo.org/topics/what-is-rural

2 U.S. Department of Health & Human Services, Health Resources & Services Administration. (2021, January). Defining rural population. Retrieved from https://www.hrsa.gov/rural-health/about-us/definition/index.html

3 Parker, K., Horowitz, J.M., Brown, A., Fry, R., Cohn, D., & Igielnik, R. (2018, May 22). What unites and divides urban, suburban, and rural communities. Pew Research Center. Retrieved from https://www.pewresearch.org/social-trends/2018/05/22/demographic-and-economic-trends-in-urban-suburban-and-rural-communities/

4 U.S. Department of Agriculture Economic Research Services. (2018, November). Rural America at a glance: 2018 edition. Economic Information Bulletin 200. Retrieved from https://www.ers.usda.gov/webdocs/publications/90556/eib-200.pdf

5 Wells, C. (2020, June). Left behind: Health care in rural America. Select findings from the 7th annual consumer healthcare survey. Transamerica Center for Health Studies. Retrieved from https://www.transamericacenterforhealthstudies.org/docs/default-source/fact-sheets/urbanicity/tchs-urbanicity-report_final

6 Hing, E. & Hsiao, C. (2014, May). State variability in supply of office-based primary care providers: United States, 2012. U.S. Department of Health & Human Services, Centers for Disease Control & Prevention, National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db151.htm#

7 Lam, O., Broderick, B., & Toor, S. (2018, December). How far Americans live from the closest hospital differs by community type. Pew Research Center. Retrieved from https://www.pewresearch.org/fact-tank/2018/12/12/how-far-americans-live-from-the-closest-hospital-differs-by-community-type/

8 Hing, E. & Hsiao, C. (2014, May). State variability in supply of office-based primary care providers: United States, 2012. U.S. Department of Health & Human Services, Centers for Disease Control & Prevention, National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db151.htm#

9 U.S. Department of Health & Human Services, Health Resources & Services Administration Data Warehouse. (2021, March 31). Data downloads. Retrieved from https://data.hrsa.gov/data/download

10 Sharma, H., Baten, R.B.A., Ullrich, F., MacKinney, C., & Mueller, K.J. (2021, February). Trends in nursing home closures in nonmetropolitan and metropolitan counties in the United States, 2008-2018. University of Iowa RUPRI Center for Rural Health Policy Analysis. Retrieved from https://rupri.public-health.uiowa.edu/publications/policybriefs/2021/Rural%20NH%20Closure.pdf

11 University of North Carolina Cecil G. Sheps Center for Health Services Research. (2021, May). Rural hospital closures. Retrieved from https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

12 The Chartis Group, Chartis Center for Rural Health. (2020, February). The rural health safety net under pressure: Rural hospital vulnerability. Retrieved from https://www.ivantageindex.com/rural-hospital-vulnerability-study/

13 Anderson, G.F. & Bai, G. (2020, July 1). COVID-19 and the financial viability of US rural hospitals. Health Affairs. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20200630.208205/full/

14 Zhao, G., Okoro, C.A., Hsia, J., Garvin, W.S., & Town, M. (2019, December 1). Prevalence of disability and disability types by urban-rural county classification—U.S., 2016. American Journal of Preventive Medicine. Retrieved from https://www.ajpmonline.org/article/S0749-3797(19)30332-0/fulltext

15 Department of Health & Human Services, Agency for Healthcare Research & Quality. (2017, October). National healthcare quality and disparities report. Chartbook on rural health care. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/chartbooks/qdr-ruralhealthchartbook-update.pdf

16 U.S. Department of Health & Human Services, Centers for Disease Control & Prevention. (2020, June 9). Urban-rural differences in COPD. Retrieved from https://www.cdc.gov/copd/features/copd-urban-rural-differences.html

17 Moy, E., Garcia, M.C., Bastian, B., Rossen, L.M., Ingram, D.D., Faul, M., Massetti, G.M., Thomas, C.C., Hong, Y., Yoon, P.W., & Iademarco, M.F. (2017, January 13). Leading causes of death in nonmetropolitan and metropolitan areas—United States, 1999-2004. U.S. Department of Health & Human Services, Centers for Disease Control & Prevention. Retrieved from https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm?s_cid=ss6601a1_w

18 Rural Health Research Gateway. (2017, November). Rural behavioral health. Retrieved from https://www.ruralhealthresearch.org/assets/658-1990/rural-behavioral-health-recap.pdf

