Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities

FY2024 Year in Review

November 2024

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From the Co-Chairs

As we approach two years since the Centers for Medicare & Medicaid Services (CMS) released the CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities, we reflect on our progress toward CMS' goals to (1) ensure affordable, accessible care for all, (2) eliminate avoidable differences in health outcomes, and (3) provide the care and support people need to thrive.

CMS actively engages in improving health outcomes in rural, Tribal, and geographically isolated (RTGI) communities (e.g., non-micropolitan areas, frontier regions, Tribal lands, islands, and US territories) through a range of strategic priorities across all its centers and offices. While many RTGI areas face unique challenges due to their remote locations and limited access to resources, they boast strong community ties and significant contributions to national and local economies through agriculture, fisheries, timber, drinking water, and energy.

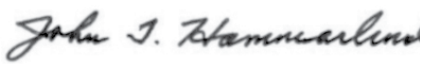
There is much for us to be proud of in fiscal year 2024. For example, we've increased investments to organizations vital to helping underserved communities, consumers, and small businesses find and enroll in quality, affordable health coverage through the Health Insurance Marketplace®[i] on HealthCare.gov. We have streamlined the prior authorization process for CMS-regulated programs such as Medicare Advantage (MA), Medicaid, and the Children's Health Insurance Program. In addition to these efforts, CMS began implementing a policy allowing Indian Health Services and Tribal facilities to convert to Rural Emergency Hospitals and released tailored resources for American Indians and Alaska Natives (AI/AN). These resources include a Tribal version of the Roadmap to Better Care, which details unique health protections in place for AI/AN people to help make health care coverage more accessible.

We also continued our commitment to those residing in the US territories, including improving access to and visibility of MA data; this is especially beneficial for Puerto Rico, which has the highest MA penetration rate across all US states and territories with 70% of its Medicare beneficiaries enrolled in an MA plan. CMS also participated in the Department of Health and Human Services visit to Guam and the Commonwealth of the Northern Mariana Islands, which included staff from the Administration for Children and Families, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and the Office of the Assistant Secretary for Health, as well as representatives from the Centers for Disease Control and Prevention.

CMS strives to improve the lives of all those served by our programs. We look forward to the work ahead and our continued collaboration and partnership with all those we serve to advance health care in rural, Tribal, and geographically isolated communities.

Sincerely,

Darci L. Graves
CMS Rural Health Council Co-Chair
CMS Office of Minority Health



John T. Hammarlund
CMS Rural Health Council Co-Chair
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[i] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

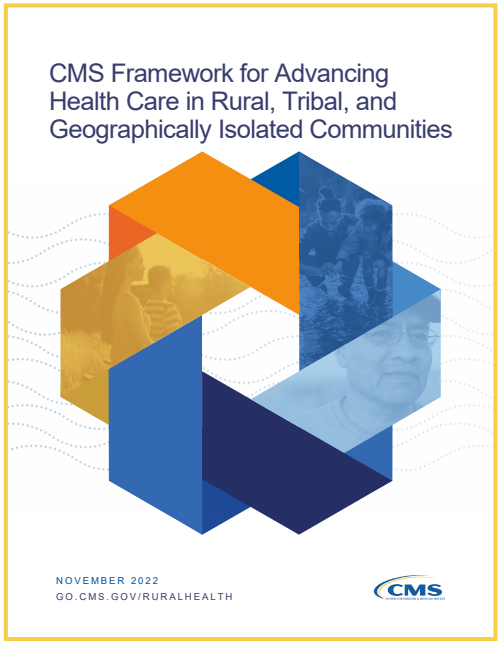
Executive Summary

In the United States, approximately one in five Americans reside in a rural, Tribal, or geographically isolated (RTGI) community.[1] These communities, made up of more than 67 million people, produce much of the nation's drinking water, food, and energy, and they have vibrant cultural heritages and strong community ties.[2] [3] Despite their economic and cultural importance, RTGI communities face challenges accessing essential health services and adequate health insurance coverage, which contribute to poor health outcomes and health inequities. Geographic barriers limiting access to services, resources, and opportunities can be further magnified for individuals with low incomes and for people of color, resulting in a complex intersection of place, class, and race. The use of a geographic lens is crucial in addressing these health disparities and advancing health equity in RTGI communities.

The Centers for Medicare & Medicaid Services (CMS) remains committed to working with RTGI communities to address disparities and advance access to high-quality, affordable health care. In alignment with the six pillars of the CMS strategic vision, CMS is working with its partners to achieve equity in access to care, quality of care, and healthy outcomes for RTGI communities. Grounded in the CMS Framework for Health Equity, CMS is working to identify and remedy systemic barriers to equity so that all those whom CMS serves can attain their optimal health, regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

CMS integrates its focus on geographic health equity across centers, programs, policies, and activities. CMS also engages partners, states, Tribes, and communities through the policymaking process and prioritizes creating and implementing innovative payment models to tackle complex health system challenges and drive health system innovation in RTGI areas. By fostering state, Tribal, and local engagement, convening diverse providers, and generating essential resources and tools, CMS aims to enhance the quality of care and health outcomes for residents in these underserved areas.

The CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities (RTGI Framework) guides and supports CMS' overall efforts to advance health equity, expand access to quality, affordable health coverage, and improve health outcomes for RTGI communities. The activities and accomplishments outlined in this report are presented in alignment with the RTGI Framework and represent CMS' commitment to advancing health equity for people living in RTGI communities.



This annual report highlights CMS' numerous activities and accomplishments in fiscal year (FY) 2024, beginning on October 1, 2023 and ending on September 30, 2024, including the following:

- **Streamlining the prior authorization process:** CMS finalized a rule (89 FR 8758) requiring Medicare Advantage, state Medicaid programs, and the Children's Health Insurance Program (CHIP) to streamline the prior authorization process, including adhering to specific prior authorization decision timeframes, providing specific reasons for denials, and annually publishing certain prior authorization metrics. These changes are expected to improve access to care for individuals in RTGI communities by reducing administrative burdens.
- **Indian Health Service (IHS) and Tribal facilities' conversion to Rural Emergency Hospitals (REHs):** CMS adopted a payment policy for IHS and Tribal Critical Access Hospitals and small hospitals, among others, to convert to REHs. This policy provides that these facilities receive payment for hospital outpatient services under the same All-Inclusive Rate as non-REH IHS or Tribal hospitals. This approach provides stability for the facilities and thus protects access to care for those served by the facilities.
- **2024 Rural Health Hackathon**: CMS hosted the first Rural Health Hackathon, a series of three in-person collaborative sessions aimed at addressing rural health challenges to generate solutions to improve clinical outcomes, increase access, and enhance care experiences for patients and providers in rural communities. The Hackathon built upon CMS' extensive outreach to rural communities through site visits and listening sessions to better understand rural health care issues.

These actions, along with the others highlighted in this report, detail CMS' commitment to improving health equity and addressing the unique needs of RTGI communities. CMS pursued a variety of different strategies to address these needs:

- **REGULATORY ACTIVITIES:** CMS engaged in rulemaking aimed at enhancing consumer protections, streamlining care processes, and protecting access to care. These actions include introducing access measures for managed care enrollees such as mandated maximum wait times for appointments, establishing a quality rating system for managed care enrollees' appointments, and allowing enrollees to compare plans based on quality and other factors.
- **PAYMENT POLICIES:** CMS introduced new payment policies to support health care providers all over the country, including in RTGI communities. These include separate payments for Community Health Integration and Social Determinants of Health Risk Assessment services, as well as updates to wage index payment methodologies for various health care facilities.
- **COVERAGE EXPANSION**: CMS expanded coverage and broadened eligibility across programs with initiatives such as extending postpartum coverage under Medicaid and CHIP for 12 months after giving birth. This effort aims to increase access to essential health services and reduce disparities in health outcomes for vulnerable postpartum populations.
- **TOOLS AND PUBLICATIONS**: CMS developed and disseminated resources to support health care providers and researchers. These include toolkits for Medicaid and CHIP telehealth, guidance for Medicaid eligibility redeterminations, and a new resource document of health equity–related data definitions to standardize across health equity research. CMS also published ownership data for all Medicare-Certified Hospices, Home Health Agencies, Federally Qualified Health Centers, and Rural Health Clinics. Making ownership information transparent benefits researchers and enforcement agencies by allowing them to identify familiar owners that have had histories of poor performance, analyze data and trends on how market consolidation impacts consumers with increased costs without necessarily improving quality of care, and evaluate the relationships between ownership and changes in health care costs and outcomes.

