Advancing Rural Health Equity

Fiscal Year 2022
Year in Review

Centers for Medicare & Medicaid Services

From the CMS Rural Health Council Co-Chairs

On behalf of the Centers for Medicare & Medicaid Services (CMS) Rural Health Council, we are pleased to present the report on Advancing Rural Health Equity – Fiscal Year 2022 Year in Review, reflecting on much of what has been accomplished as part of our collective efforts to serve people in rural, tribal, and geographically isolated communities.

We are extremely proud of the work CMS has undertaken as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes. In fiscal year 2022, these efforts included advancing an innovative model that aims to enhance access to high-quality, equitable health outcomes in rural areas, supporting states to extend Medicaid and Children's Health Insurance Program postpartum coverage to 12 months, and expanding health insurance coverage to a record 14.5 million Americans in the 2022 individual health insurance market.

By working to address the disparities that underlie our health system, CMS continues to advance health equity across Medicare, Medicaid, the Children's Health Insurance Program, and the Marketplaces. While doing this, we are also working to ensure that the opportunities and barriers that make rural, tribal, and geographically isolated communities unique are appropriately celebrated and addressed.

The actions detailed in this year's annual report demonstrate CMS' commitment to improving the health and wellbeing of individuals living and working in rural areas. They span a wide breadth of the agency's authorities and roles, including regulation, payment, coverage, tools and publications, partner engagement, health system innovations, and regional coordination.

CMS strives to improve the lives of our enrollees. 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
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Executive Summary

Rural, tribal, and geographically isolated communities[i] account for a significant portion of the population and economy of the U.S. These communities play a vital role in supporting the health and wellbeing of all Americans by providing water, food, energy, and outdoor recreation. Yet many of these communities face structural barriers to achieving equitable health outcomes, such as practitioner shortages, hospital closures, and long distances to care. The Centers for Medicare & Medicaid Services (CMS) is committed to working with rural communities to address these disparities and advance access to high-quality, affordable health care for all Americans living in rural areas.

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 rural communities. The CMS Office of Minority Health (OMH) serves as the principal advisor to the agency on advancement of optimal health for all people. The office provides subject matter expertise to CMS on closing gaps in health coverage to expand access and improve health outcomes and quality. OMH conducts research and analyses to inform innovative solutions to lower costs, promote disease prevention, and reduce the incidence and severity of chronic disease to deliver a healthier America. In collaboration and consultation with its partners, CMS is developing and implementing innovative payment and policy solutions designed to meet the needs of rural, tribal, and geographically isolated communities. CMS facilitates transformation and improvement in the rural health care system, integrating its focus on rural health equity across all agency centers, programs, policies, and activities.

The activities and accomplishments outlined in this report represent CMS' commitment to advancing health equity for people living in rural, tribal, and geographically isolated communities in fiscal year (FY) 2022. They are presented across 10 priority focus areas: Medicaid and the Children's Health Insurance Program (CHIP), Medicare, Marketplace, Rural Health Workforce, Models and Demonstrations, Long-Term Services and Supports, Maternal Health, Mental Health and Substance Use Disorders, Quality, and the Coronavirus Disease 2019 (COVID-19).

CMS highlights include the following:

- **Community Health Access and Rural Transformation (CHART) Model:** Lead Organizations awarded cooperative agreements under this innovative model that aims to enhance access to high-quality, equitable health outcomes in rural areas began developing and implementing health care redesign strategies for rural communities in Alabama, South Dakota, Texas, and Washington. CMS is providing funding for rural communities to build systems of care through a Community Transformation Track.
- **Postpartum Coverage Expansion:** As of September 2022, a total of 24 states and the District of Columbia (D.C.) have adopted new options to extend Medicaid and CHIP postpartum coverage to 12 months, improving access to essential health care for an estimated 361,000 pregnant and postpartum individuals.
- **Quality:** CMS has proposed policies, conducted research, and engaged partners to improve the quality of care provided in rural communities. In FY 2022, CMS released its National Quality Strategy, Health Equity Strategy, and several cross-cutting initiatives, all of which outline the agency's commitment to advance health equity, expand coverage, and improve health outcomes, including for rural and underserved communities.

[i] The term "geographically isolated" is used to refer to frontier or remote communities, as well as the U.S. territories and other island communities.

These and other actions detailed in this year's annual report demonstrate CMS' commitment to improving the health and wellbeing of individuals living and working in rural areas. They span a wide breadth of the agency's authorities and roles, including regulation, payment, coverage, tools and publications, health system innovations, partner engagement, and coordination and outreach. The CMS activities included in this annual report are summarized below.

- **REGULATORY ACTIVITIES:** Regulatory efforts that continue to promote and extend flexibilities for providers and other partners were a large part of CMS' actions to improve rural health this year. Through rulemakings in FY 2022, CMS finalized changes to lower out-of-pocket prescription drug costs for individuals enrolled in Medicare Part D beginning in 2024. Additionally, CMS issued an emergency regulation to ensure that eligible staff at health care facilities participating in Medicare and Medicaid programs receive COVID-19 vaccination.

- **PAYMENT POLICIES:** Enhanced payment and other CMS policies paved the way for rural health facilities and practitioners to implement innovative care practices. CMS extended the temporary inclusion of certain telehealth services on the telehealth services list (which makes them eligible for Medicare payment) through 2023, and adopted changes to enhance the use of telehealth for mental and behavioral health care services. CMS established direct Medicare payments for physician assistants, and refined CMS policies for Evaluation and Management visits to better reflect the evolving role of non-physician practitioners as members of the medical team. CMS made changes to allow rural teaching hospitals participating in an accredited rural training track to receive increases to their full-time equivalent staffing caps. Finally, CMS provided 100% federal matching funds to states to cover COVID-19 vaccine counseling visits and expanded coverage of outpatient pulmonary rehabilitation services paid under Medicare Part B for individuals with COVID-19.

- **COVERAGE EXPANSION:** Efforts to expand access to and enrollment in health care coverage across Medicare, Medicaid, CHIP, and the Marketplaces allowed more individuals living in rural communities to obtain the care they need. As a result of these efforts, 275,000 additional Missourians are now eligible for comprehensive health coverage as a result of Medicaid expansion, and CMS directed hundreds of millions of dollars as specified by the American Rescue Plan to Basic Health Programs in Minnesota and New York to support health care coverage for over 1 million individuals. Moreover, as of September 2022, an additional 361,000 pregnant and postpartum individuals annually in 24 states and D.C. are eligible for 12 months of postpartum coverage following these states' adoption of new options to extend continuous postpartum Medicaid and CHIP coverage.

- **TOOLS AND PUBLICATIONS:** The research and tools CMS published this year sought to provide insights and guidance on rural-relevant health issues for individuals CMS serves, providers, policymakers, researchers, and other partners. CMS released a tool to assist states and other partners in preparing for the unwinding period following the end of the COVID-19 Public Health Emergency. CMS also took various actions, including launching a website and hotline, to educate health care consumers about their rights and protections under the newly implemented No Surprises Act. CMS published a report examining inequities in quality of care over a 10-year period for individuals enrolled in Medicare Advantage plans.

- **HEALTH SYSTEMS INNOVATION:** Several payment and practice innovations moved forward this year to test and bolster improvements to the rural health care system. These included

ongoing implementation, evaluations, and updates to CMS Innovation Center models—such as the CHART Model and the Pennsylvania Rural Health Model, which focus on rural populations—and models designed to address the needs of specific subgroups of people CMS serves, such as the Million Hearts® Cardiovascular Disease Risk Reduction Model for Medicare enrollees at elevated risk of having a heart attack. These models promote health equity among rural and underserved communities as they seek to address disparities in access, care quality, and outcomes experienced by these populations.

- **PARTNER ENGAGEMENT:** CMS engaged with individuals and organizations living and working in rural, tribal, and geographically isolated communities to help connect more people to essential health care services and support health care professionals in addressing barriers to quality measurement in rural settings. CMS engaged in robust outreach efforts to help individuals enroll in health insurance plans through the Marketplace with zero or low premiums after application of Marketplace subsidies and provided funding to organizations to connect more eligible children, parents, and pregnant individuals to health care coverage through Medicaid and CHIP. CMS conducted six public listening sessions to inform updates to the CMS Rural Health Strategy and ensure that the strategic framework reflects the needs and priorities of those living and working in rural, tribal, and geographically isolated communities. Finally, CMS engaged with partners and tribal organizations to support quality improvement initiatives for American Indian/Alaska Native communities, and encourage discussion and feedback on health equity.
- **COORDINATION AND OUTREACH:** Through its Regional Rural Health Coordinators, CMS maintained bi-directional communication with providers, partners, and other individuals CMS serves in rural, tribal, and geographically isolated communities. Across the CMS Regions, the Rural Health Coordinators conducted outreach to understand the issues rural providers and individuals CMS serves are facing, and offered information and resources to support rural health care coverage and services. Moreover, the CMS Division of Tribal Affairs worked closely with tribal communities and leaders, including through the Tribal Technical Advisory Group and All Tribes Consultation Webinars, to seek input and advice on proposed rules and initiatives and enhance Tribal Nations' access to CMS programs.