19 Kozhimannil, K.B., Interrante, J.D., Henning-Smith, C., & Admon, L.K. (2019, December). Rural-urban differences in severe maternal morbidity and mortality in the U.S., 2007-15. Health Affairs. Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00805

20 Ely, D.M., Driscoll, A.K., & Mathews, T.J. (2017, September). Infant mortality rates in rural and urban areas in the United States, 2014. U.S. Department of Health & Human Services, Centers for Disease Control & Prevention National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db285.htm

21 Rural Health Information Hub. (2019). Mortality by race for metro and nonmetro counties, 2019. Retrieved from https://www.ruralhealthinfo.org/charts/55

22 James, C.V., Moonesinghe, R., Wilson-Frederick, S.M., Hall, J.E., Penman-Aguilar, A., & Bouye, K. (2017, November 17). Racial/ethnic health disparities among rural adults—United States, 2012-2015. U.S. Department of Health & Human Services, Centers for Disease Control & Prevention. Retrieved from https://www.cdc.gov/mmwr/volumes/66/ss/ss6623a1.htm

23 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2019, September) Improving access to maternal health care in rural communities, Issue brief. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf

24 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, February 26). FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act implementation part 44. Retrieved from https://www.cms.gov/files/document/faqs-part-44.pdf

25 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2020, November 1). CMS takes steps to ensure Medicare beneficiaries have wide access to COVID-19 antibody treatment. Retrieved from https://www.cms.gov/newsroom/press-releases/cms-takes-steps-ensure-medicare-beneficiaries-have-wide-access-covid-19-antibody-treatment

26 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (n.d.). Acute Hospital Care at Home. Retrieved from https://qualitynet.cms.gov/acute-hospital-care-at-home

27 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services Office of Minority Health. (2021, January 22). C2C COVID-19 resources. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/consumerresources/c2c-covid-19-resources

28 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2020, October 14). State Medicaid & CHIP Telehealth Toolkit, Policy consideration for states expanding use of telehealth, COVID-19 version: Supplement #1. Retrieved from https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf

29 Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment

Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID–19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID–19, 85 FR 84,472 (2020, December 28).

30 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services Center for Clinical Standards and Quality. (2021, January 11). New platform for submissions of 1135 waiver requests and inquiries—Go Live. Retrieved from https://www.cms.gov/files/document/qso-21-11-all.pdf

31 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2020, November 10). CMS takes steps to ensure Medicare beneficiaries have wide access to COVID-19 antibody treatment. Retrieved from https://www.cms.gov/newsroom/press-releases/cms-takes-steps-ensure-medicare-beneficiaries-have-wide-access-covid-19-antibody-treatment

32 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, October 6). COVID-19 frequently asked questions (FAQs) on Medicare fee-for-service (FFS) billing. Retrieved from https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

33 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, March 10). Nursing Home Center. Retrieved from https://www.cms.gov/nursing-homes

34 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, July 2). COVID-19 frequently asked questions (FAQs) on Medicare fee-for-service (FFS) billing. Retrieved from https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

35 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, January 21). COVID-19 listening sessions with CMS Office of Minority Health—January 22, 26, & 28. Retrieved from https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2021-01-21-mlnc

36 Murthy, B.P. et al. (2021, May 21). Disparities in COVID-19 vaccination coverage between urban and rural counties—United States, December 14, 2020-April 10, 2021. U.S. Department of Health & Human Services, Centers for Disease Control & Prevention. Retrieved from https://www.cdc.gov/mmwr/volumes/70/wr/mm7020e3.htm

37 Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 FR 71,142 (2020, November 2).

38 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2020, October 16). Enforcement discretion relating to certain pharmacy billing. Retrieved from https://www.cms.gov/files/document/snf-enforcement-discretion-letter.pdf

39 American Rescue Plan Act of 2021, Public Law No. 117-2 § 9811 (2021)

40 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, May 5). Coverage and reimbursement of COVID-19 vaccines, vaccine administration, and cost-sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program. Retrieved from https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf

41 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, August 30). Temporary increases to FMAP under sections 9811, 9814, 9815, and 9821 of the ARP and administrative claiming for vaccine incentives, SHO# 21-004. Retrieved from https://www.medicaid.gov/sites/default/files/2021-08/sho-21-004_1.pdf

42 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, August 30). Medicaid and CHIP coverage and reimbursement of COVID-19 testing under the American Rescue Plan Act of 2021 and Medicaid coverage of habilitation services, SHO# 21-003. Retrieved from https://www.medicaid.gov/sites/default/files/2021-09/sho-21-003.pdf

43 Medicare and Medicaid Programs; COVID-19 Vaccine Requirements for Long-Term Care (LTC) Facilities and Intermediate Care Facilities for Individuals With Intellectual Disabilities (ICFs-IID) Residents, Clients, and Staff, 86 FR 26,306 (2021, May 21).