- **HEALTH SYSTEMS INNOVATION**: CMS continued to drive health systems innovation through models and demonstrations, such as launching the Making Care Primary Model and introducing the Innovation in Behavioral Health Model, Transforming Episode Accountability Model, and the Transforming Maternal Health Model. These models aim to improve patient care, reduce hospital readmissions, and enhance health outcomes by providing resources and technical assistance to states.
- **PARTNER ENGAGEMENT**: CMS actively engaged with health care leaders and partners across diverse geographies through road trips, conferences, and forums. Regional teams conducted nearly **2,100 engagements in CMS' ten regions** between January and August 2024. These engagements inform CMS programs and policies through the identification of opportunities and promising practices shared by those residing and working in rural communities.
- **COORDINATION AND OUTREACH**: CMS proactively engaged in open dialogue with RTGI communities to better understand and address their unique health care needs. For example, CMS staff traveled to Pacific and Caribbean territories this year to connect with local providers and government entities on how CMS can best support their health care systems and address health disparities. Through these coordination and outreach efforts, CMS staff gained valuable insights into the challenges these communities face and identified opportunities for collaboration and program improvements to enhance health care access and quality.

Table of Contents

Introduction

Addressing Health Equity for Rural, Tribal, and Geographically Isolated Communities

The term "rural, Tribal, and geographically isolated" (RTGI) encompasses a diverse range of communities, including non-micropolitan areas, frontier regions, Tribal lands, islands, and US territories. These areas often face unique challenges due to their remote locations and limited resources. However, they also possess important strengths, including strong community ties.[4] Many RTGI communities are vital to national and local economies through their contributions to agriculture, fisheries, drinking water, recreation, and energy.[5] Despite their importance, RTGI communities experience significant population health disparities compared to urban areas, driven by geographic isolation, limited health care infrastructure, and socioeconomic barriers.[6] Health equity and access to health care in these regions are pressing concerns, as residents often encounter substantial barriers to health care, including inadequate transportation, limited broadband access, and fewer health care providers.[7]

Geography is an important consideration for health outcomes and systems as population health in RTGI areas is influenced by factors such as higher rates of chronic diseases, behavioral health issues, and lower life expectancy.[8] Barriers to accessing high-quality health care include not only physical distance but also social determinants of health (SDOH) such as economic instability, educational limitations, and environmental factors.[9] Many RTGI communities are designated as Medically Underserved Areas and Health Professional Shortage Areas.[10] The US territories and Tribal Nations face similar challenges as rural areas due to geographic isolation, such as lack of broadband access, higher poverty rates, inadequate transportation, and health workforce shortages.[11] [12] As a result, these communities are often included in CMS programs designed for rural areas in order to address overlapping challenges and improve health outcomes. Increased attention to RTGI communities is essential to addressing health disparities and promoting equitable access to health care.

CMS Strategic Priorities Related to Rural Health

CMS' goals are to ensure that every person can access the care they seek at an affordable cost, eliminate avoidable differences in health outcomes, and provide the care and support people need to thrive. CMS is actively engaged in addressing and improving health outcomes in RTGI communities through a range of strategic priorities across all its centers and offices. These include:

The CMS Strategic Pillars: These pillars guide the agency's overall direction and include advancing health equity, improving the quality of care, and strengthening the nation's health care infrastructure. These priorities are interwoven into all CMS initiatives and policies to ensure comprehensive support for everyone CMS serves.

The CMS Framework for Health Equity 2022–2032: This long-term framework defines health equity as the attainment of the highest level of health for all people, whereby every person has a fair and just opportunity to attain their optimal health regardless of their race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, preferred language, and geography – including whether they live in a rural or other underserved community. The framework emphasizes the importance of addressing social determinants of health and implementing policies that promote equitable health care access and outcomes. The CMS Framework for Health Equity builds on the Biden-Harris

Administration's commitment to advancing racial equity and support for underserved communities through the federal government.

The CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities: This framework outlines the specific strategies and actions CMS is taking to improve health outcomes in RTGI areas. It focuses on community partnerships, enhancing data collection and transparency, and tailoring CMS programs to meet the needs of RTGI populations.

The Rural Health Cross-Cutting Initiative: This initiative is specifically designed to address the unique needs of RTGI populations by improving access to care, enhancing health care delivery systems, and fostering innovation in rural health practices.

The Rural Health Council: The CMS Rural Health Council convenes members across CMS to enhance health care access and innovation in RTGI regions and facilitate discussions on the impact of CMS policies on rural communities. Additionally, the Council supports Rural Health Coordinators from each Regional Office who regularly engage with rural communities.

Purpose of this Report

This report provides an overview of CMS' efforts to advance health equity and improve health outcomes in RTGI communities during fiscal year (FY) 2024 in alignment with the CMS RTGI Framework. This report examines various programs and policies implemented across all CMS centers, focusing specifically on activities with relevance to and impact on RTGI communities.

The scope of this report encompasses a wide range of CMS activities, from policy and regulatory activities to outreach and community engagement, all aimed at addressing the unique challenges RTGI communities face. By highlighting these efforts, the report demonstrates CMS' ongoing commitment to ensuring that all Americans, regardless of their geographic location, have access to high-quality, affordable health care.

Apply a Community-Informed Geographic Lens to CMS Programs and Policies

To incorporate a community-informed geographic lens into its programs, policies, and initiatives, CMS has engaged with local RTGI communities to elevate diverse voices and perspectives, particularly from communities that are underserved and disproportionately impacted by a lack of health care and other resources. Over the past year, CMS deepened relationships with RTGI communities to better understand their needs and the impacts of CMS programs and policies by engaging with RTGI communities, convening health care leaders from diverse geographies, and generating resources and tools for RTGI communities to use.

Engaging with Rural, Tribal, and Geographically Isolated Communities

CMS took proactive steps to regularly and meaningfully engage individuals living in RTGI communities to better understand how CMS programs and policies can meet their unique needs. The CMS Rural Health Coordinators conducted outreach across the ten CMS regions to engage with the

public locally. Through these engagements, the regions heard from diverse voices across the RTGI health care landscape, including sole community hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Accountable Care Organizations (ACOs), behavioral health providers, public health departments, and aging service providers, to strengthen their relationships across the health system. The CMS Rural Health Open Door Forum also served as a key platform this year for CMS to engage directly with people in RTGI communities.[13] Open dialogue from these sessions and the local engagement activities allow CMS to gain a better understanding of the challenges these communities face and enable CMS to disseminate important information about changes in regulations and quality program initiatives directly to RTGI communities.

To foster meaningful communication and address the specific needs of CAHs, CMS conducted a series of listening sessions to directly engage with these providers on their unique challenges and to share valuable updates. Staff from Regions 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont), 2 (New Jersey, New York, Puerto Rico, Virgin Islands), and 3 (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia) jointly hosted a 90-minute session with more than 80 CAHs from eight states. This forum allowed CMS to gain deeper insights into the unique experiences of small rural providers.

Additionally, Region 5 (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin) staff engaged with the State Offices of Rural Health, identifying maternal health as a pressing topic across the six states. As a result, CMS visited CAHs in Indiana and Minnesota to connect with providers and discuss concerns around the availability of obstetrical services in their communities and opportunities for CMS support. Region 7 (Iowa, Kansas, Missouri, Nebraska) and Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming) staff also hosted a listening session with CAHs and other providers in Kansas, North Dakota, and Wyoming that highlighted how rural providers are addressing behavioral health needs. These sessions exemplify CMS' commitment to open dialogue and support for CAHs, ensuring that the voices of rural health care providers are heard and valued. CMS shared the learnings from these engagements throughout the agency and incorporated key takeaways into future planning and program improvements.

CMS also engaged directly with people living on Tribal lands and in US territories, many of whom experience geographic isolation and have unique health and health care needs. CMS worked closely with Tribal communities and Tribal leaders, including through the CMS Tribal Technical Advisory Group and All Tribes Calls and Webinars, to seek input and advice on proposed rules and initiatives, enhance access to CMS programs including Medicare, Medicaid, and CHIP, hold trainings, and disseminate information on issues and policies with particular impact for American Indian and Alaska Native (AI/AN) enrollees. CMS also brought health coverage resources directly to Tribal communities through the Community Connections Tour to make it easier for people living in Tribal communities across Navajo Nation and different American Indian Pueblos in northern New Mexico to enroll in coverage.[14] Additionally, CMS staff visited the Caribbean territories of Puerto Rico and the US Virgin Islands in April 2024. During the visit, CMS staff met with 120 participants to understand the experiences of providing and accessing comprehensive health care across the US territories. CMS will use information collected from these sessions to design innovative solutions to challenges unique to the US territories.

In July 2024, CMS Region 9 (Arizona, California, Hawaii, Nevada, Pacific Territories) staff, alongside colleagues from other Department of Health and Human Services (HHS) agencies, visited Guam. In collaboration with staff across HHS operating divisions, CMS engaged

with several beneficiary and clinician partner organizations, including clinicians at each of the two Federally Qualified Health Centers (FQHCs) on the island, all three hospitals, staff and students supporting nurse and allied-health professional training programs at Guam Community College and University of Guam, and the Guam Behavioral Health and Wellness Clinic. These engagements allowed CMS to discuss key policies and priorities related to behavioral health, telehealth, health equity, and workforce development, as well as technical guidance for all provider types working to reopen after temporary closures in the wake of Typhoon Mawar. These key discussions identified several opportunities for further collaboration between CMS and the Guam Department of Public Health and Social Services to increase access to health care and reduce administrative burden on the island.