This annual report describes CMS' FY 2022 actions to improve rural health and health care. These actions provide a snapshot of CMS' ongoing commitment to enhance health outcomes and health care access for people in rural, tribal, and geographically isolated communities. CMS looks forward to continuing its progress in helping to achieve rural health equity in collaboration with its federal and other partners.

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Introduction

Why Rural Health?

Approximately 61 million Americans live in rural, tribal, or geographically isolated areas spread across vast and varied landscapes that encompass micropolitan and frontier regions, Tribal Nations, and U.S. territories.[1] As vital sources of water, food, energy production, and outdoor recreation, rural communities play an important role for the health and wellbeing of all Americans.[2]

While these communities are all different, many people living in rural, tribal, and geographically isolated areas experience barriers to economic opportunities and important services such as health care and internet.[3, 4, 5] In comparison to their urban counterparts, residents of these areas have higher average poverty rates.[6, 7, 8] Rural communities also tend to be home to a higher proportion of older residents, yet often have fewer available services in areas such as housing, transportation, social services, and nutrition services to support aging in place.[9, 10] Overall, people living in rural areas face disparities in health outcomes and access to care compared to those living in urban areas.[11, 12] Some of the health disparities experienced by rural communities are briefly summarized below.

In this report, general references to "rural communities" are inclusive of individuals in rural and frontier areas, Tribal Nations, and those residing in the U.S. territories. These communities often face unique barriers to accessing health care.

Rural-Urban Health Disparities

On average, people living in rural communities are more likely to die prematurely from heart disease, cancer, unintentional injury, chronic lower respiratory disease, stroke, and suicide compared to those in urban areas.[13, 14] Rates of obesity and diabetes are higher in rural areas than in non-rural areas.[15, 16] Rural populations experience poorer average maternal health outcomes compared to their non-rural counterparts, including higher pregnancy-related mortality.[17] Opioid overdose rates are disproportionately high in rural populations, as are rates of substance use for alcohol, tobacco, and methamphetamines.[18, 19] Moreover, an estimated one in three rural adults, compared with approximately one in four adults nationwide, lives with a disability impacting their hearing, vision, cognition, mobility, self-care, or independent living.[20]

Many rural Americans face barriers to accessing comprehensive, high-quality, and affordable health care services. People living in rural communities may be less likely to have health insurance and to receive preventive services, and are more likely to live further from a hospital compared to Americans living in urban areas.[21, 22] Many rural residents experience longer travel times to reach their health care practitioners and frequently lack access to public transportation, which can impede timely access to necessary care.[23, 24] Some rural communities also have poorer high-speed internet access and adoption compared to urban communities, due to limited broadband infrastructure, lack of digital literacy, and/or affordability of internet plans.[25, 26] This hinders their ability to leverage online health care information and participate in telehealth visits with their health care practitioners.

Practitioner shortages and facility closures in rural areas further impede access to care. For example, health care facilities operated by the Indian Health Service, which are an important source of care for tribal communities, report approximately 25 percent vacancy rates for health care providers.[27] Most U.S. territories have also reported health care provider shortages, which combined with remote island

geographies, can cause individuals to have to travel long distances to receive health care services not available on-island.[28] Overall, rural areas account for approximately 66 percent of federally designated Health Professional Shortage Areas, which include shortages of primary care, dental health, and behavioral health practitioners.[29] Compared to urban hospitals, rural hospitals have lower average operating margins, and are at greater risk of closure. Since 2010, 138 rural hospitals have closed.[30] These closures reduce access to emergency, primary, and specialty care, and may lead patients to delay or forgo necessary care.[31] Many rural hospitals have closed their obstetric (OB) units, leaving fewer than half of rural counties with OB units.[32] Moreover, between 2008 and 2018, an estimated 500 out of more than 4,500 rural nursing homes closed or merged, leaving approximately 10 percent of rural counties without a nursing home and impeding access to nursing home care for aging rural Americans.[33]

Racial and Ethnic Diversity and Disparities in Rural Communities

Rural communities are increasingly diverse.[34] Based on 2020 Census data, 24 percent of rural Americans identified as part of racial or ethnic minority groups.[35] Within rural communities, people from racial and ethnic minority groups experience greater health inequities compared to non-Hispanic White counterparts. For example, rural residents who are Black and/or American Indian/Alaska Native (AI/AN) experience worse maternal health outcomes on average compared to non-Hispanic White people.[36] Rural residents from racial and ethnic minority groups are more likely to experience barriers to health care access.[37] Compared to rural residents who are non-Hispanic White, people from racial and ethnic minority groups living in rural areas are more likely to report not having primary care providers, forgoing medical care due to cost, and having fair or poor health status.[38]

COVID-19 Pandemic

The ongoing Coronavirus Disease 2019 (COVID-19) pandemic continues to present unprecedented challenges for rural communities. Many of the factors described above, such as the higher average proportion of older adults, likelihood of being uninsured, prevalence of certain medical conditions, and distance to health care facilities, place rural communities at greater risk for adverse outcomes from COVID-19.[39] Despite early surges of COVID-19 cases in urban areas, rural areas have experienced higher overall COVID-19 incidence and mortality rates than urban areas.[40] People who identify as Black, Hispanic, or AI/AN have experienced significantly higher rates of COVID-19 cases and death compared to people who identify as White.[41] Moreover, on average, rural counties lagged behind urban counties on COVID-19 vaccination rates: as of January 2022, the rural vaccination rate was nearly 48 percent, compared to over 60 percent in urban counties.[42] Additionally, the COVID-19 pandemic has exacerbated existing health workforce shortages and compounded the financial strains of rural hospitals.[43]

Advancing Rural Health Solutions

In response to ongoing and emerging challenges, many rural, tribal, and geographically isolated communities have designed and implemented creative solutions in partnership with state and federal agencies to address local health problems. For example, rural communities implemented a broad array of innovative initiatives in response to COVID-19, mobilizing outreach and support for those impacted by the pandemic, helping people access computers for telehealth visits, and bringing vaccines into hard-to-reach communities through mobile vaccination clinics and door-to-door vaccination initiatives, among countless others.[44] Literature indicates that during the COVID-19 Public Health Emergency (PHE), federal and state actions, such as federal financial aid, temporary waivers, and flexibilities have helped to slow the pace of rural hospital closures and ensure broader availability of health care coverage and services for rural Americans.[45, 46, 47, 48, 49, 50]

The Centers for Medicare & Medicaid Services (CMS) strives to be a partner and a leader in this work, amplifying and building on existing rural innovations, and advancing rural health care solutions to achieve health equity for all Americans. Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally Facilitated Health Insurance Marketplace®[ii] offer important sources of health care coverage for millions of Americans living in rural, tribal, and geographically isolated areas. From January 2021 through February 2022, nearly 700,000 rural Americans gained health insurance coverage through the Affordable Care Act (ACA)[51] Marketplaces, for which federal subsidies were enhanced under the American Rescue Plan Act (ARP),[52] and over 1.8 million rural Americans enrolled in coverage through the most recent HealthCare.gov Open Enrollment Period.[53] This report summarizes a variety of actions taken across CMS as part of its commitment to ensuring that all Americans have access to high-quality, equitable, and affordable health care.

CMS Strategic Priorities Related to Rural Health

In collaboration with states and rural partners, CMS has sought to advance health equity for rural, tribal, and geographically isolated communities in alignment with broader CMS strategic priorities. The CMS strategic vision, released in September 2021, outlines the following six CMS strategic pillars that describe how the agency will focus its efforts to serve the public as a trusted partner and steward, dedicated to advancing health equity, expanding coverage, and improving health outcomes:[54]

- Advance health equity by addressing the health disparities that underlie our health system.
- Build on the ACA and expand access to quality, affordable health coverage and care.
- Engage our partners and the communities we serve throughout the policymaking and implementation process.
- Drive innovation to tackle our health system challenges and promote value-based, person-centered care.
- Protect our programs' sustainability for future generations by serving as a responsible steward of public funds.
- Foster a positive and inclusive workplace and workforce, and promote excellence in all aspects of CMS' operations.

In support of CMS' priorities under each of these pillars, CMS identified several cross-cutting initiatives. In particular, the Rural Health cross-cutting initiative will work across CMS programs to promote access to high-quality, equitable care for all people served by CMS programs in rural, tribal, and geographically isolated communities. As part of this initiative, CMS is building on previous efforts in consultation with the CMS Rural Health Council to develop a comprehensive framework outlining CMS' strategic priorities to advance health equity, expand access, and improve health outcomes for rural, tribal, and geographically isolated communities.[55]

Additionally, the CMS Office of Minority Health (OMH) serves as the principal advisor to the agency on advancement of optimal health for all people. The office provides subject matter expertise to CMS on closing gaps in health coverage to expand access and improve health outcomes and quality. OMH conducts research and analyses to inform innovative solutions to lower costs, promote disease prevention, and reduce the incidence and severity of chronic disease to deliver a healthier America.