44 U.S. Department of Health & Human Services. (2021, June). Medicare payment for COVID-19 vaccination administration in the home. Retrieved from https://www.cms.gov/files/document/vaccine-home.pdf

45 U.S. Department of Health & Human Services. (n.d.). We Can Do This, COVID-19 public education campaign, rural communities. Retrieved from https://wecandothis.hhs.gov/rural-community-toolkit

46 U.S. Department of Health & Human Services, Indian Health Service. (2021, August 12). Coronavirus (COVID-19). Retrieved from https://www.ihs.gov/coronavirus/

47 Hing, E. & Hsiao, C. (2014, May). State variability in supply of office-based primary care providers: United States, 2012. U.S. Department of Health & Human Services, Centers for Disease Control & Prevention, National Center for Health Statistics. Retrieved from https://www.cdc.gov/nchs/products/databriefs/db151.htm#

48 Wengle, E., Blumberg, J., Holahan, J. (2018, November). Are Marketplace premiums higher in rural than in urban areas? Robert Wood Johnston Foundation. Retrieved from https://www.urban.org/sites/default/files/publication/99341/moni-ruralurban_-_final_1.pdf

49 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, January 28). 2021 Special Enrollment Period in response to the COVID-19 emergency. Retrieved from https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency

50 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, March 1). CMS announces additional Navigator funding to support Marketplace Special Enrollment Period. Retrieved from https://www.cms.gov/newsroom/press-releases/cms-announces-additional-navigator-funding-support-marketplace-special-enrollment-period

51 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (n.d.). 2021 final Marketplace special enrollment period report. Retrieved from https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf

52 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, March 12). American Rescue Plan and the Marketplace, Fact sheet. Retrieved from https://www.cms.gov/newsroom/fact-sheets/american-rescue-plan-and-marketplace

53 Branham, K.D., Conmy, A.B., DeLeire, T., Musen, J., Xiao, X., Chu, R.C., Peters, C., & Sommers, B.D. (2021, April 1). Access to Marketplace plans with low premiums on the federal platform. U.S. Department of Health & Human Services, Assistant Secretary for Planning & Evaluation. Retrieved from https://aspe.hhs.gov/system/files/pdf/265321/ASPE%20ACA%20Low%20Premium%20Plans%20Issue%20Brief%20II.pdf

54 Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards, 86 FR 24,140 (2021, May 5).

55 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, August 27). Biden-Harris Administration quadruples the number of health care Navigators ahead of HealthCare.gov open enrollment period. Retrieved from https://www.cms.gov/newsroom/press-releases/biden-harris-administration-quadruples-number-health-care-navigators-ahead-healthcaregov-open

56 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021). 2021 CMS Navigator cooperative agreement awards. Retrieved from https://www.cms.gov/files/document/2021-navigator-grant-recipients.pdf

57 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, June 21). State exchange modernization grant program, IE-HBE-21-001, CFDA 93.525. Retrieved from https://www.grants.gov/web/grants/search-grants.html?keywords=state-based

58 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, August). CCIIO data brief series, State innovation waivers: State-based reinsurance programs. Retrieved from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-Aug2021.pdf

59 Medicare Payment Advisory Commission. (2017, June). Medicare beneficiary demographics. Retrieved from http://www.medpac.gov/docs/default-source/data-book/jun17_databooksec2_sec.pdf

60 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2020, December 3). Medicare provider utilization and payment data. Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data

61 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; Physician-Owned Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots, Radiation Oncology Model; and Reporting Requirements for Hospitals and Critical Access Hospitals (CAHs) To Report COVID-19 Therapeutic Inventory and Usage and To Report Acute Respiratory Illness During the Public Health Emergency (PHE) for Coronavirus Disease 2019 (COVID-19), 85 FR 85,866 (2020, December 29).

62 Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements, 86 FR 39,104 (2021, July 23).

63 Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements, 86 FR 39,104 (2021, July 23).