Convening Health Care Leaders from Diverse Geographies

CMS engaged with health care leaders, providers, and partners across the health care system to raise awareness of health equity issues in RTGI communities. CMS hosted the 2024 Quality Conference, attracting more than 5,000 health care leaders nationwide both virtually and in-person to address key health system challenges.[15] The conference showcased CMS' commitment to RTGI communities through a comprehensive agenda, diverse presenters, and sessions that highlighted the importance of health equity in quality care. The conference featured a session on applying a community-informed, geographic lens to CMS' work, focusing on the specific needs of people living in the US territories and Tribal Nations.

Additionally, the 2024 CMS Health Equity Conference convened federal agencies, health care provider organizations, community-based organizations, academic institutions, and others, both in-person and virtually.[16] The agenda included numerous sessions focused on RTGI communities, including sessions on Tribal health equity and the inclusion of the US territories in national datasets. CMS announced the 2024 Health Equity Award winners at the conference, including Augusta Health, which serves neighborhoods in Virginia's Shenandoah Valley with rural geographic barriers and local cities with high poverty rates and adverse social and health barriers through the Primary Care Mobile Clinic program.[17]

This year, CMS took proactive steps to collaborate with RTGI providers and health care leaders on innovative solutions to their unique geographic challenges. CMS hosted the first Rural Health Hackathon, a series of collaborative sessions aimed at addressing rural health challenges. The sessions brought together various voices, including care providers, community organizations, tech entrepreneurs, and policy experts, to generate solutions to improve clinical outcomes, increase access to care, and enhance care experiences for patients and providers in rural communities. Additionally, CMS Region 10 (Alaska, Idaho, Oregon, and Washington) staff facilitated a meeting with hospital associations and regional staff from other federal agencies, including the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), to discuss emergency department boarding and discharge challenges. These conversations led to the implementation of tracking methods in Alaska and Idaho, expanded data collection in Washington and Oregon, and enhanced coordination across departments to improve service transitions.

Generating Resources and Tools to Ensure Quality Care and Continued Coverage

Recognizing the complexities of eligibility redeterminations for Medicaid and CHIP, with particular attention to the "unwinding" of coverage following the end of the Medicaid continuous enrollment condition authorized by the Families First Coronavirus Response Act, CMS developed resources for providers, states, and enrollment assisters to ensure continuity of health care coverage for eligible individuals, including those living in RTGI communities. CMS released specific resources for Tribal communities and Indian Health Care Providers (IHCPs) to ensure they have the resources they need to assist their communities with the Medicaid and CHIP eligibility renewal process.[18] CMS also released the Tribal Protections in Medicaid and CHIP Managed Care Oversight Toolkit that provides resources for states, managed care plans,[ii] and IHCPs to maximize the benefits of Medicaid and CHIP delivered through managed care plans for AI/AN enrollees.[19] These resources are critical in addressing the unique health coverage needs of AI/AN enrollees, who have the highest uninsured rate among demographic groups in the US.[20]

In addition to creating resources, CMS continued to invest in Marketplace Navigators in rural and underserved areas through a new Notice of Funding Opportunity, which will offer up to $500 million in grants for five years. Through these grants, CMS will make 120 awards to organizations, including those serving RTGI communities, to support Navigators in the Federally-facilitated Marketplaces.[21] Emphasizing this commitment, CMS awarded $100 million to 44 Navigator grantees in states with Federally-facilitated Marketplaces, specifically targeting underserved communities.[22] Among these Navigator grantees is Rural Health Project, Inc., which will target 12 rural counties in northwestern Oklahoma – home to one of the largest US populations of citizens from the Marshall Islands. By providing language support in Marshallese, Rural Health Project is one of several Navigator groups working to improve the quality and cultural competency of Navigator services. Navigators are important for rural and underserved communities as they assist consumers in establishing eligibility, preparing applications, and enrolling in coverage, facilitating the enrollment of a record-breaking 21.4 million people who signed up for Marketplace coverage during open enrollment this year.[23]

In 2023, CMS launched a series of resources to support the enhancement of Medicaid School-based Services (SBS), including:

- a comprehensive guide to SBS, Delivering Services in School-based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming,
- a Technical Assistance Center (TAC) to help engage states, and
- a $50 million state grant initiative to enhance and expand school-based health services, particularly behavioral health services, through Medicaid and CHIP.

Supported by the Bipartisan Safer Communities Act, the grants will distribute up to $2.5 million to awarded states.[24] This initiative uses schools as a setting for Medicaid health care delivery services, potentially benefiting children in rural areas by reducing travel for health appointments and improving follow-up care. In alignment with these efforts, CMS released the first set of Medicaid School-Based Services Frequently Asked Questions (FAQs), which address frequently asked policy questions from state Medicaid and education agencies, local education agencies, and school-based entities as they work to provide greater assistance to children enrolled in Medicaid. The TAC supports the operationalization of school-based services, providing resources to enhance early identification of health needs and connect students to a broad range of health care services, including behavioral health resources.

[ii] "Managed care plans" means managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, as defined in 42 CFR 438.2. The toolkit describes the statutory framework that allows states and Tribes to establish an Indian Managed Care Entity, which may include managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, primary care case management programs, or primary care case management program entities, per regulations at 42 CFR 438.14.

CMS also launched new resources to support individuals enrolling in and maintaining Medicaid and CHIP coverage. These resources include Medicaid and CHIP eligibility renewal guidelines, assistance for Medicaid managed care plans in completing enrollee signatures, and resources to help families navigate their state Medicaid fair hearing process.[25] A new Medicaid and CHIP Renewals Toolkit provides health care providers with information on coverage options for those who were disenrolled during the Medicaid eligibility renewal and unwinding process related to the COVID-19 public health emergency (PHE).

Additionally, CMS developed resources focused on populations who may face specific challenges in accessing and maintaining coverage. For example, CMS released a coverage guide, in partnership with the Department of Justice, to assist individuals re-entering the community after incarceration with their coverage options and health care needs.[26] CMS also released a Tribal version of the Roadmap to Better Care, which details the unique health protections in place for AI/AN people to help make health care coverage more accessible.

Increase Collection and Use of Standardized Data to Improve Health Care for Rural, Tribal, and Geographically Isolated Communities

Data collection and standardization are essential for policymaking and for monitoring health outcomes in RTGI communities. CMS worked closely with health care providers, organizations, and government entities to improve the collection and use of comprehensive, interoperable, standardized, individual-level demographic health outcomes and health-related social needs data. Tribal communities and people living in the US territories are often excluded or inaccurately represented in health care data, and CMS is committed to improving data transparency, quality, and accessibility.[27] [28] By enhancing data transparency, sharing data for easier decision-making, and producing data-informed research, CMS is actively working to address the health care needs of RTGI communities.

Enhancing Data Transparency

In FY 2024, CMS implemented several initiatives to enhance the reporting and transparency of health data and information, driving quality improvement and informed decision-making. CMS released a Request for Information to gather public feedback on enhancing Medicare Advantage (MA) data capabilities and increasing transparency for all MA plans. Despite lower MA penetration in rural areas compared to urban areas, there has been an increase in rural MA penetration, exceeding the growth rate of enrollment in non-rural areas.[29] This rapid growth underscores the importance of using data to improve transparency and quality of care within MA plans. Moreover, improving access to and visibility of MA data would be beneficial not only for mainland areas but also for Puerto Rico, which has the highest MA penetration rate across all US states and territories, with 70% of its Medicare beneficiaries enrolled in an MA plan.[30] [31] [32]

This year, CMS continued its ongoing efforts to enhance transparency surrounding ownership data across various types of health care facilities. CMS released updated full ownership data for FQHCs

and RHCs.[33] [34] This is a continuation of previous ownership data releases, including change of ownership data and full ownership data for hospitals, skilled nursing facilities, home health agencies, and hospices. Making facility ownership information transparent benefits researchers and enforcement agencies by allowing them to identify common owners with histories of poor performance, analyze data and trends on market consolidation impacts, and evaluate the relationships between ownership and changes in health care costs and outcomes.[35]

Furthermore, CMS took measures to enhance transparency specifically in relation to nursing home ownership and acquisition. CMS issued a final rule to implement portions of section 6101 of the Affordable Care Act, which mandates greater transparency regarding the ownership and management of nursing homes (88 FR 80141).[36] [37] The final rule aims to empower nursing home residents and their families to make informed decisions about care and to hold nursing homes accountable for the service they provide by requiring nursing homes to disclose additional ownership and management information to CMS and states and by making this information public. CMS also revised the Form CMS-855A Medicare enrollment application such that all institutional providers that complete the revised Form CMS-855A must disclose whether a particular owning or managing entity is a private equity company or real estate investment trust.

Sharing Data for Easier Decision-Making

To drive quality improvement and inform decision-making in RTGI communities, CMS implemented several initiatives to analyze and share health data and information. CMS launched the "Birthing-Friendly" designation on its Care Compare online tool and interactive map, which is designed specifically so users can identify hospitals and health systems that participate in statewide or national perinatal quality improvement collaborative programs.[38] This designation helps residents in all 50 states, the District of Columbia, and the five US territories find local facilities committed to high-quality, evidence-based maternal care.