[ii] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

Purpose of This Report

This report describes CMS actions, including programs, policies, and outreach, that have impacted rural health in FY 2022. These activities either have a specific focus related to rural, tribal, and geographically isolated populations, or they are designed for all those participating in CMS programs, and thus will benefit these populations. The activities and accomplishments outlined in this report underscore CMS' commitment to improving rural health. In alignment with the CMS strategic vision and the CMS Framework for Health Equity, they represent steps to achieve high-quality, affordable care that improves health outcomes and promotes health equity for people in rural areas.

Each of the report sections listed below summarizes CMS activities relevant to areas of particular importance to rural health:

- Medicaid and CHIP
- Medicare
- Marketplace
- Rural Health Workforce
- Models and Demonstrations
- Long-Term Services and Supports
- Maternal Health
- Mental Health and Substance Use Disorders
- Quality
- COVID-19

These focus areas capture efforts under CMS programs (Medicaid and CHIP, Medicare, and the Health Insurance Marketplaces®), innovative models and demonstrations to test potential health care delivery and payment solutions, and other initiatives across the agency to address the persistent health inequities and challenges facing many rural communities described above. Although some CMS activities may span multiple focus areas, each activity is included in only one focus area in this report.

Throughout this report, the term "state," unless otherwise indicated, includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.[57]

Medicaid and CHIP

Medicaid is an essential source of comprehensive health care coverage for millions of Americans living in rural communities. Approximately 17 percent (14 million) of individuals covered by Medicaid live in rural areas, comprising almost a quarter of rural Americans under age 65.[58] In FY 2022, CMS took strategic steps through the Medicaid and CHIP programs to facilitate equitable access to comprehensive health care coverage. CMS also supported states as they prepare for the unwinding of the COVID-19 PHE, including the end of the requirement that states accepting a temporary federal Medicaid funding increase maintain continuous Medicaid enrollment for most enrollees through the end of the month in which the COVID-19 PHE ends.

CMS continued to promote Medicaid expansion and provided states with resources to offer comprehensive health care coverage to millions of additional individuals. Since the enactment of the ACA in 2010, 39 states (including the District of Columbia) and three U.S. territories have expanded Medicaid coverage to the adult group.[59] These Medicaid expansions have resulted in more than 21 million people receiving Medicaid coverage, and have helped address health disparities, including for women and for people from racial and ethnic minority groups.[60] People living in rural areas in states that have not expanded Medicaid to the new adult group under the ACA (i.e., "non-expansion states") are more likely to be uninsured than those living in states that have expanded Medicaid.[61] Medicaid expansion is associated with improved rural hospital financial performance and lower likelihood of rural hospital closure.[62, 63] In FY 2022, Missouri became the newest state to implement Medicaid expansion under the ACA. As of October 2021, 275,000 Missourians gained eligibility for comprehensive health coverage.[64] Eligible individuals under Missouri's Medicaid expansion disproportionately live in rural areas (41 percent), making expansion a significant step toward bridging gaps in health care access for Missourians living in rural areas.[65]

Additionally, as a result of its Medicaid expansion, Missouri became eligible to receive an estimated $968 million in additional funding for its Medicaid program over the next two years, made available through the ARP.[66] In Minnesota[67] and New York,[68] hundreds of millions of dollars in ARP funding were directed to Basic Health Programs (BHPs), thereby increasing these states' ability to provide health care coverage to over 1.1 million individuals combined in New York and Minnesota covered under their BHPs.[69, 70] Minnesota and New York are the only two states currently implementing BHPs, a coverage program available under the ACA for certain individuals whose income is above levels that would otherwise make them eligible for Medicaid and CHIP. Building on successes in these two states, CMS is eager to provide technical assistance to other states considering a BHP.[71]

CMS continued to invest in outreach to ensure that eligible individuals enroll in Medicaid and CHIP. The agency awarded a record $49 million to fund organizations to connect more eligible children, parents, and pregnant individuals to health care coverage through Medicaid and CHIP. Awardees—including local governments, a tribal organization, federal health safety net organizations, non-profits, and schools—are working to reduce the number of uninsured children by conducting outreach to enroll and retain eligible children in Medicaid and CHIP.[72]

Additionally, CMS issued guidance to State Medicaid Directors on a new Medicaid health home benefit for children with medically complex conditions. Beginning October 1, 2022, states can opt, under this benefit, to cover care management, care coordination, patient and family support, and similar services that are expected to support a family-centered system of care for Medicaid-eligible children with

medically complex conditions. By implementing this benefit, states can cover coordination of care for children with medically complex conditions, including coordination of the full range of pediatric services they need and coordination of care and services from out-of-state providers.[73]

CMS has been working with states and other partners to prepare for the eventual end of the COVID-19 PHE. In March 2022, CMS issued a State Health Official letter to provide guidance and assist states in preparing for the unwinding of the continuous Medicaid enrollment requirement and other federal waivers and flexibilities. The letter described how states may distribute eligibility and enrollment work in the post–COVID-19 PHE period, mitigate loss of coverage for individuals who are eligible for Medicaid, and smoothly transition individuals between coverage programs, including coverage through the Marketplace with financial subsidies.[74] CMS released various resources to support the COVID-19 PHE unwinding, including a tool that highlights fundamental actions states should take to prepare for unwinding, and provides existing CMS guidance and other resources to support state planning efforts.[75] These preparations are essential to ensuring that millions of individuals with Medicaid coverage maintain access to health care coverage after the COVID-19 PHE unwinding.

CMS also conducted outreach to trusted community partners, including those delivering health care, education, and social services, to ensure that individuals currently enrolled in Medicaid and CHIP have the information they need to maintain Medicaid coverage and access to services after the COVID-19 PHE ends. CMS Region II (New Jersey, New York, Puerto Rico, and Virgin Islands) hosted a rural health town hall, in which Medicaid representatives and other partners discussed post-COVID-19 PHE transitions, including for telehealth services, and reported severe workforce shortages in community mental health centers affecting access to services. Additionally, CMS Region X (Alaska, Idaho, Oregon, and Washington) reached out to community organizations representing or serving farm workers, minority populations, immigrants, education providers, and senior service providers in rural areas of the region to encourage their participation in CMS Medicaid Unwinding Information Sessions and share needed information with their networks.

In FY 2022, in addition to the COVID-19 PHE, CMS responded to public health emergencies such as those declared in Puerto Rico,[76] Kentucky,[77] Florida,[78] and South Carolina,[79] making resources and flexibilities available to ensure hospitals and other facilities could continue to operate and provide access to care to those impacted by natural disasters in these locations.[80, 81, 82, 83] To help Medicaid and CHIP agencies prepare for and respond to future PHEs, disasters, and other emergencies, the CMS Medicaid and CHIP Coverage Learning Collaborative developed a toolkit on strategies available to support Medicaid and CHIP operations and enrollees, including an inventory of available flexibilities and authorities that can be leveraged in the event of a PHE.[84]

Medicare

Medicare provides health care coverage to millions of adults who are older or who have disabilities. Approximately a third of rural adults are enrolled in Medicare.[85] In FY 2022, CMS continued to examine lessons learned from COVID-19 PHE flexibilities and waivers, and enacted policies to improve equitable access to high-quality, affordable care for individuals enrolled in its Medicare programs.

During the COVID-19 PHE, CMS expanded its Medicare telehealth policy to facilitate safe access to health care for individuals enrolled in Medicare. Before the pandemic, payment for telehealth services was limited

to Medicare enrollees receiving services in designated rural areas[86] and receiving care via a device with two-way audio and video capability,[87] among other conditions. Most of these restrictions were temporarily waived for the duration of the COVID-19 PHE, and as a result, there was a rapid expansion in telehealth use nationwide. Medicare enrollees living in rural areas accounted for a small proportion of the growth in telehealth use compared to urban areas; [88] however, early in the pandemic, telehealth offered by rural providers in federally qualified health centers (FQHCs) and rural health clinics (RHCs) increased nearly 100-fold.[89] Analyses of 2020 data found that the share of Medicare enrollees who had an audio-only telehealth visit was higher among those living in rural areas (65 percent),[90] suggesting that limited access to broadband and internet-enabled devices may have impeded telehealth use for some Medicare enrollees in rural areas.[91, 92] Based on these analyses, further work is needed to ensure equitable access to high-quality care through telehealth, especially for those living in rural areas with limited broadband access or other barriers to telehealth access. For example, CMS is helping build awareness about a new Federal Communications Commission initiative, the Affordable Connectivity Program, that is helping to lower the cost of broadband service and connective devices like a laptop or tablet.[93]