64 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, Office of Minority Health. (2019, November). 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

65 Oyeka, O., Ullrich, F., & Mueller, K. (2019, April). Medicare Advantage enrollment update 2018. RUPRI Center for Rural Health Policy Analysis. Retrieved from https://rupri.public-health.uiowa.edu/publications/policybriefs/2019/Medicare%20Advantage%20Enrollment%20Update%202018.pdf

66 Jonk, Y., O'Connor, H., Casey, M., & Moscovice, I. (2013, May). Comparing rural and urban Medicare Part D enrollment patterns and prescription drug coverage rates. University of Minnesota Rural Health Research Center. Retrieved from http://rhrc.umn.edu/wp-content/files_mf/may2013partdpolicybrief.pdf

67 O'Connor, H., Henning-Smith, C., Casey, M., & Moscovice, I. (2015, July). Differences in Part D plans offered to rural and urban Medicare beneficiaries. University of Minnesota Rural Health Research Center. Retrieved from https://3pea7g1qp8f3t9ooe3z3npx1-wpengine.netdna-ssl.com/wp-content/uploads/2017/11/ruralurban-partd.pdf

68 Barker, A. (2019, December). Effect of population size on rural health insurance premiums in the federal employees health benefits program. Health Affairs. Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00912

69 Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, 86 FR 5,864 (2021, January 19).

70 Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equip-

ment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID–19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID–19, 85 FR 84,472 (2020, December 28).

71 Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 FR 77,492 (2020, December 2).

72 Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements, 86 FR 39,104 (2021, July 23).

73 U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality. (2012, January). Primary care workforce facts and states no. 3. Retrieved from https://www.ahrq.gov/sites/default/files/publications/files/pcwork3.pdf

74 Foutz, J., Artiga, S., & Garfield, R. (2017, April 25). The role of Medicaid in rural America. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/

75 Costello, A.M. (2021, January 7). Opportunities in Medicaid and CHIP to address social determinants of health (SDOH). U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

76 American Rescue Plan Act of 2021, Public Law No. 117-2 § 9814 (2021).

77 Foutz, J., Artiga, S., & Garfield, R. (2017, April 25). The role of Medicaid in rural America. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/

78 Kaufman, B.G., Reiter, K.L., Pink, G.H., & Holmes, G.M. (2016, September). Medicaid expansion affects rural and urban hospitals differently. Health Affairs. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0357

79 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, July 1). Oklahoma's Medicaid expansion will provide access to coverage for 190,000 Oklahomans. Retrieved from https://www.cms.gov/newsroom/press-releases/oklahomas-medicaid-expansion-will-provide-access-coverage-190000-oklahomans

80 American Association of Retired Persons (AARP). (2019, June). 2018 home and community preferences survey: A national survey of adults age 18-plus, A look at rural communities. Retrieved from https://www.aarp.org/content/dam/aarp/research/surveys_statistics/liv-com/2019/home-community-preferences-rural-communities.doi.10.26419-2Fres.00231.010.pdf

81 Coburn, A.F., Griffin, E., Thayer, D., Croll, Z., & Ziller, E. (2016, June). Are rural older adults benefiting from increased state spending on Medicaid home and community based services? Maine Rural Health Research Center. Retrieved from http://muskie.usm.maine.edu/Publications/rural/Medicaid-Home-Community-Based-Services-Rural.pdf

82 Murray, C., Tourtellotte, A., Lipson, D. & Wysocki, A. (2021, January 7). Medicaid long term services and supports annual expenditures report, Federal fiscal years 2017 and 2018. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf

83 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2020, November). Long-term services and supports rebalancing toolkit. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf

84 American Rescue Plan Act of 2021, Public Law No. 117-2 § 9817 (2021).

85 Costello, A.M. (2021, May 13). Implementation of American Rescue Plan Act of 2021 Section 9817: Additional support for Medicaid home and community-based services during the COVID-19 emergency. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf

86 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (n.d.). Money Follows the Person. Retrieved from https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html

87 Consolidated Appropriations Act of 2021, Public Law No. 116-260, Title II, § 204 (2021).

88 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2020, September). Request for information: Recommended measure set for Medicaid-funded home and community-based services. Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/downloads/rfi-hcbs-recommended-measure-set.pdf

89 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, May 18). Long-term services and supports technical assistance center. Retrieved from https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center

90 U.S Department of Health & Human Services, Office of Minority Health. (2021, May 21). Profile: American Indian/Alaska Native. Retrieved from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62

91 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2019, September) Improving access to maternal healthcare in rural communities, Issue brief. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf

92 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (n.d.) Maternal & infant health care quality. Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health-care-quality/index.html