CMS outlined its comprehensive data sharing strategy and recent initiatives to enhance data accessibility and support for Innovation Center model participants in a published Health Affairs blog. The strategy includes enhancing technical assistance and learning activities, particularly for rural providers. The blog details steps CMS has already taken, such as releasing data through the CMS Virtual Research Data Center for more than 20 models and providing bundled-payment data to ACOs. By improving data sharing and offering targeted technical assistance, CMS aims to gain valuable insights into care patterns and payment initiatives, potentially leading to better resource allocation and improved patient outcomes in rural and underserved areas.

Additionally, CMS updated the Mapping Medicare Disparities (MMD) Tool to include 2018 MA data and new visual enhancements. Previously reliant only on Medicare Fee-for-Service data, the tool's inclusion of MA data provides a more comprehensive view of health care disparities, particularly benefiting rural communities where MA penetration has nearly quadrupled since 2010, reaching 40% in 2023.[39] By highlighting these disparities, the MMD Tool aids policymakers and health care providers in developing targeted interventions to improve health care equity in these areas.

Creating Data-Informed Resources and Policies

As part of its ongoing efforts to measure disparities in access to care and make focused, evidence-based investments to improve health equity in RTGI communities, CMS released several data-

informed research products, such as reports and data briefs. Notably, this year's Rural-Urban Disparities in Health Care in Medicare Report revealed that rural enrollees generally receive lower quality care than the national average.[40] The findings highlight significant disparities in health care access and outcomes between rural and urban areas, underscoring the need for targeted interventions to support rural populations. Additionally, the report examines differences in care quality between urban and rural AI/AN MA enrollees. The analysis indicates variations in quality and access to care based on location, suggesting that geographic factors play a substantial role in health care disparities for AI/AN people.

Using data to assess the impact of its programs on rural communities, CMS released performance and participation data from the 2022 Quality Payment Program. The data revealed that rural clinicians are increasingly participating in the Merit-based Incentive Payment System, with participation rates rising from 2.61% in 2019 to 5.49% in 2022.[41] Furthermore, rural clinicians are receiving payment adjustments at a rate consistent with the overall average, demonstrating their growing engagement and performance in the program. CMS also produced an infographic that synthesizes demographic data on access to care measures, health care utilization, and health status among Medicaid and CHIP enrollees seeking pregnancy-related care. This includes data on AI/AN enrollees and those residing in rural areas. Notably, in 18 states, over 30% of these enrollees live in rural areas.

This year, CMS made meaningful progress on improving data collection of demographics and measures related to health equity. CMS released a new resource document of health equity–related data definitions, standards, and stratification processes, which includes a section on geographic definitions of rural.[42] Identifying standard definitions for CMS in geographic health equity research will support consistency across the agency, as rurality can be defined differently across agencies and research institutions. CMS also updated the Health Insurance Marketplace® application with new optional questions on sexual orientation and gender identity, enabling patients to affirm their identities and aiding in the analysis of health coverage disparities.[43] Standardizing these measures will facilitate more consistent and accurate data collection, allowing for better comparison and analysis of health equity issues across different populations and regions.

CMS also used data to identify challenges and implement policies to address them. For the 2025 benefit year, CMS finalized a proposal to recalibrate the HHS risk adjustment models using enrollee-level External Data Gathering Environment data from 2019, 2020, and 2021.[44] CMS also finalized a proposal to recalibrate the Cost Sharing Reduction (CSR) adjustment factors for AI/AN zero-cost sharing and limited cost sharing CSR plan variant enrollees for the 2025 benefit year and to retain the finalized AI/AN CSR adjustment factors for all future benefit years unless changed through notice-and-comment rulemaking. This recalibration aims to improve model prediction accuracy for the AI/AN population, mitigate adverse selection, and incentivize issuers to engage the AI/AN population, which has been historically underserved and faces significant health disparities.[45]

Finally, CMS provided resources to health researchers as part of its commitment to measuring and eradicating health disparities, including geographic disparities. CMS' Minority Research Grant Program released the 2024 Notice of Funding Opportunity for researchers at minority-serving institutions who are investigating or addressing health care disparities affecting CMS' focus populations, including people who live in rural areas and people otherwise adversely affected by persistent poverty or inequality. In addition, CMS launched the Tribal Data Learning Community pilot program, which allows Tribal Epidemiology Centers to freely access the Chronic Conditions Data Warehouse to foster the development of a research analytic method for disseminating practices relevant to Tribal communities.[46]

Strengthen and Support Health Care Professionals in Rural, Tribal, and Geographically Isolated Communities

CMS used available authorities and resources to support the financial stability of health care professionals, particularly in RTGI communities, where there are pronounced shortages across nearly every level and type.[47] Approximately 70% of primary care Health Professional Shortage Area (HPSA) designations are in rural or partially rural areas.[48] [49] Additionally, many people in the US territories live in a county that qualifies as an HPSA or Medically Underserved Area/Medically Underserved Population, and almost all Indian Health Service (IHS) facilities, Tribally-Operated 638 Health Programs, and Urban Indian Health Programs have HPSA designations.[50] The insufficient supply of health care workers in RTGI areas goes well beyond physician and nursing shortfalls, impacting all areas of the health care sector, including behavioral health and emergency medical service providers.[51] By promoting stability through payment policies, focusing on health care professional recruitment and retention, and providing resources for health care professionals, CMS seeks to support and strengthen the health care workforce in RTGI communities.

Promoting Stability through Payment Policies

To support health care organizations and professionals, CMS introduced payment changes to promote financial sustainability and success for providers and organizations in rural and Tribal areas. The calendar year (CY) 2024 Medicare Hospital Outpatient Prospective Payment System (OPPS) final rule (88 FR 81540) implemented a policy under which IHS and Tribal hospitals that convert to Rural Emergency Hospitals (REHs) are paid for hospital outpatient services under the same All-Inclusive Rate as non-REH IHS or Tribal hospitals.[52] These hospitals will also receive the REH monthly facility payment consistent with how this payment is applied to REHs that are not Tribal- or IHS-operated, they are allowed certain flexibilities around staffing requirements, and they can gain access to technical assistance through the HRSA REH Technical Assistance Center, all of which provide stability and promote access to Tribal and IHS hospitals.[53]

The FY 2025 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) final rule (89 FR 68986) includes a separate payment under the IPPS for small, independent hospitals, many of which are rural, for establishing and maintaining a buffer stock of essential medicines for use during future shortages.[54] This policy aims to foster a more reliable and resilient supply of essential medicines for patients in these hospitals.

To enhance payment accuracy, CMS finalized updates to the wage index payment adjustment for several types of health care facilities, including skilled nursing facilities, inpatient rehabilitation facilities, inpatient psychiatric facilities, hospices, and hospitals.[55] [56] [57] [58] These updates consider the most current regional cost variations by incorporating new Office of Management and Budget statistical areas, including for facilities in Puerto Rico.[59] [60] [61] [62] These changes aim to ensure more accurate and equitable payment adjustments by better reflecting the costs and needs of providers, including RTGI providers. In addition, CMS clarified payment limits for Medicaid Disproportionate Share Hospital payments to enhance administrative efficiency, which could impact efficiencies for hospitals in rural areas.[63]

The CY 2024 Medicare Physician Fee Schedule (PFS) final rule (88 FR 78818) implemented a new Medicare benefit category for services billed by marriage and family therapists (MFTs) and mental health counselors (MHCs) under Medicare Part B. It also allowed MFTs and MHCs to furnish behavioral health services in RHCs and FQHCs.[64] This rule also introduced coding and payment changes, which are applicable to RHCs and FQHCs, to better account for resources used in providing patient-centered care involving a multidisciplinary team. CMS also finalized coding and payments for Community Health Integration, SDOH Risk Assessment, and Principal Illness Navigation services.[65] These codes involve certain types of health care support staff, such as community health workers, care navigators, and peer support specialists.[66] These aim to address unmet SDOH needs affecting patient diagnosis and treatment and help Medicare enrollees with high-risk conditions identify and connect with appropriate resources. Additionally, the CY 2024 Medicare Hospital OPPS final rule (88 FR 81540) established payment for intensive outpatient program (IOP) services, allowing certain providers, including hospital outpatient departments, Community Mental Health Centers, RHCs, FQHCs, and Opioid Treatment Programs, to provide IOP services.[67]

CMS also worked to ensure adequate payment for Medicaid providers through two final rules. The Medicaid and CHIP Managed Care Access, Finance, and Quality final rule (89 FR 41002) streamlines State Directed Payments (SDPs) by removing regulatory barriers and eliminating the need for written prior approval for SDPs that are minimum fee schedules set at the Medicare payment rate, while also enhancing quality standards and fiscal and program integrity standards for SDPs. The rule allows for the use of In Lieu of Services and Settings as substitutes for covered services or settings under the state plan. The Ensuring Access to Medicaid Services final rule (89 FR 40542) requires that within six years (beginning July 9, 2030), states generally assure that, subject to certain exceptions, providers spend a minimum of 80% of total Medicaid payments received for homemaker services, home health aide services, and personal care services on total compensation for direct care workers who furnish those services to individuals enrolled in Medicaid Home- and Community-Based Services programs, rather than administrative costs or profit.[68] This rule also requires states to form an advisory committee consisting of direct care workers, beneficiaries, and other interested parties to meet at least every two years to advise and consult on payment rates paid to direct care workers. Additionally, this rule includes requirements for states to publish a comparative rate analysis of Medicaid rates against Medicare rates by service type and geography every two years, and mandates states demonstrate that proposed rate reductions and restructurings will not negatively impact access to care. These rules could be beneficial to rural communities as the provisions may help attract and retain home care providers and direct care workers whose work is critical in areas with limited health care facilities.