The Consolidated Appropriations Act (CAA), 2022 extended certain telehealth flexibilities under Medicare, which would otherwise expire with the COVID-19 PHE, for an additional 151 days beyond the eventual end of the COVID-19 PHE. This extension will enable Congress and CMS to continue to examine results and lessons learned from the use of telehealth during the pandemic to inform potential permanent policy changes.[94] These provisions extended changes that allow for individuals enrolled in Medicare to receive telehealth services regardless of geographic location, and at other locations including in their home. The CAA, 2022 will also allow Medicare to continue to pay for telehealth services furnished using audio-only technology, as well as telehealth services provided by FQHCs and RHCs.[95] Finally, the CAA, 2022 directed $62,510,000 in federal grants to telemedicine and distance learning services in rural areas.[96]

The calendar year (CY) 2022 Medicare Physician Fee Schedule (PFS) final rule implemented these CAA, 2022 provisions and extended the temporary inclusion of certain Medicare telehealth services, which will remain on the Medicare Telehealth Services List through December 31, 2023. This extension will allow additional time for CMS to receive feedback from the public and assess whether to permanently add these telehealth services to the Medicare telehealth services list.[97]

Under the CY 2022 Medicare PFS final rule, CMS also adopted changes to encourage growth in the diabetes prevention program. CMS anticipates these changes will result in more suppliers, enhanced access to diabetes prevention program services for people with Medicare in rural areas, and a reduction in the incidence of diabetes in people with Medicare living in both urban and rural communities. The final rule also allows for Medical Nutrition Therapy services to be paid by Medicare with no out-of-pocket costs and furnished via telehealth, benefiting those in rural areas who experience barriers to accessing these services.[98]

In the CY 2023 Medicare Advantage and Part D final rule, CMS finalized changes to lower out-of-pocket prescription drug costs for individuals enrolled in Medicare Part D beginning in 2024. Specifically, CMS finalized a policy that requires Part D plans to apply all price concessions they receive from network pharmacies to the negotiated price at the point of sale, so that the individual can also share in the savings.[99] The final rule also included consumer protections to hold plans accountable for detecting and preventing the use of confusing or potentially misleading marketing activities by third-party marketing organizations, and measures to promote transparency in Medicare Advantage and Part D plans' underlying costs, revenue, and supplemental benefit expenditures related to the calculation and verification of the Medical Loss Ratio.[100] Similarly, in the CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System final rule, CMS finalized changes to the hospital price transparency regulation to increase compliance with rules designed to ensure that people know how much a hospital charges for items and services.[101]

CMS took initial steps to implement a new provider designation, "Rural Emergency Hospitals" (REHs), by issuing proposed conditions of participation, payment policies, and Medicare enrollment requirements.[102, 103] These policies, which were subsequently finalized on November 1, 2022, will take effect on January 1, 2023.[104] Established under the CAA, 2021, this new provider type is designed to help small rural hospitals and critical access hospitals (CAHs) avoid closures and promote equity in health care for those living in rural communities by facilitating access to needed services.[105, 106]

CMS Region VII (Iowa, Kansas, Missouri, and Nebraska) hosted a series of learning opportunities to provide rural health care providers with information about CMS and federal partnerships, Medicare Administrative Contractor (MAC) interactions, and mental health care and substance use disorder treatment. Through these sessions, CMS discussed a range of topics, such as health equity; hospital price transparency; the No Surprises Act; and how to partner with the CMS Regional Office, other federal entities, and the MAC. These sessions also provided resources about CMS programs, strategic priorities, and proposed rules (e.g., the Hospital Inpatient Prospective Payment System).

Marketplace

The ACA Marketplace offers a critical source of health insurance coverage for individuals and families who are not eligible for Medicaid or do not otherwise have access to coverage. Individuals living in rural areas comprise approximately 15 percent of plan selections among HealthCare.gov enrollees.[107] There are fewer insurers on average in rural counties than in urban counties, and the limited competition often leads to higher premiums. As of March 2021, rural residents comprised a disproportionately large share of uninsured adults who may be eligible to enroll in Marketplace coverage on HealthCare.gov, compared to urban adults.[108]

To address this gap in affordable coverage, CMS took several steps in FY 2022 to improve access and enrollment in the Federally-facilitated and State-based Marketplaces, decreasing inequities in access to coverage and care for individuals in rural communities. Subsidies provided through the ARP expanded access for individuals to enroll in zero- and low-premium health insurance plans after subsidies through the Marketplace.[109] The consumer portions of premiums for plans sold through the HealthCare.gov Marketplaces fell by an average of 23 percent,[110] and 2.8 million more consumers received premium tax credits in 2022 compared to 2021 as a result of ARP investments.[111] The enhanced financial help that was put in place by the ARP was recently extended through 2025 by the Inflation Reduction Act, which was signed into law on August 16, 2022.[112] A record 14.5 million Americans signed up for or were automatically re-enrolled in 2022 individual market health insurance coverage through the Marketplaces, outpacing 2021 enrollment by 20 percent in the 33 states using HealthCare.gov.[113]

The strong enrollment numbers were the result of robust outreach efforts, including community engagement through the Champions for Coverage program, additional funding, and quadrupling the number of Navigators available to assist consumers, including those living in rural, tribal, and geographically isolated communities.[114] More than 1,500 certified Navigators held more than 1,800 outreach and education events at accessible areas—such as local libraries, vaccination clinics, food drives, county fairs, and job fairs.[115] Building on that progress, in August 2022 CMS awarded $98.9 million in grant funding to enable Navigator organizations to retain staff and add to the existing Navigators who will help consumers navigate enrollment through the Marketplace, Medicaid, and CHIP for the 2023 Open Enrollment Period. This is the largest Navigator funding award that CMS has

provided to date, and it forms part of CMS' strategic efforts to make health coverage more equitable and accessible by reaching people where they are. Navigators will focus on outreach to particularly underserved communities, including people who identify as racial and ethnic minorities such as AI/AN, people in rural communities, the LGBTQ+ community, refugee and immigrant populations, families with low household income, pregnant women and new mothers, veterans, small business owners and their employees, individuals with language barriers, and those lacking reliable transportation or internet access.[116, 117, iii]

CMS Administrator Chiquita Brooks-LaSure and CMS Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming) met with Navigators and assisters for Colorado's State-based Marketplace to discuss Marketplace enrollment and consumer savings from the ARP. Across all rural Colorado counties, enhanced Marketplace subsidies have led to a 19 percent increase in Marketplace enrollment over the last year, and a 16 percent decrease in rural residents' net premiums. Furthermore, CMS approved Colorado's Section 1332 State Innovation Waiver amendment request to create the "Colorado Option," a state-specific health coverage plan that will make insurance more affordable and accessible for nearly 10,000 Coloradans starting in 2023.[118]

Additionally, CMS published the U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2023 final rule, which implements new measures that will support consumers in finding the right form of quality, affordable health care coverage on HealthCare.gov to meet their individual needs.[119] This rule makes it easier for people to choose the best plan to meet their needs by standardizing plan options. With standardized maximum out-of-pocket limitations, deductibles, and cost-sharing features, consumers will be able to more directly compare important plan attributes, such as premiums, provider networks, prescription drug coverage, and quality ratings when choosing a plan. The rule also helps ensure that patients have access to the right provider, at the right time, in an accessible location, by requiring Qualified Health Plans on the Marketplace to ensure that certain classes of providers are available within required time and distance parameters.[120] This is particularly important for individuals living in rural, tribal, and geographically isolated communities who often face greater health care provider shortages and travel longer distances for health care services than those living in urban areas.

Kentucky, Maine, and New Mexico successfully transitioned from HealthCare.gov to their own State-based Marketplaces for the 2022 plan year. The transition will allow these states to continue to build on efforts to meet the specific and unique needs of their residents through localized, state-driven outreach and coverage options in the Marketplace. CMS also invested $20 million of ARP grant funding in State-based Marketplaces, including $1 million for each of these three states. These funds will be used to increase consumer access, modernize information technology systems, and/or conduct targeted consumer outreach activities to help make health care coverage enrollment smoother.[121]

The No Surprises Act, which took effect in FY 2022, created new consumer protections against surprise billing. The No Surprises Act is expected to reduce the burden of medical debt by limiting out-of-pocket costs for items and services covered by the law. People living in rural areas are more likely to have significant medical debt compared to those living in urban areas.[122] The protections apply to people with most types of private health insurance and prevent them from receiving surprise medical bills for emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. The law also established a dispute resolution process for payment disputes between plans and providers, and another process for disputes between providers and the uninsured or self-pay patients.[123] While people with Medicare and Medicaid were already generally protected from surprise medical bills, individuals who receive health coverage through a group or individual health plan, including through a Marketplace, are now afforded these protections too. CMS took various actions in FY 2022, including launching a website and hotline, to educate health care consumers about their rights and protections under the new law.[124]

[iii] This list is a subset of the populations that Navigator organizations plan to target, as outlined in their approved cooperative agreement applications. For a full list, please see 2022 CMS Navigator Cooperative Agreement Awardees.