93 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (n.d.) Improving postpartum care learning collaborative. Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/maternal-infant-health/quality-improvement/postpartum-care/index.html

94 Medicaid and CHIP Payment and Access Commission. (2020, January). Medicaid's role in financing maternity care. Retrieved from https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf

95 American Rescue Plan Act of 2021, Public Law No. 117-2 § 9812 (2021).

96 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, April 12). Illinois continuity of care and administrative simplification. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/il-continuity-care-admin-simplification-ca.pdf

97 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021). 2021 core set of maternal and perinatal health measures for Medicaid and CHIP (maternity core set). Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/downloads/2021-maternity-core-set.pdf

98 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2020, December). Medicaid and CHIP beneficiary profile: Maternal and infant health. Retrieved from https://www.medicaid.gov/medicaid/quality-of-care/downloads/mih-beneficiary-profile.pdf

99 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Changes to Medicaid Provider Enrollment; and Changes to the Medicare Shared Savings Program, 86 FR 44,774 (2021, October 1).

100 National Advisory Committee on Rural Health and Human Services. (2016, July). Families in crisis: The human service implications of rural opioid misuse. Retrieved from https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/rural/publications/2016-opioid-abuse.pdf

101 Rural Health Information Hub. (n.d.). Barriers to mental health treatment in rural areas. Retrieved from https://www.ruralhealthinfo.org/toolkits/mental-health/1/barriers

102 Panchal, N., Kamal, R., Cox, C., & Garfield, R. (2021, February 10). The implications of COVID-19 for mental health and substance use. Kaiser Family Foundation. Retrieved from https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

103 Centers for Medicare & Medicaid Services. (2020, October 31). Medicaid & CHIP and the COVID-19 Public Health Emergency, Preliminary Medicaid & CHIP data snapshot. Retrieved from https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot.pdf

104 Medicaid Program; Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Part Liability (TPL) Requirements, 85 FR 87,000 (2020, December 31).

105 Costello, A.M. (2020, December 30). Mandatory Medicaid state plan coverage of medication-assisted treatment. U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf

106 American Rescue Plan Act of 2021, Public Law No. 117-2 § 1947 (2021).

107 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, August 13). American Rescue Plan Act (ARP) of 2021: Section 9813 State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services, CMS-212-21-001, CFDA 93.639. Retrieved from https://www.grants.gov/web/grants/search-grants.html?keywords=93.639

108 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, May 6). Value in opioid use disorder treatment demonstration program. Retrieved from https://innovation.cms.gov/innovation-models/value-in-treatment-demonstration

109 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2020, December 22). CMS announces approval of Oklahoma & Maine's substance use disorder demonstrations, the 30th and 31st to expand access to combat the opioid crisis. Retrieved from https://www.cms.gov/newsroom/press-releases/cms-announces-approval-oklahoma-maines-substance-use-disorder-demonstrations-30th-and-31st-expand

110 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, May 12). CHART Model. Retrieved from https://innovation.cms.gov/innovation-models/chart-model

111 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. Frontier Community Health Integration Project Demonstration. Retrieved from https://innovation.cms.gov/innovation-models/frontier-community-health-integration-project-demonstration

112 Romaire, M., Rutledge, R., Haque, S., Moore, P., Banger, A., & DeStefano, S. (2020, November). Frontier Community Health Integration Project (PCHIP) Demonstration evaluation, Final evaluation report. RTI International. Retrieved from https://innovation.cms.gov/data-and-reports/2020/fchip-final-eval-rpt

113 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, June 7). Accountable Health Communities Model. Retrieved from https://innovation.cms.gov/innovation-models/ahcm

114 Rural Policy Research Institute Center for Rural Health Policy Analysis. (2020, November). Rural innovation profile: Accountable Health Communities Model – Two rural participants' experiences. Retrieved from https://ruralhealthvalue.public-health.uiowa.edu/files/Rural%20AHC%20Profile.pdf

115 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (n.d.). The Accountable Health Communities Health-Related Social Needs Screening Tool. Retrieved from https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

116 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, June). A guide to using the Accountable Health Communities Health-Related Social Needs Screening Tool: Promising practices and key insights. Retrieved from https://innovation.cms.gov/media/document/ahcm-screening-tool-companion

117 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, May 4). Million Hearts®: Cardiovascular Disease Risk Reduction Model. Retrieved from https://innovation.cms.gov/innovation-models/million-hearts-cvdrrm