Health Care Professional Recruitment and Retention

CMS continued to actively implement programs and policies that bolster health professional recruitment and combat worker shortages in rural, Tribal, and other underserved communities. Previously, CMS established policies to implement 1,000 new Medicare-funded physician residency slots to qualifying hospitals authorized by the Consolidated Appropriations Act, 2021, phasing in 200 slots per year over five years, beginning in FY 2023.[69] In November 2023, CMS awarded the second round of 200 new graduate medical education residency slots to 99 qualifying hospitals, which became effective July 1, 2024.[70] [71] This initiative is a step toward addressing the growing need for health care professionals, particularly in rural and underserved areas. Additionally, CMS implemented policies

to govern the application and award process for 200 additional residency training slots distributed under section 4122 of the Consolidated Appropriations Act, 2023.[72] At least half of the total positions will be dedicated to psychiatry or related subspecialties, and the policy will focus on HPSAs to help bolster the healthcare workforce in rural and underserved areas, to the extent slots are available. CMS estimates that this additional funding will total approximately $74 million in support for teaching hospitals from FY 2026 through FY 2036.[73]

In August 2024, CMS finalized a rule to update Medicare payments and policies, including increased payment rates for certain acute care hospitals and Long-Term Care Hospitals (89 FR 68986).[74] The rule includes a policy change to recognize the higher costs that hospitals incur when treating individuals experiencing housing insecurity.

Additionally, CMS sought to address staffing shortages in Medicare- and Medicaid-certified long-term care facilities. CMS issued a final rule to enhance health and safety standards in nursing homes certified by Medicare and Medicaid by establishing national minimum staffing requirements to ensure residents receive adequate care and to support workers by guaranteeing sufficient staffing levels (89 FR 40876).[75] The rule outlines a delayed implementation period for rural facilities to allow these facilities more time and flexibility to implement the policy as well as hardship exemptions for eligible facilities that are facing a significant staffing hardship, despite their best efforts to hire and a financial commitment to staffing. CMS has announced that they will be investing more than $75 million to launch a national nursing home staffing campaign to increase the number of nurses in nursing homes, thereby enhancing residents' health and safety. CMS will also be making it easier for individuals to become nurse aides by streamlining the process for enrolling in training programs and finding placement in a nursing home.[76]

In alignment with these efforts, CMS issued guidance to State Medicaid Directors, allowing states to expand the pool of skilled professional medical personnel to include additional behavioral health professionals.[77] This expansion is particularly vital for rural areas where access to specialized care is often limited. The guidance also allows states to claim administrative federal match dollars for nurse advice lines, a crucial tool for connecting coverage and critical health services, particularly in rural areas. CMS also released a frequently asked questions document to clarify Medicaid and CHIP coverage policies for peer support services. The document underscores the importance of states expanding these services and ensuring that payment rates offer a living wage for peer support providers, which is crucial for workforce recruitment and retention.[78]

Resources for Health Care Professionals

CMS developed and disseminated resources and tools to support health care entities subject to data reporting requirements in RTGI areas. CMS released revised guidance on the enrollment and conversion process for REHs to aid eligible providers in participating in Medicare and Medicaid. This provider type, created by the Consolidated Appropriations Act, 2021, aims to address rural hospital closures. CMS also released the Medicare Ground Ambulance Data Collection System (GADCS): Rural and Super Rural Organizations Tip Sheet for reporting data. Accurate submission of data from all types of ground ambulance operations can highlight geographic differences in costs, revenues, and services.[79] Moreover, CMS posted an updated FAQ resource with additional information to help hospitals understand and meet new hospital price transparency compliance requirements. The FAQ also provides information for consumers that is inclusive of RTGI hospitals, enabling patients to access available

information about prices of health care services in diverse geographic locations and make more informed decisions about their health care.[80]

CMS also took measures to support the health care workforce that provides obstetrical and pregnancy-related care. To support compliance with the Emergency Medical Treatment and Labor Act, CMS created resources to help hospitals fulfill their obligations, including training materials, best practices, and establishing a dedicated support team.[81] These resources respond to increasing inquiries about meeting federal obligations, particularly for hospitals responding to pregnancy-related emergencies.

Optimize Medical and Communication Technology for Rural, Tribal, and Geographically Isolated Communities

Telehealth services improve access to care for individuals in RTGI and underserved areas.[82] By bridging the gap between patients and providers, these technologies facilitate continuous and comprehensive care, regardless of physical location. Recognizing the transformative potential of these technologies, CMS collaborated with health care organizations and government entities to optimize and increase the use of medical and communication technology across its programs. To effectively use these technologies in RTGI communities, CMS is developing policies to increase telehealth access and coverage and encourage uptake of health information technologies.

Developing Policies to Increase Telehealth Access and Coverage

CMS explored opportunities to enhance the uptake and coverage of telehealth and other virtual services where appropriate to deliver high-quality care in RTGI communities. Through the CY 2024 Medicare PFS final rule (88 FR 78818), CMS finalized the proposal to add health and well-being coaching services to the Medicare Telehealth Services list on a temporary basis for CY 2024 and Social Determinants of Health Risk Assessment on a permanent basis. The CY 2024 Medicare PFS final rule also extends flexibilities for Opioid Treatment Programs to provide periodic assessments via audio-only telecommunication through the end of 2024, which could expand access for RTGI communities with unreliable internet access.[83] The final rule extended the option to offer virtual Medicare Diabetes Prevention Program (MDPP) services until December 31, 2027, as long as suppliers maintain an in-person Centers for Disease Control and Prevention organization code. This extension enables MDPP suppliers to continue to offer MDPP services virtually for enrollees at risk for type II diabetes, potentially benefiting the Pacific territories, where the nearest MDPP supplier is approximately 3,000 miles away.[84]

CMS provided telehealth flexibilities to increase access to behavioral health care in RTGI communities. The CY 2024 Medicare PFS final rule (88 FR 78818) implemented a delay in the requirement for an in-person visit with a physician or practitioner within six months prior to initiating mental health telehealth services, and again at subsequent intervals as the Secretary determines appropriate, as well as similar requirements for RHCs and FQHCs. CMS also implemented a policy to add MFTs and MHCs to the list of distant site practitioners who can furnish telehealth services, and allow addiction, drug, or alcohol counselors who meet all requirements of MHCs to enroll in Medicare as an MHC.[85] These updates in the CY 2024 Medicare PFS final rule to extend telehealth services

and distant site practitioners could particularly impact rural communities and people living in the US territories by using technology to facilitate access to behavioral health services and practitioners.

CMS also enhanced access to behavioral health care for MA enrollees in the CY 2025 MA and Part D final rule (89 FR 30448) by requiring existing network adequacy evaluation standards to apply to a new facility-specialty provider category called "Outpatient Behavioral Health," which includes marriage and family therapists, mental health counselors, addiction medicine physicians, Opioid Treatment Program providers, Community Mental Health Centers, and other providers. In addition, CMS added this Outpatient Behavioral Health facility specialty to the list of the specialty types for which an MA organization will receive a 10% credit towards meeting required network adequacy standards when its contracted network of providers includes one or more Outpatient Behavioral Health telehealth providers who provide additional telehealth benefits for covered services.[86] [87] Rural areas face significant shortages in behavioral health care services and struggle with recruiting and retaining behavioral health professionals.[88] [89] Moreover, providers in the US territories are seeing a significant increase in demand for telehealth services and in the number of patients seeking behavioral health and substance use disorder (SUD) services.[90]

In July 2024, CMS Region 4 (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee) staff met with Medical University of South Carolina/South Carolina Telehealth Alliance to discuss their virtual care initiative for improving access to specialty care and equity for safety net populations in rural South Carolina. CMS staff established a new partnership with this organization to continue discussions on the initiative after recognizing its significant impact.

Encouraging Health Information Technologies

CMS continued to promote the uptake of health information technologies in RTGI communities. In FY 2024, CMS took multiple measures to use information technology (IT) to expand behavioral health and substance use treatment capacity. CMS issued an informational bulletin highlighting examples of state Medicaid information technology expenditures that could qualify for enhanced federal matching rates. The bulletin provides guidance on how states can apply for an enhanced Medicaid matching rate to improve behavioral health and substance use disorder treatment for Medicaid recipients.