Rural Health Workforce

Rural communities face longstanding health workforce shortages, and recent health facility closures have further limited access to care in many communities. Rural health care facilities report challenges recruiting and retaining health care workers, such as physicians, advanced practice providers, nurses, community and public health workers, and nurse aides.[125, 126] Rural providers have historically operated on thin margins, with 47 percent of rural providers reporting that they operated "in the red" before the COVID-19 pandemic began.[127] The pandemic has further exacerbated these financial challenges and health workforce shortages in rural communities.[128] A 2022 U.S. Surgeon General's Advisory highlighted the urgent need to address the health worker burnout crisis across the country, including rural areas, calling for a whole-of-society response to address the factors underpinning burnout.[129]

CMS Region IX (Arizona, California, Hawaii, Nevada, and the Pacific Territories) held two virtual Rural Town Halls with the U.S. Territories of Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa to collect feedback regarding key issues facing providers and individuals seeking care in the Pacific territories. Participants highlighted the challenges around maintaining a strong health workforce in the Pacific territories. The limited availability of hospitals and clinics is compounded by workforce shortages, often causing individuals to travel off-island to seek care.

CMS established policies in the FY 2022 Inpatient Prospective Payment System final rule to implement provisions of the CAA, 2021 to establish 1,000 new Medicare-funded physician residency slots for qualifying hospitals, promote training opportunities in rural areas, and increase graduate medical education payments to hospitals meeting certain criteria beginning in FY 2023.[130, 131] Based on rulemaking published in the Federal Register in December 2021, CMS estimated that funding for the additional residency slots will total approximately $1.8 billion over the next 10 years. This represents the largest increase in Medicare-funded residency slots in over 25 years. CMS will phase-in 200 slots per year over the next five years, and will prioritize applications from qualifying hospitals serving geographic areas and underserved populations with the greatest need. Additionally, the final rule allows rural teaching hospitals participating in an accredited rural training track to receive increases to their full-time equivalent staffing caps.[132] To further promote workforce development and training in rural areas, the FY 2023 Hospital Inpatient Prospective Payment System and Long-Term Care Hospital Prospective Payment System final rule also introduced changes to Graduate Medical Education policies, allowing additional cap slots for urban hospitals that establish new "rural training tracks" (now called Rural Training Programs) with rural hospitals.[133]

Finally, the CY 2022 Medicare PFS final rule made changes to implement section 403 of the CAA, 2021 to allow Medicare to make direct payments to physician assistants for professional services they provide under Part B beginning January 1, 2022. Prior to this change, Medicare could make payment only to the employer or independent contractor of a physician assistant.[134] The final rule further refined CMS policies for split (or shared) Evaluation and Management visits, which are visits provided in a facility setting by a physician and non-physician practitioners (NPPs) in the same group, to better reflect the evolving role of NPPs as members of the medical team, and to clarify conditions of payment for Medicare reimbursement.[135] NPPs can play an especially important role in rural communities where there are physician shortages.

Models and Demonstrations

CMS, in large part through the CMS Center for Medicare & Medicaid Innovation, is designing and testing new models of care to advance rural health equity, improve the rural health care delivery system, and lower costs. In FY 2022, CMS explored and continued innovative ways to advance high-quality, equitable access to care in rural communities through national and state-based models and demonstrations, creating opportunities for state and local partners to test innovative approaches to support rural providers and advance health equity in rural communities.

National Models and Demonstrations

The Community Health Access and Rural Transformation (CHART) Model aims to enhance access to high-quality, equitable health outcomes in rural areas by offering increased financial sustainability for participating rural acute care hospitals, CAHs, and rural emergency hospitals; operational and regulatory flexibilities; and technical assistance to support local communities' efforts. The model's Community Transformation Track pre-implementation period began in October 2021, and will be followed by a six-year performance period beginning in January 2023. During the pre-implementation period, awardees are developing a health care redesign strategy for their defined communities in Alabama, South Dakota, Texas, and Washington to follow over the course of the model. During the performance period, awardees and participating hospitals will implement these health care design strategies while participating hospitals adopt their capitated payments, with the aim that these interventions improve access to high-quality care for individuals in rural communities, while providing payment stability to participating hospitals.[136]

CMS redesigned the Global and Professional Direct Contracting (GPDC) Model to better reflect the agency's vision of creating a health system that achieves equitable outcomes through high-quality, affordable, person-centered care. The Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model, a redesign of the GPDC Model, addresses partner feedback, participant experience, and Administration priorities, including CMS' commitment to advancing health equity.[137] The ACO REACH Model strives to promote health equity and address disparities for underserved communities, continue the momentum of provider-led organizations participating in risk-based models, and protect individuals receiving care with enhanced provider vetting and monitoring and increased transparency. Testing of the redesigned model will begin in January 2023 and extend for four performance years.[138]

CMS Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) hosted a town hall to offer information to rural health partners about the ACO REACH Model and provide updates about the CHART Model. CMS has continued to check in with one of the CHART Model lead organizations at the University of Alabama Birmingham for partner feedback.

The Frontier Community Health Integration Project Demonstration aims to develop and test new models of integrated, coordinated health care in the most sparsely populated rural counties. Originally implemented from 2016 to 2019, the CAA, 2021 extended the demonstration for five years.[139] The new cost reporting period began on January 1, 2022. Under this demonstration, CMS is engaging CAHs to increase access to services that are often unavailable in frontier communities, with the goal of avoiding expensive transfers to hospitals in larger communities. CMS will evaluate whether providing these services in frontier communities can improve the quality of care received by individuals with Medicare coverage, increase patient satisfaction, and reduce Medicare expenditures.[140]

The Rural Community Hospital Demonstration is testing the feasibility and advisability of cost-based reimbursement for small rural hospitals that are too large to be CAHs. The demonstration, which began in 2004, was recently granted a five-year extension through the CAA, 2021 and continued implementation in FY 2022.[141] The Rural Community Hospital Demonstration has provided participating hospitals with higher Medicare payments for covered inpatient hospital services, resulting in better financial positions for those hospitals. CMS is assessing the financial impact on participating hospitals, as well as the effect on health care for the populations served.[142]

The Comprehensive Primary Care Plus (CPC+) Model concluded its four-year performance period on December 31, 2021, and CMS has since posted its fourth annual CPC+ evaluation report. As the largest primary care payment and delivery reform model ever tested in the U.S., CPC+ aimed to strengthen primary care through regionally based, multi-payer payment reform and care delivery transformation.[143, 144] About a quarter of participating practices were located in rural and suburban areas. CPC+ required practices to transform care delivery across five key functions: access and continuity, care management, comprehensiveness and coordination, patient and caregiver engagement, and planned care and population health. Overall, participating practices reported increased use of on-site behaviorists, a decrease in long-term opioid use and potential overuse, and reduced acute care utilization. Practices reported plans to continue processes implemented under CPC+ after the model ended, to ensure a range of options for accessing primary care, use data to inform practice improvements, and offer “episodic” care management for patients with a recent hospital admission or emergency department visit.[145]

The Maternal Opioid Misuse (MOM) Model addresses fragmentation in the care of pregnant and postpartum individuals with Medicaid who have opioid use disorder through state-driven transformation of the delivery system serving this population. A Pre-Implementation Evaluation Report posted in February 2022 described early observations about how awardees and care delivery partners are implementing their MOM Model interventions and responding to challenges arising from the COVID-19 pandemic.[146] CMS is supporting awardees in eight states (Colorado, Indiana, Maine, Maryland, New Hampshire, Tennessee, Texas, and West Virginia) as they complete their first year of care delivery and prepare to implement their coverage and payment strategies. Seven of eight states are implementing the model in rural areas. The anticipated performance period end date is December 2024.[147]

Finally, the Million Hearts® Cardiovascular Disease (CVD) Risk Reduction Model posted its fourth and final evaluation report in February 2022. Over four years (from 2017 to 2020), the model enrolled more than 250,000 individuals with Medicare who were at elevated risk of having a heart attack over 10 years. Participating organizations were similarly spread throughout the country and across urban and rural areas.[148] Overall, for individuals in the model’s intervention group, CVD risk factors (e.g., systolic blood pressure and low-density lipoprotein) decreased by 1.3 percent compared to the control group (among enrollees with the highest CVD risk), and the model appeared to reduce all-cause mortality by 0.3 percentage points. The evaluation of the model concluded that modest incentives can improve CVD medication use and reduce CVD risk factors in varied clinical settings.[149]

State-Based Models and Demonstrations

The Pennsylvania Rural Health Model tests whether global budgets will enable participating rural hospitals to invest in quality and preventive care and tailor services to better meet the needs of local communities. The model, currently in its fourth of six performance years, aims to improve rural Pennsylvanians’ access to high-quality care and improve health outcomes, including reduced rural health disparities, improved chronic disease management and preventive screenings, and decreased mortality from substance use disorders.[150] Five commercial payers have partnered with CMS in the model, and 18 rural hospitals are participating in the model. The global budgets have provided financial stability to participants, particularly during COVID-19.[151]