118 Blue, L., Peterson, G., Kranker, K., Huffman, T., Steiner, A., Markovitz, A., Williams, M., Stewart, K., Rollison, J., Pu, J., Concannon, T., Hiatt, L., Quereshi, N., Ogbuefi, P., Magid, D., Conwell, L., & McCall, N. (2020, November). Evaluation of the Million Hearts® Cardiovascular Disease Risk Reduction Model: Third annual report. Mathematica. Retrieved from https://innovation.cms.gov/data-and-reports/2021/mhcvdrrm-thirdannevalrpt

119 Peikes, D. et al. (2021, January). Independent evaluation of the Comprehensive Primary Care Plus (CPC+), Third annual report. Mathematica. Retrieved from https://innovation.cms.gov/data-and-reports/2021/cpc-plus-third-anual-eval-report

120 Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; New Categories for Hospital Outpatient Department Prior Authorization Process; Clinical Laboratory Fee Schedule: Laboratory Date of Service Policy; Overall Hospital Quality Star Rating Methodology; Physician-Owned Hospitals; Notice of Closure of Two Teaching Hospitals and Opportunity To Apply for Available Slots, Radiation Oncology Model; and Reporting Requirements for Hospitals and Critical Access Hospitals (CAHs) To Report COVID-19 Therapeutic Inventory and Usage and To Report Acute Respiratory Illness During the Public Health Emergency (PHE) for Coronavirus Disease 2019 (COVID-19), 85 FR 85,866 (2020, December 29).

121 Medicare Program; End-Stage Renal Disease Prospective Payment System, Payment for Renal Dialysis Services Furnished to Individuals with Acute Kidney Injury, End-Stage Renal Disease Quality Incentive Program, and End-Stage Renal Disease Treatment Choices Model, 86 FR 36,322 (2021, July 9).

122 Maryland Health Services Cost Review Commission. (n.d.) Maryland's Total Cost of Care Model. Retrieved from https://hscrc.maryland.gov/Pages/tcocmodel.aspx

123 Pennsylvania Department of Health. (n.d.). Pennsylvania Rural Health Model. Retrieved from https://www.health.pa.gov/topics/Health-Innovation/Pages/Rural-Health.aspx

124 Rural Health Information Hub (2021, March 23). Vermont. Retrieved from https://www.ruralhealthinfo.org/states/vermont

125 Loganathan, S. (2021, August). Evaluation of the Vermont All-Payer Accountable Care Organization Model, first evaluation report. NORC at the University of Chicago. Retrieved from https://innovation.cms.gov/data-and-reports/2021/vtapm-1st-eval-full-report

126 Methods and Leading Practices for Advancing Equity and Support for Underserved Communities Through Government, 86 FR 24,029 (2021, May 5).

127 Knudson, A., Popat, S., Hu, W., Mueller, C., Hallman, V., & Miller, C. (2020, December). Examining rural hospital bypass for inpatient services. CMS Alliance to Modernize Healthcare. Retrieved from https://www.cms.gov/files/document/ruralhospitalbypassfinalreport.pdf

128 Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2022 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Proposed Changes to Medicaid Provider Enrollment; and Proposed Changes to the Medicare Shared Savings Program, 86 FR 25,070 (2021, May 10).

129 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, April 8). Fiscal Year 2022 Hospice Payment Rate Update Proposed Rule CMS-1754-P, Fact sheet. Retrieved from https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2022-hospice-payment-rate-update-proposed-rule-cms-1754-p

130 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, April 7). Fiscal Year (FY) 2022 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Proposed Rule (CMS-1748-P), Fact sheet. Retrieved from https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-inpatient-rehabilitation-facility-irf-prospective-payment-system-pps-proposed

131 U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2021, April 8). Fiscal Year (FY) 2022 Skilled Nursing Facility Prospective Payment System Proposed Rule (CMS-1746-P), Fact sheet. Retrieved from https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-skilled-nursing-facility-prospective-payment-system-proposed-rule-cms-1746-p

132 Medicare and Medicaid Programs; CY 2022 Home Health Prospective Payment System Rate Update; Home Health Value-Based Purchasing Model Requirements and Proposed Model Expansion; Home Health Quality Reporting Requirements; Home Infusion Therapy Services Requirements; Survey and Enforcement Requirements for Hospice Programs; Medicare Provider Enrollment Requirements; Inpatient Rehabilitation Facility Quality Reporting Program Requirements; and Long-Terms Care Hospital Quality Reporting Program Requirements, 86 FR 35,874 (2021, July 7).

133 Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements, 86 FR 39,104 (2021, July 23).