CMS also introduced the Innovation in Behavioral Health (IBH) Model to enhance care quality and health outcomes for Medicaid and Medicare enrollees with behavioral health conditions and/or SUDs. This state-based model, led by state Medicaid agencies, aims to align payment between Medicaid and Medicare for integrated services. The model will expand health IT capacity through targeted investments in interoperability and tools, including electronic health records (EHRs). These investments and tools will allow community behavioral health practitioners to improve quality reporting and data sharing.[91] RTGI facilities often lack substantial investment in health IT and EHRs. Despite most rural hospitals having EHR systems, only 48% can fully participate in EHR interoperability due to challenges with investment and maintenance costs, workflow automation, and staff participation.[92] Furthermore, not all health care providers in AI/AN communities use EHRs or can securely share information electronically.[93] The IBH model could benefit rural and AI/AN communities and US territories by enhancing technology to provide comprehensive, integrated care.

CMS continued to promote meaningful use of EHR and emerging technologies in RTGI communities. In the FY 2025 IPPS and LTCH PPS final rule (89 FR 68986), CMS made several significant updates to measures and reporting required by the Medicare Promoting Interoperability Program to enhance the program's impact.[94] The Medicare Promoting Interoperability Program encourages eligible

hospitals and CAHs to adopt, implement, upgrade, and demonstrate meaningful use of certified electronic health record technology. These updates are designed to support the integration and optimization of health information technologies, including in RTGI communities.

Finally, CMS updated its guidance on texting patient orders.[95] Hospitals and CAHs can now include text orders in the patient's medical record or electronic health record via a secure platform that is compliant with HIPAA and with the Medicare Conditions of Participation. This change streamlines the communication process within health care facilities, enabling quicker response times and more efficient care delivery, which is particularly beneficial in resource-constrained RTGI communities.

Expand Access to Comprehensive Health Care Coverage, Benefits, and Services and Supports for Individuals in Rural, Tribal, and Geographically Isolated Communities

CMS continued to build on efforts to cover a broad array of services and supports to improve health outcomes and help address social risk factors in RTGI communities. Lack of health care coverage can severely impact an individual's ability to access necessary health care services, contributing to disparities in health outcomes.[96] People living in RTGI communities have less access to health care due to geographic isolation (e.g., provider shortages, limited insurance options, and infrastructure challenges). CMS is bridging these gaps and promoting equitable health care for all individuals in RTGI communities by increasing access to health services and benefits, expanding eligibility across programs, and enhancing consumer protections to improve access and coverage.

Increasing Access to Health Services and Benefits

CMS expanded health coverage and benefits through new and existing programs. CMS also released four reports showcasing historic gains in health insurance coverage due to the Affordable Care Act (ACA).[97] [98] [99] [100] More than 21 million consumers selected or were automatically re-enrolled in health insurance through HealthCare.gov and State-based Marketplaces during the 2024 Open Enrollment Period. These reports also reveal that more than 45 million people now have coverage due to the ACA's Marketplaces and Medicaid expansion.[101] This increase in coverage is particularly significant for RTGI communities, where access to health insurance has historically been limited.[102] Expanding coverage ensures more residents in these areas can receive necessary medical care, reducing health disparities and improving overall health outcomes.[103]

This year, CMS continued its focus on reducing the cost of prescription drugs under Medicare through the implementation of policies established by the Inflation Reduction Act of 2022 (IRA). First, CMS released comprehensive guidance to implement the Medicare Prescription Payment Plan, a new payment option created under the IRA that requires Part D plan sponsors to provide their enrollees with the option to pay out-of-pocket prescription drug costs in the form of monthly payments over the course of the plan year instead of all at once to the pharmacy. This program aims to alleviate the financial burden of upfront out-of-pocket prescription costs for seniors and people with disabilities that are enrolled in Part D. Second, CMS finalized significant updates to Part D for 2025, which include a historic cap on annual out-of-pocket costs at $2,000, elimination of the coverage gap phase of the benefit, and continuation of no cost sharing for certain recommended adult vaccines and a $35 cost sharing cap on a month's supply of each covered insulin product.[104] [105] Rural Medicare Part

D enrollees are likely to benefit from these provisions as they have higher rates of certain chronic conditions and have reported greater health care costs and difficulty affording prescription drugs.[106]

CMS released the negotiated Maximum Fair Prices (MFPs) for the ten selected drugs under the Medicare Drug Price Negotiation Program for the first cycle of negotiations. These negotiated MFPs will be effective January 1, 2026. These historic negotiations aim to reduce costs for Medicare beneficiaries, enhancing access to life-saving treatments and lowering drug costs.[107] Projected savings for people enrolled in the Medicare prescription drug benefit in 2026 are estimated at $1.5 billion, alongside other cost-saving measures from the Inflation Reduction Act.[108] CMS also sought public comment on the second cycle of negotiations under the Medicare Drug Price Negotiation Program. Lastly, in each quarter of FY 2024 CMS announced cost savings for certain prescription drugs available through Medicare Part B for some Medicare enrollees with lowered Part B coinsurance rates as part of the Medicare Prescription Drug Inflation Rebate Program; this included lower Part B coinsurance rates on 34 drugs in Quarter 1, 48 drugs in Quarter 2, 41 drugs in Quarter 3, and 64 drugs in Quarter 4.[109] [110] [111] [112] [113]

CMS also expanded access to a range of health services and treatments through the CY 2024 Medicare PFS final rule (88 FR 78818). The rule expanded coverage of diabetes screening tests and simplified and expanded related regulations, reducing provider and patient burden. This rule also codified payment for dental services inextricably linked to certain cancer treatments, further broadening the scope of essential health services covered under Medicare.[114]

In addition to expanding access in the Medicare program, CMS worked to improve access to services and benefits in the individual health insurance market. The HHS Notice of Benefit and Payment Parameters for 2025 (89 FR 26218) finalized several measures to enhance health care access and simplify enrollment. These measures include requirements, effective beginning in plan year 2026, for State-based Marketplaces[iii] to establish and impose network adequacy standards for Qualified Health Plans (QHPs) that are at least as stringent as standards for QHPs offered on the Federally-facilitated Marketplaces. Measures also include removing the regulatory prohibition on issuers from including routine non-pediatric dental services as an essential health benefit (EHB), which allows states to add routine non-pediatric dental services as an EHB by updating their EHB-benchmark plans. The final rule also requires State-based Marketplaces to operate a centralized eligibility and enrollment platform to streamline the application process.[115] CMS also released a final rule (88 FR 44596) on short-term, limited-duration insurance and independent, non-coordinated excepted benefits coverage to improve access to affordable coverage, strengthen insurance markets, and promote consumer understanding of coverage options.[116]

This year, CMS continued working with states to expand access to a range of behavioral and reproductive health services. In partnership with SAMHSA, CMS added 10 new states to the Certified Community Behavioral Health Clinic (CCBHC) Medicaid Demonstration Program under the Bipartisan Safer Communities Act. The program provides sustainable funding to states to expand access to mental health and substance use services through CCBHCs, which offer a comprehensive range of services, including 24/7 crisis services.[117] This program is particularly beneficial for rural and Tribal communities, which often have limited access to behavioral health treatment and higher rates of

[iii] State-based Marketplaces refers to State-based Exchanges and State-based Exchanges on the Federal platform.

mental distress and depression.[118] CMS also launched the Expanding Access to Women's Health Grant, which offers 24 months of funding to 14 states for planning and implementing activities with respect to certain pre-selected federal market reforms and consumer protections related to enhancing and expanding access to reproductive and maternal health coverage and services. These activities may include addressing disparities in reproductive and maternal health outcomes. The program's expansion will help participating states address maternity care access disparities in rural and Tribal communities.[119]

Finally, CMS sought to address administrative barriers to health care access through a rule requiring MA, Medicaid, and CHIP programs to streamline the prior authorization process (89 FR 8758).[120] The rule, which includes requirements for adhering to specific prior authorization decision timeframes, providing specific reasons for denials, and annually publishing certain prior authorization metrics, is expected to improve access to care for individuals in RTGI communities by reducing administrative burdens associated with the prior authorization process.[121] Prior authorization continues to be an important issue for rural communities as rural MA enrollees increase.[122] This rule makes a substantial step toward reducing the administrative burden on rural health systems and improving patient access to services.