Under a Medicaid section 1115 demonstration, North Carolina launched the Healthy Opportunities Pilots program to address social determinants of health.[152] Program funds, totaling $650 million in federal Medicaid funds over five years, will be used to implement evidence-based interventions in four domains: food, housing, transportation, and interpersonal violence/toxic stress. The program will assess the effectiveness of these nonmedical services in improving health outcomes and lowering health care costs. In 2022, food, housing, and transportation services were launched across pilot regions. The section 1115 demonstration authorizes the pilot program through October 31, 2024.[153]

CMS approved an extension of Vermont's Medicaid section 1115 demonstration, Global Commitment to Health. This extension—through December 31, 2027—will enable the state to continue to test, monitor, and evaluate a managed care–like delivery system, home- and community-based services (HCBS), and novel pilot programs, as well as pursue innovations to maintain high-quality services and programs that are cost-effective. Over the past 15 years, the Global Commitment to Health demonstration has been a key driver for major expansions of health coverage in Vermont. As a result of these efforts, Vermont has nearly universal health coverage, has one of the healthiest populations in the nation, and serves nearly 60 percent of enrollees eligible for nursing facility care in a home- or community-based setting.[154]

Long-Term Services and Supports

Medicaid is the primary payer across the nation for long-term services and supports (LTSS). LTSS refers to both institutional care (e.g., in a nursing home) and HCBS. Millions of Americans need LTSS because of disabling conditions and chronic illnesses, and people living in rural areas often experience challenges in accessing LTSS.[155, 156] In FY 2022, CMS acted to improve both access to and the quality of LTSS in rural communities.

CMS approved Medicaid section 1115 demonstrations in Alabama and California that will create pathways to support care for people outside of traditional health care settings and increase access to HCBS. Alabama's Community Waiver Program will operate alongside an HCBS 1915(c) waiver to meet the needs of individuals who prefer to receive services and supports in their home or community setting rather than in an institutional setting. Together, Alabama's 1115 demonstration and HCBS 1915(c) waiver will enable the state to redesign its HCBS system, as well as create a new program to support individuals with intellectual disabilities.[157] The California Advancing and Innovating Medi-Cal (CalAIM) initiative is California's Medicaid section 1115 demonstration, which operates alongside the state's managed care section 1915(b) waiver. Among several priorities, CalAIM will address enrollees' health-related social needs and strengthen access to care, including HCBS. It will provide $4.3 billion in funding for the state's HCBS program and implement interventions designed to prevent institutionalization for at-risk populations. [158]

For each state or territory not currently participating, CMS announced it would offer $5 million to expand access to HCBS through Medicaid's Money Follows the Person (MFP) program.[159] Originally authorized in 2005, the MFP program has distributed more than $4 billion to states to support individuals who choose to transition out of institutions and back into their homes and communities. In August 2022, CMS awarded approximately $25 million in grants to Illinois, Kansas, New Hampshire, American Samoa, and Puerto Rico to support the early planning phase for their MFP programs. With a total of 41 states and territories participating in MFP, these awards marked the first time the MFP grants were made available to territories.[160] This opportunity may be especially beneficial for some individuals living in rural, tribal, and geographically isolated communities to access high-quality HCBS in homes and communities of their choice.

CMS notified states that they have an additional year—through March 31, 2025—to demonstrate compliance with the requirement to spend state funds made available through the federal medical assistance percentage (FMAP) increase under section 9817 of the ARP to expand, enhance, or strengthen HCBS for Medicaid enrollees who require LTSS. Section 9817 of the ARP provided a temporary 10 percentage point increase to the FMAP for certain Medicaid expenditures for HCBS. States must use state funds equivalent to the amount of federal funds attributable to the increased FMAP on state activities to bolster HCBS in Medicaid. States may use this ARP funding to improve and expand HCBS in rural, tribal, and geographically isolated communities. The extended timeframe will help states facilitate high-quality, cost-effective, person-centered services for individuals covered by Medicaid in their homes and communities.[161]

The CY 2022 Home Health Prospective Payment System final rule included provisions to address challenges facing individuals with Medicare who receive care at home. The rule implements nationwide expansion of the Home Health Value-Based Purchasing Model to incentivize quality of care improvements to the delivery of home health services for people with Medicare, with the first performance year beginning on January 1, 2023.[162] It also made improvements to the Home Health Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, and Inpatient Rehabilitation Facility Quality Reporting Program, revising quality measures to reduce burden and increase focus on patient outcomes, and finalizing proposals to begin collecting data on coordination of care. Changes under this rule will strengthen CMS' data collection efforts to identify and address disparities for people who live in rural areas, among other populations. In addition, the rule finalized mandatory COVID-19 reporting requirements for nursing homes. Finally, it implemented provisions of the CAA, 2021 to strengthen oversight, enhance enforcement, and establish consistent and transparent survey requirements in hospice programs serving people with Medicare.[163]

In April 2022, CMS for the first time publicly released data on mergers, acquisitions, consolidations, and changes of ownership for hospitals and nursing homes participating in Medicare. This data, which CMS expects to release quarterly going forward, is intended to help researchers, state and federal enforcement agencies, and the public analyze trends and issues in health care markets and, more specifically, provide insight into how the ownership of hospitals and nursing homes impacts costs and outcomes for consumers, including in underserved areas.[164] Additionally, in September 2022 CMS made additional data publicly available that provides more information about the ownership of all Medicare-certified nursing homes. This data will, for the first time, give state licensing officials, state and federal law enforcement, researchers, and the public an enhanced ability to identify common owners of nursing homes across nursing home locations.[165] These data releases are part of a larger effort to enhance transparency and accountability and promote competition in the health care industry. To improve the safety and quality of the nation's nursing homes, in June 2022 CMS also updated guidance on health and safety standards that nursing homes must meet to participate in Medicare and Medicaid.[166] In August 2022, CMS issued an informational bulletin detailing actions that states can take using existing Medicaid authorities to drive better health outcomes for nursing home residents and improve staff pay, training, and retention efforts.[167]

Additionally, the CY 2022 PFS final rule implemented changes made under the CAA, 2021 to enable RHCs and FQHCs to receive payment for hospice attending physician services when provided by physicians, nurse practitioners, and physician assistants under certain conditions.[168, 169, 170] Prior to these changes, which took effect on January 1, 2022, RHCs and FQHCs were not authorized to offer these services under Medicare. During a hospice election, hospice attending physician services can take place at the individual's home, a Medicare-certified hospice freestanding facility, skilled nursing facility, or hospital.[171]

In February and April 2022, CMS Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas) hosted two virtual events for more than 200 long-term care ombudsmen representing all five states. At these events, CMS provided targeted training on a variety of topics, including Medicare Part A,

Medicare Advantage, and Medigap coverage. In addition, the long-term care ombudsmen provided feedback to CMS on issues like advocating for individuals living in rural nursing facilities.

Maternal Health

Overall, Medicaid covers over 42 percent of U.S. births;[172, 173] in rural areas, Medicaid covers approximately 50 percent of births and 56–67 percent of births for racial and ethnic minority populations (including people who are Black, AI/AN, Native Hawaiian or Pacific Islander, and Hispanic or Latino).[174] Many people lose coverage after 60 days postpartum, despite the fact that in the U.S., approximately 12 percent of maternal deaths occur between 43 days and one year postpartum.[175] Loss of health coverage increases the risk of adverse health outcomes, including pregnancy-related conditions that emerge after the 60-day period. The ARP included provisions to support pregnant and postpartum individuals through Medicaid by providing a state option to extend postpartum coverage for 12 months following the end of the pregnancy, regardless of changes in circumstances. States that adopt this option also must provide full benefits under Medicaid and CHIP.[176] In FY 2022, CMS supported states to improve access to a range of maternal health services for rural communities, people from racial and ethnic minority groups, and families with lower incomes, and also acted to reduce inequities in postpartum coverage, as described below.