Expanding Eligibility Across Programs

CMS increased health care coverage through opportunities in eligibility and enrollment across its programs. CMS supported various state-level coverage expansions, approving a range of proposals to improve access to care through Medicaid and CHIP. North Carolina expanded Medicaid eligibility to approximately 600,000 adults who were not previously eligible for Medicaid in the state.[123] In FY 2024, CMS approved 12 months of extended Medicaid and CHIP postpartum coverage in nine states: Montana, New Hampshire, Missouri, Nebraska, Mississippi, Alaska, Texas, Utah, and Nevada.[124] [125] [126] [127] [128] [129] [130] [131] [132] These approvals bring the total number of states that have implemented extended postpartum coverage to 46, along with Washington, D.C. and the US Virgin Islands.[133]

Additionally, CMS approved requests from eight states in FY 2024 (New Mexico, Colorado, Alabama, Washington, Montana, Nevada, Maryland, and New Hampshire) to expand Medicaid mental health and substance use services through community-based mobile crisis intervention teams.[134] [135] [136] [137] [138] [139] [140] [141] In total, 20 states and Washington, D.C. have expanded access to behavioral health services through mobile crisis intervention teams.[142] [143]

Enhancing Consumer Protections to Improve Access and Coverage

CMS bolstered consumer protections to safeguard coverage and streamline enrollment. For CY 2025, CMS finalized several policy and technical changes to the MA Program aimed at improving patient experiences and outcomes. These changes include a policy requiring MA plans to provide mid-year notifications of unused supplemental benefits to enrollees who have not accessed these benefits within the first six months of the year.[144] The rule (89 FR 30448) also ensures MA plans analyze their utilization management policies from a health equity perspective, enhances enrollees' rights to appeal coverage termination decisions for non-hospital provider services, and increases the percentage of dually eligible enrollees in plans that cover both Medicare and Medicaid.[145]

CMS worked to simplify the application, eligibility determination, enrollment, and renewal processes for Medicaid, CHIP, and Basic Health Programs (BHPs) through the Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes final rule (89 FR 22780).[146] The rule's provisions aim to reduce coverage disruptions, further streamline Medicaid and CHIP eligibility and enrollment processes, reduce the administrative burden on states and people applying to and enrolled in Medicaid and CHIP programs, and increase enrollment and retention of eligible individuals. Additionally, CMS extended temporary unwinding-related section 1902(e)(14)(A) waivers through June 30, 2025, along with other flexibilities to assist eligible individuals in maintaining their Medicaid and CHIP coverage.[147] CMS also extended a temporary special enrollment period until November 30, 2024 to help individuals transition from Medicaid or CHIP to Marketplace coverage.[148] These actions are particularly important for RTGI communities, which often face additional challenges in renewing coverage due to factors like longer distances to eligibility offices and limited internet access.[149]

CMS proactively enhanced consumer protections for Medicaid and CHIP enrollees through a set of new rules. These rules include the Medicaid and CHIP Managed Care Access, Finance, and Quality final rule (89 FR 41002) that specifically strengthens standards for timely access to care and for states' monitoring and enforcement efforts; enhances quality standards and fiscal and program integrity standards for SDPs; specifies the scope of In Lieu of Services and Settings to better address health-related social needs (HRSNs); further specifies medical loss ratio requirements; and establishes a quality rating system for Medicaid and CHIP managed care plans.[150]

In addition, the Ensuring Access to Medicaid Services final rule (89 FR 40542) focuses on improving access to Home- and Community-Based Services (HCBS) across fee-for-service and managed care delivery systems by requiring states to report on several items, including: payment transparency, quality measures, wait list management, and wait times between date of authorization and date of services received for individuals newly receiving services.[151] This HCBS information is especially important for rural Medicaid Long-Term Services and Supports enrollees, who are less likely to receive HCBS than their urban counterparts.[152] This rule also mandates public disclosure of provider payment rates for certain HCBS services (personal care, homemaker, home health aide, and habilitation services).

Additionally, in partnership with the Departments of Labor and Treasury, CMS issued a set of final rules to enhance access to mental health and substance use disorder care for more than 150 million people with private health coverage (89 FR 77586).[153] These rules aim to ensure parity between mental health and medical benefits, building on the Mental Health Parity and Addiction Equity Act of 2008. The rules prohibit more restrictive nonquantitative treatment limitations for mental health care and require plans to evaluate and adjust these limitations to ensure equitable access. The rules emphasize the careful design of provider networks and apply to most health plans starting in 2025, with some provisions effective in 2026.

Drive Innovation and Value-Based Care in Rural, Tribal, and Geographically Isolated Communities

Over the past decade, the transition from volume-based to value-based health care and payment has been widely tested through various models. These programs prioritize better patient care, improved population health, and smarter spending. However, these payment systems can pose challenges for RTGI providers, who have fewer resources to engage in new payment models. Constrained financial and staffing resources can create challenges around managing or upgrading health IT and data, ensuring compliance with requirements, and dealing with uncertain effects of model participation on provider finances and administrative compliance burden.[154] To better serve rural and underserved

patients' engagement in value-based care, CMS continues to use its existing authorities to test new value-based payment and care models that meet the needs of RTGI communities.

Investing in Accountable Care Organizations and Relationships

CMS continued to make progress on its goal of having all people with original Medicare in an Accountable Care relationship with their health provider by 2030. In 2024, about 13.7 million people with original Medicare were aligned to an ACO.[155] With the addition of 50 new ACOs and 71 renewals, the total number of ACOs in the program is now 480. CMS introduced changes to the Shared Savings Program specifically designed to increase ACO participation in rural and underserved areas. CMS announced that 19 new ACOs in the Medicare Shared Savings Program are receiving more than $20 million in Advance Investment Payments (AIPs), which enable entities in rural and underserved areas to join together as ACOs and build the infrastructure needed to succeed in the program.[156] With the addition of the ACOs receiving AIPs, ACOs are delivering care to people with original Medicare in 9,032 FQHCs, RHCs, and CAHs, an increase of 27% from 2023. CMS is preparing to test the ACO Primary Care Flex Model, a voluntary model empowering primary care providers in eligible ACOs to deliver person-centered care under the Shared Savings Program.[157] Starting January 1, 2025, this initiative aims to further expand Accountable Care to people with original Medicare and direct health care dollars towards underserved populations, promoting health equity and better outcomes. The model provides resources and flexibility to ACOs, encouraging the formation of new ACOs and supporting existing ones, particularly attracting safety net providers such as FQHCs and RHCs.

Other CMS efforts to drive innovation and value-based care in RTGI communities focus on enhancing care quality, expanding access to essential services, and promoting health equity. For example, the ACO Realizing Equity, Access, and Community Health (ACO REACH) Model, comprising 122 ACOs and 1,042 FQHCs, RHCs, and CAHs, served an estimated 2.6 million people in 2024.[158] The Kidney Care Choices Model includes 123 Kidney Contracting Entities and CMS Kidney Care First Practices, accountable for the care of 282,335 Medicare enrollees with chronic kidney disease and end-stage renal disease. CMS is committed to addressing the unique health care challenges faced by these communities and ensuring that all individuals receive high-quality, comprehensive care.

Other CMS Innovation Center Models

This year, CMS used equity principles to design and test models in payment and care delivery. In a recent Health Affairs blog, CMS outlined new 2024 initiatives that create pathways for safety net providers, including rural health clinics, to join care improvement models.[159] CMS announced seven new model tests that aim to improve outcomes and reduce costs, including for those in rural and Tribal communities. CMS announced the mandatory Transforming Episode Accountability Model, which launches on January 1, 2026 and aims to improve patient care, minimize avoidable hospital readmissions, and promote long-term health outcomes by holding hospitals accountable for the cost and quality of care for 30 days from post-surgery discharge.[160] The model includes different policies for safety net hospitals to participate with lower levels of risk and reward and a pricing methodology that acknowledges underserved individuals by adjusting for beneficiary social risk. The model also includes the Decarbonization and Resilience Initiative, a voluntary element of the announced model, to assist participating hospitals as they aim to collect, monitor, assess, and address the threats of

climate change.[161] Given that RTGI communities may be especially vulnerable to the effects of climate change, this initiative will be important for CMS to understand the effects of climate change on health outcomes, costs, and quality.

CMS announced the Transforming Maternal Health (TMaH) Model, which is a 10-year initiative to enhance maternal health and birth outcomes for people enrolled in Medicaid and CHIP.[162] Through TMaH, CMS will offer states resources and technical assistance to improve maternal health care outcomes and access for people with Medicaid or CHIP, providing expanded access to services and resources, including midwives, doulas, and perinatal community health workers. As many rural areas are facing maternity ward closures and maternal health deserts, TMaH can equip states with additional resources to expand access. [163] Lastly, CMS launched the Guiding an Improved Dementia Experience (GUIDE) Model, with 390 organizations from every state participating.[164] The GUIDE model may benefit rural and geographically isolated communities by aiming to enhance the quality of life for people with dementia, reduce caregiver strain, and help individuals remain in their homes and communities.

CMS continues to implement and evaluate numerous other innovative national models that aim to increase access to care, improve the quality of care, and decrease costs. The States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, launched by CMS in FY 2024, is an 11-year voluntary model aimed at improving health outcomes and equity.[165] It encourages states to invest in primary care and community resources, offering up to $12 million in funding per state. This year, CMS announced the first states to participate in Cohorts 1 and 2 of the AHEAD Model; Maryland and Vermont will participate in Cohort 1, while Connecticut and Hawai'i will participate in Cohort 2.[166] CMS also launched the Making Care Primary Model on July 1, 2024. This 10.5-year initiative, which will be tested in eight states, aims to improve care management and coordination, and to address HRSNs like housing and nutrition. The model includes 133 participants representing 772 practices, with 55 FQHCs and 94 small primary care organizations, including Tribal providers.