CMS released a Maternity Care Action Plan, which described a holistic and coordinated approach across CMS to improve health outcomes and reduce inequities for people during pregnancy, childbirth, and the postpartum period. The plan outlines priorities such as technical assistance for states to extend postpartum coverage, policies to support a diverse provider workforce, and other equity-focused initiatives.[177]

As of September 2022, 24 states and D.C. adopted options to extend Medicaid and CHIP postpartum coverage to 12 months. In FY 2022, California; Connecticut; Florida; Hawaii; Indiana; Kansas; Kentucky; Maine; Maryland; Massachusetts; Michigan; Minnesota; New Jersey; New Mexico; North Carolina; Ohio; Oregon; South Carolina; Tennessee; Virginia; Washington state; Washington, D.C.; and West Virginia extended postpartum coverage in their Medicaid and CHIP programs from the 60-day period to 12 months, joining Louisiana and Illinois, which adopted extensions in FY 2021. CMS continues to work with other states that have proposed adopting the ARP option to extend postpartum coverage to 12 months. As a result of these efforts, an estimated 361,000 pregnant and postpartum individuals annually are eligible for 12 months of postpartum coverage.[178, 179, 180, 181]

In May 2022, CMS published a report titled Advancing Rural Maternal Health Equity to raise awareness of efforts with rural partners, identify collaborative opportunities, and summarize next steps to advance rural maternal health care equity across the country. The report summarizes opportunities, in alignment with CMS' cross-cutting initiative on maternity care, for the agency to build on collaborations with federal, regional, state, and local partners to deliver more equitable, affordable, and quality maternal health care to rural communities.[182]

In August 2022, CMS established a new "Birthing-Friendly" hospital designation intended to drive improvements in maternal health outcomes. This designation, which will take effect in Fall 2023 and will be publicly reported, will assist consumers in choosing hospitals that have demonstrated a commitment to maternal health and the delivery of high-quality maternity care through their participation in quality improvement collaboratives and implementation of best practices that advance health care quality, safety, and equity for pregnant and postpartum parents.[183]

CMS Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) hosted two virtual town halls with CAH leadership in Maine and New Hampshire that focused on barriers to sustaining OB services in rural hospitals, such as low patient volume and OB staffing requirements for CAHs. During these town halls, CAHs shared practical solutions for CMS that utilize existing staff and available resources within rural and geographically isolated communities. CMS continues to work with these groups to address their questions related to maternal health requirements and access to services.

Finally, CMS is working to ensure access to a full range of reproductive health care services, including safe and legal abortion care and contraception. In August 2022, CMS issued a letter to U.S. governors inviting them to work with CMS and apply for Medicaid section 1115 demonstrations to provide increased access to care for women from states where women may be denied critical medical care.[184] CMS, along with the Departments of Labor and the Treasury, also issued guidance clarifying protections for birth control coverage. Under the ACA, most private health plans are required to provide coverage for birth control and family planning counseling at no additional cost.[185]

Mental Health and Substance Use Disorders

CMS took several actions in FY 2022 to enhance access to mental health care and substance use disorder prevention and treatment. These services are especially important in rural communities, which have greater overall shortages of behavioral health providers and higher incidence of suicide as well as certain substance use disorders (SUDs). According to an FY 2022 HHS report, major increases in the use of telehealth services helped maintain access to certain types of health care services during the COVID-19 pandemic, especially behavioral health services. Medicare telehealth visits comprised a third of total visits with behavioral health specialists in 2020.[186]

CMS released the CMS Behavioral Health Strategy in May 2022, which describes goals, objectives, and supporting activities to improve access to substance use disorder prevention, treatment and recovery services, mental health services, crisis intervention, and acute and chronic pain care, and to further enable care that is well-coordinated and effectively integrated. The strategy also seeks to remove barriers to care and services, and to adopt a data-informed approach to evaluate the agency's behavioral health programs and policies.[187]

CMS took steps to strengthen and expand access to behavioral health care services for children in Medicaid, including issuing guidance documents to states reminding them of their mandate to cover behavioral health services for children in Medicaid, and urging them to expand school-based health care, including behavioral health care.[188] Additionally, CMS and other agencies across HHS issued a joint letter to states, tribes, and jurisdictions encouraging them to prioritize and maximize their efforts to strengthen children's mental health and wellbeing, and outlining HHS's plans to support and facilitate state-level coordination across federal funding streams to advance and expand mental health services for children.[189]

Aligned with its strategic commitment to drive innovation to support health equity and high-quality, person-centered care, CMS adopted changes in the CY 2022 PFS final rule to implement changes made by the CAA, 2021 to enhance the use of telehealth and other telecommunication technologies for

providing mental and behavioral health care services under Medicare. CMS eliminated geographic restrictions and allowed Medicare payment for telehealth services involving evaluation, diagnosis, and treatment of mental health disorders that individuals received from their homes. To facilitate access to telehealth services for individuals covered by Medicare in areas with limited broadband infrastructure, Medicare will also allow counseling and therapy services, including counseling and therapy services for the treatment of substance use disorders provided through Opioid Treatment Programs, to be delivered via audio-only telephone calls when audio-visual communication is not available to the enrollee and all other requirements are met. Finally, Medicare will pay for mental health visits furnished by FQHCs and RHCs via telehealth communications beyond the end of the COVID-19 PHE.[190]

CMS worked with states to implement a new option, made available by the ARP, for supporting community-based mobile crisis intervention services for individuals with Medicaid. The new option enables states to integrate mobile crisis intervention services into their Medicaid programs and offers additional tools and resources to strengthen these programs. The agency also awarded $15 million in planning grants to 20 states to support development of these services.[191] In September 2022, Oregon became the first state to adopt this Medicaid State plan amendment, which will allow the state to provide community-based stabilization services to individuals experiencing mental health and/or substance use crises throughout the state by connecting them to a behavioral health specialist 24 hours per day, every day of the year.[192]

CMS Region VII (Iowa, Kansas, Missouri, and Nebraska) hosted a virtual listening session for rural health care providers on mental health care and SUD treatment. The session reviewed numerous resources, such as the newly launched 9-8-8 suicide prevention hotline, resources for harm reduction, and information on combatting stereotypes related to SUDs. Additionally, CMS reviewed opportunities for participants to apply for State Opioid Response and Rural Emergency Medical Services training grants.

Quality

CMS has proposed policies, conducted research, and engaged partners to improve the quality of care provided in rural communities. In FY 2022, CMS released its National Quality Strategy, Health Equity Strategy, and several cross-cutting initiatives, all of which outline the agency's commitment to advance health equity, expand coverage, and improve health outcomes, including for rural and underserved communities.[193, 194, 195] To further the knowledge base around quality measurement in rural settings and provide recommendations on the selection of quality and efficiency measures for CMS programs, the National Quality Forum (NQF) Measures Applications Partnership (MAP) convened a MAP Rural Health Advisory Group. In FY 2022, the MAP Rural Health Advisory Group released multiple reports focused on quality measurement in rural communities, including an environmental scan to understand changes in the rural measurement landscape since 2017, and a final report outlining the Rural Health Advisory Group's recommended list of the 37 best-available measures to address the needs of rural populations.[196] Additionally, the NQF convened the multistakeholder Rural Telehealth and Healthcare System Readiness Committee to offer guidance on a conceptual measurement framework to inform quality and performance improvement for care delivered via telehealth in rural areas in response to disasters.[197] These reports offer key recommendations for future quality measurement in rural settings.

CMS published a report examining inequities in quality of care over a ten-year period, titled Trends in Racial, Ethnic, Sex, and Rural-Urban Inequities in Medicare Advantage: 2009–2018. The report offers an analysis of historical trends in inequities by race, ethnicity, sex, and geography (rural-urban) among individuals enrolled in Medicare Advantage plans, examining the extent to which there has been progress in addressing inequities in those areas.[198] The report noted that further investigation is needed to better understand the reasons for large improvements in care that occurred for people living in rural areas as well as for individuals who are Black and/or Hispanic, and apply lessons learned to ensure continued progress toward health equity.[199]

On July 21, 2022, CMS released the first-ever HCBS Quality Measure Set to promote consistent quality measurement within and across state Medicaid HCBS programs. The measure set is intended to provide insight into the quality of HCBS programs and enable states to measure and improve health outcomes for people relying on LTSS in Medicaid.[200] The release of this voluntary measure set is also a critical step to promoting health equity among the millions of older adults and people with disabilities who need LTSS because of disabling conditions and chronic illnesses.[iv]

The Quality Payment Program (QPP), which started in January 2017, is designed to incentivize clinicians to provide high-value, high-quality care with Medicare payment increases while also reducing payments to those clinicians who are not meeting performance standards.[201] Within QPP, the Merit-based Incentive Payment System (MIPS) measures clinician performance across four areas: quality, improvement activities, promoting interoperability, and cost.[202] During the 2022 performance year, QPP offered flexibilities for small practices, and those in rural locations and Health Professional Shortage Areas, to help clinicians meaningfully participate and succeed in MIPS. These practices had reduced reporting requirements in the performance category of "improvement activities" and small practices also had reduced report requirements for "promoting interoperability."[203]

CMS held two public webinars in April and May 2022, titled Rural Health Quality: How CMS Initiatives Improve the Way We Measure and Address Gaps in Care. The webinars highlighted the unique challenges surrounding quality measurement in rural settings and described how CMS is working to address these issues. During the webinars, CMS reviewed resources and programs available to rural providers to help improve quality of care.[204] Additionally, CMS accepted applications for its 2022 Minority Research Grant Opportunity, which will offer $1 million in grant funding to support researchers at minority-serving institutions who are exploring how CMS can better meet the health care needs of the people it serves, including racial and ethnic minority populations, LGBTQ+ persons, persons with disabilities, persons who live in rural areas, and persons otherwise adversely affected by persistent poverty or inequality.[205]

CMS continued to support quality improvement initiatives for Indian Health Service and Tribally operated hospitals participating in Medicare. The Partnership to Advance Tribal Health (PATH), funded by CMS, consists of a strategic partnership of organizations committed to improving health care for AI/AN communities. PATH supports Indian Health Service hospitals to identify operational improvement needs and implement best practices. In particular, PATH assists participants in assessing patient, family, and tribal engagement to strengthen the relationships between the hospitals and the communities.[206, 207] Moreover, in FY 2022, the CMS Division of Tribal Affairs and the Tribal Technical Advisory Group established a Health Equity Subcommittee to provide Tribal Consultation and input to the CMS Health Equity Framework and developed the definition of health equity specific to people who identify as AI/AN.[208] In collaboration with CMS, the National Indian Health Board held a World Café Health Equity Listening Session and Health Equity Summit in FY 2022 and is producing a report with outcomes and recommendations to CMS.[209]

[iv] For more information on the purpose of the measure set, the measure selection criteria, and considerations for implementation, see the State Medicaid Director Letter. CMS strongly encourages states to use this information to assess and improve quality and outcomes in their HCBS programs. CMS expects to update the measure set in the future, including adding newly developed measures that address measure gaps, as the field of HCBS measure development advances.

CMS also conducted outreach locally. CMS Regions IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) and VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas) collaborated with a Beneficiary and Family Centered Care Quality Improvement Organization to educate individuals, families, and caregivers in rural and underserved communities on Immediate Advocacy, which is a no-cost service that helps Medicare enrollees quickly resolve problems they may be experiencing with medical care and services. Through this collaboration, CMS helped disseminate a resource on Immediate Advocacy that rural partners can share in their communities. Additionally, CMS Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin) hosted a "Real Time" webinar for partners serving rural communities in the region. This session focused on new strategic initiatives, including CMS' Advancing Health Equity and Rural Health cross-cutting initiatives.

COVID-19

As the COVID-19 pandemic continued to take a toll on rural communities, CMS took numerous actions to facilitate equitable access to COVID-19 vaccines, tests, and treatments for people living in rural areas, people with lower incomes, and people who are medically underserved.

The COVID-19 vaccine is the best defense against severe illness, hospitalization, and death from the virus.[210] In FY 2022, CMS continued to work to promote and ensure access to COVID-19 vaccination, including booster doses, for all eligible Americans. Currently, individuals with Medicare and CHIP coverage as well as most individuals with Medicaid coverage can receive COVID-19 vaccines, including boosters, at no cost, through these coverage programs.[211] Under the CY 2022 PFS final rule, CMS extended the current Medicare payment rate for COVID-19 vaccine administration through one year beyond the end of the COVID-19 PHE.[212] Fee-for-Service Medicare also offers additional payment for vaccines administered in the home for individuals with Medicare who have difficulty leaving their homes or are hard to reach. This payment is intended to help individuals overcome geographic, clinical, socioeconomic, or other barriers to getting a COVID-19 vaccine.[213]

Additionally, CMS is currently providing 100 percent federal matching funds to states for their Medicaid and CHIP expenditures on COVID-19 vaccines and COVID-19 vaccine administration.[214, 215] To support providers as they continue to help address vaccine hesitancy, CMS issued a State Health Official Letter providing guidance on Medicaid and CHIP coverage and payment for "stand-alone vaccine counseling."[v] As described in this letter, CMS is currently providing 100 percent federal matching funds to state Medicaid agencies for expenditures on stand-alone COVID-19 vaccine counseling for Medicaid enrollees under the age of 21 who are eligible for the Early and Periodic Screening, Diagnostic, and Treatment benefit.[216]

COVID-19 vaccination is especially important for health care workers. An emergency regulation issued by CMS required COVID-19 vaccination of eligible staff at health care facilities that participate in the Medicare and Medicaid programs.[217] Moreover, the Supreme Court subsequently recognized CMS' authority to set a consistent COVID-19 vaccination standard for workers in facilities that participate in Medicare and Medicaid. CMS' vaccine rule covers an estimated 10.4 million health care workers at

[v] The term "stand-alone vaccine counseling" refers to when a patient and/or caregiver receives counseling about a vaccine from a health care practitioner but the patient does not actually receive the vaccine dose at the same time as the counseling (that is, there is no actual delivery or injection of a vaccine during the practitioner visit) because it is not appropriate to provide the vaccine dose at that time.

76,000 medical facilities.[218] CMS has compiled federal resources on the COVID-19 vaccine for health care professionals, partners, and patients, which include resources for improving vaccine confidence and uptake in rural communities.

Additionally, making widespread COVID-19 testing available remains an important component of the federal government's strategy to reduce the spread of COVID-19, curb outbreaks, and allow schools and businesses to remain open.[219] CMS is ensuring access to over-the-counter, at-home COVID-19 tests by covering them without cost sharing for individuals in Original Medicare and Medicare Advantage during the COVID-19 PHE, and by requiring insurance companies and group health plans to cover the cost of these tests.[220] These updates build on previous guidance to state Medicaid and CHIP programs that at-home COVID-19 tests that have been provided to individuals with Medicaid or CHIP coverage by a qualified provider must be covered without cost sharing.[221, 222]

Finally, CMS continued to ensure access to evidence-based treatment and rehabilitation options for COVID-19. Under the CY 2022 PFS final rule, CMS expanded coverage of outpatient pulmonary rehabilitation services paid under Medicare Part B to individuals who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks.[223]

CMS continues its work to support states and other partners to respond as the pandemic evolves. For example, CMS Region III (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia) hosted quarterly meetings with the State Offices of Rural Health in all five states in the region to discuss CMS updates on COVID-19 policies. These updates equipped the State Offices of Rural Health with up-to-date information to enhance community awareness and education on COVID-19, and helped to increase COVID-19 vaccinations in rural communities. As noted above, the agency will also continue to work in close collaboration with partners to help them prepare for the COVID-19 PHE unwinding, and ensure that individuals in rural areas with Medicare, Medicaid, or Marketplace health coverage maintain their access to affordable, comprehensive health coverage.

The Way Forward

The activities and initiatives described in this report are part of an ongoing commitment to improving the health and wellbeing of individuals participating in CMS programs and health care consumers living in rural, tribal, and geographically isolated communities. Going forward, CMS will build on these efforts to develop and implement programs and policies that foster access to high-quality care for people living in rural communities, support rural health care professionals, and address the unique economics of health care delivery in rural areas. CMS Rural Health Coordinators in the 10 CMS Regional Offices will continue to strengthen partnerships with local organizations and support the unique and diverse needs of rural providers and communities. CMS is dedicated to supporting advancements and transformations of the rural health system to improve outcomes for Americans living in rural areas and advance rural health equity.

As in previous years, CMS is committed to continuing its work to improve access to high-quality, equitable care in rural, tribal, and geographically isolated areas through initiatives that will build on the developments and achievements of FY 2022. CMS anticipates expanding promising programs; implementing rules, such as those detailing the REH designation; and leveraging current research and community engagement activities to inform work across the agency. CMS will also act to implement

existing and new legislation and policies. For example, CMS will be working with people covered by its programs, as well as health industry, state, and local partners, to implement the provisions of the recently passed Inflation Reduction Act of 2022, which will meaningfully lower health care costs for millions of people with Medicare coverage.[224] CMS will also support rural payers, health care professionals, and communities as policies evolve. CMS will continue this important work in collaboration with its rural partners to ensure that all individuals in rural communities have access to high-quality, affordable, and equitable health care.

Appendix A: Acronym List

Acronym	Full Term
ACA	Affordable Care Act
ACO	Accountable Care Organization
AI/AN	American Indian/Alaska Native
ARP	American Rescue Plan Act of 2021
BHP	Basic Health Program
CAA	Consolidated Appropriations Act
CAH	Critical Access Hospital
CalAIM	California Advancing and Innovating Medi-Cal
CDC	Centers for Disease Control and Prevention
CHART	Community Health Access and Rural Transformation
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CPC+	Comprehensive Primary Care Plus
CVD	Cardiovascular Disease
CY	Calendar Year
D.C.	District of Columbia
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GPDC	Global and Professional Direct Contracting
HCBS	Home- and Community-Based Services
HHS	U.S. Department of Health & Human Services
LTSS	Long-Term Services and Supports
MAC	Medicare Administrative Contractor
MAP	Measures Applications Partnership
MFP	Money Follows the Person
MIPS	Merit-based Incentive Payment System
MOM	Maternal Opioid Misuse
NPP	Non-Physician Practitioner
NQF	National Quality Forum
OB	Obstetric
PATH	Partnership to Advance Tribal Health
PFS	Physician Fee Schedule
PHE	Public Health Emergency
QPP	Quality Payment Program
REACH	Realizing Equity, Access, and Community Health
REH	Rural Emergency Hospital
RHC	Rural Health Clinic
SUD	Substance Use Disorder

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