Additionally, CMS released the third annual Maternal Opioid Misuse (MOM) Model Evaluation Report. The MOM Model aims to enhance care quality for pregnant and postpartum Medicaid patients with opioid use disorder and their infants in seven states during its second year of implementation. The evaluation report details that nearly all MOM Models served rural areas of their states, and rural delivery partners reported having expanded access to community resources through the model.[167]

State-based Innovation Models and Demonstrations

CMS continued to partner with states in developing, implementing, and iterating on innovative models for health care services and delivery. CMS approved section 1115 Medicaid demonstrations in several states, including Missouri, Arizona, Oregon, Montana, Rhode Island, Utah, New York, Tennessee, Delaware, and Massachusetts, to test interventions to address essential health care needs such as improving access to HCBS, enhancing primary and behavioral health care, mitigating direct care worker shortages, and expanding eligibility for CHIP.[168] [169] [170] [171] [172] [173] [174] [175] [176] [177] Specifically, the Delaware Diamond State Health Plan will allow for coverage of home-delivered food, diapers, and wipes for postpartum members who meet required clinical risk factors for up to twelve weeks, and states such as Massachusetts removed the waiver of retroactive eligibility, allowing people with Medicaid up to three months of retroactive coverage.

In November 2023, CMS published a CMCS Informational Bulletin and a framework of services and supports to address HRSNs that CMS considers allowable under specific Medicaid and CHIP

authorities.[178] Additionally, CMS saw a major milestone in coverage of HRSN services in Medicaid and CHIP with the approval of an historic amendment to New York's Medicaid section 1115 demonstration. This approval allows New York to make substantial investments in a series of comprehensive Medicaid initiatives, including establishing sustainable base rates for safety net hospitals, which particularly impacts rural hospitals that are facing ongoing financial challenges.[179] The demonstration amendment also connects people to housing and nutritional support services, enhances access to treatment for SUD, and invests in the state's health care workforce.[180] New York's demonstration amendment builds on previously approved demonstrations in Arizona, Massachusetts, New Jersey, Oregon, Washington, and Arkansas, which are designed to improve health equity through meeting HRSNs.

This year, Oregon became the third state to implement a Basic Health Program following CMS approval. The Oregon BHP enables the state to provide essential health benefits to individuals with household incomes between 133% and 200% of the federal poverty level who would be otherwise eligible for QHP coverage and to lawfully present noncitizens with household incomes below 200% of the federal poverty level who are not eligible for Medicaid, covering approximately 55,000 residents.[181] CMS also approved an amendment to Arizona's Parents as Paid Caregivers and KidsCare Expansion section 1115 Medicaid demonstrations, which enables Arizona to reimburse parents for providing direct care to their minor children. This strategy addresses the direct care worker shortage and improves access to care for rural and geographically isolated communities.[182]

Additionally, CMS approved North Carolina's proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts to incentivize hospitals to relieve existing medical debt and prevent the accumulation of new debt, potentially addressing $4 billion in debt and offering enhanced Medicaid payments to participating hospitals.[183] These state-based innovation models and demonstrations underscore CMS' commitment to fostering health equity and improving health care delivery across the nation.

CMS approved a series of groundbreaking Medicaid and CHIP demonstrations that will allow Illinois, Kentucky, Oregon, Utah, and Vermont to provide coverage to eligible individuals in certain carceral facilities before their expected release from incarceration. These demonstrations address the significant health needs of incarcerated individuals and ensure a seamless transition back into the community.[184] This initiative includes coverage for substance use disorder treatment and chronic health conditions up to 90 days before release.

CMS engaged with rural community providers in Region 6 (Arkansas, Louisiana, New Mexico, Oklahoma, Texas) to discuss the impact of innovation models on rural health care. Providers in Region 6 highlighted the success of models like Arkansas' State Transformation Collaborative (STC), which focuses on integrated data sharing to improve care coordination. Local providers attribute STC's success to strong collaborative relationships, which they noted are crucial for rural settings. CMS will continue to engage with local providers and communities to understand the impact of CMS state models and demonstrations on rural and Tribal communities.

In addition to supporting Medicaid and CHIP innovation, CMS supported ongoing implementation of federal and state partnership models and demonstrations aimed at people in diverse geographies. CMS released a progress report on the Maryland Total Cost of Care Model. The model tests whether state accountability and provider incentives can improve care and population health for people with Medicare while reducing costs. The report shows that the model has had positive effects on spending and service use in its first four years, reduced racial and geographic disparities in quality of care, and improved timely follow-up for chronic conditions, potentially reducing hospital admissions.[185]

Supporting States and Providers Experiencing Public Health Emergencies

CMS supported state Medicaid and CHIP agencies and other state and local agencies to prepare for and respond to PHEs, disasters, and threats. CMS announced new resources and flexibilities to support those affected by Hurricane Beryl in Texas, Tropical Storm Debby in Florida, Georgia, and South Carolina, and Hurricane Francine in Louisiana following the President's emergency declaration and HHS' PHE determination for each of these emergencies.[186] [187] [188] CMS also provided additional resources and flexibilities to support Florida, Georgia, North Carolina, Tennessee, and South Carolina in response to Hurricane Helene.[189] CMS collaborated with these states to ensure continued access to health care. Key measures include waivers for health care providers, special enrollment periods for insurance coverage, and a disaster toolkit for Medicaid and CHIP agencies.

CMS also collaborated with providers through local engagement activities to design innovative solutions to strengthen health system resilience in the face of natural disasters and emergencies. Over this year, CMS Region 10 staff maintained engagement with the Oregon Hospital Association to address hospital transition challenges. In response, Oregon launched a statewide system for real-time referrals to inpatient facilities, providing hourly updates on available hospital, long-term care, and behavioral health beds. Initially designed for discharges and medical transfers, this system has also proven invaluable during emergencies like fires and flooding and is now being marketed to 20 other states.

The Path Forward

As CMS continues to improve health care in RTGI communities, its efforts are guided by a commitment to advancing health equity and addressing the unique challenges these areas face. CMS must navigate evolving challenges, including the transition to the post-pandemic health care ecosystem, ensuring coverage and access through Medicaid unwinding and redetermination, and addressing the financial pressures leading to the closure of many rural hospitals. CMS' role in the evolving health care landscape, marked by a shift to value-based payment, increased MA enrollment, and the tenth anniversary of the Affordable Care Act, presents both challenges and opportunities in CMS' advancement of RTGI health care.

CMS recognizes the important role it plays in the unique economics of providing health care in RTGI areas. By using a geographic lens, CMS aims to be increasingly responsive to the needs of these communities. Ongoing engagement with RTGI communities and adaptive policy development are essential to refining programs and addressing emerging challenges. As CMS moves forward, it remains committed to continuous improvement and responsiveness to the evolving needs of RTGI communities. By maintaining a focus on health equity and implementing inclusive and geographically informed strategies, CMS strives to ensure that all residents, regardless of location, have access to high-quality, comprehensive health care.

Acronyms

Acronym	Definition
ACA	Affordable Care Act
ACO	Accountable Care Organization
AHEAD	States Advancing All-Payer Health Equity Approaches and Development
AI/AN	American Indian/Alaska Native
AIP	Advance Investment Payment
BHP	Basic Health Program
CAH	Critical Access Hospital
CBHC	Community Behavioral Health Clinic
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost Sharing Reduction
CY	Calendar Year
EHB	Essential Health Benefit
EHR	Electronic Health Record
FAQ	Frequently Asked Questions
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GUIDE	Guiding an Improved Dementia Experience
HCBS	Home- and Community-Based Services
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HRSN	Health-Related Social Need
IBH	Innovation in Behavioral Health
IHCP	Indian Health Care Provider
IHS	Indian Health Service
IOP	Intensive Outpatient Program
IPPS	Inpatient Prospective Payment System
IRA	Inflation Reduction Act of 2022
IT	Information Technology
LTCH PPS	Long-Term Care Hospital Prospective Payment System
MA	Medicare Advantage
MDPP	Medicare Diabetes Prevention Program
MFP	Maximum Fair Price
MFT	Marriage and Family Therapist

Acronym	Definition
MHC	Mental Health Counselor
MMD	Mapping Medicare Disparities
MOM	Maternal Opioid Misuse
OPPS	Outpatient Prospective Payment System
PFS	Physician Fee Schedule
PHE	Public Health Emergency
QHP	Qualified Health Plan
REH	Rural Emergency Hospital
RHC	Rural Health Clinic
RTGI	Rural, Tribal, and Geographically Isolated
SAMHSA	Substance Abuse and Mental Health Services Administration
SBS	School-based Services
SDOH	Social Determinants of Health
SDP	State Directed Payment
STC	State Transformation Collaborative (Arkansas)
SUD	Substance Use Disorder
TAC	Technical Assistance Center
TEAM	Transforming Episode Accountability Model
TMaH	Transforming Maternal Health
US	United States

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NOTE: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

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NOVEMBER 2024