



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

FY2023 Year in Review

NOVEMBER 2023



From the Co-Chairs

Last November, the Centers for Medicare & Medicaid Services (CMS) released its [Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities](#). This Framework, informed by so many who are impacted by CMS programs, outlines six priorities to guide efforts across CMS programs and operations. The results of many of these efforts are reflected in this report on Advancing Health Equity in Rural, Tribal, and Geographically Isolated Communities: FY 2023 Year in Review.

CMS is transforming health and health care systems in rural, tribal, and geographically isolated communities by advancing health equity, expanding coverage, and improving health outcomes. In fiscal year 2023, we saw the end of the public health emergency and record numbers of individuals sign up for health care coverage in Affordable Care Act Marketplaces during the 2022–2023 open enrollment season.¹ In addition, we saw CMS leadership traveling and engaging with those that CMS serves in Puerto Rico, the US Virgin Islands, Alaska, Hawaii, and across the continental US. We also saw the establishment of a new provider type, the Rural Emergency Hospital, to help address hospital closures that impact too many.

We aim to ensure that the opportunities that make rural, tribal, and geographically isolated communities unique are appropriately celebrated and that barriers are addressed. We continue to advance health equity across Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Marketplaces.

This year’s annual report demonstrates CMS’ ongoing commitment to advancing health equity for individuals living and working across diverse geographies. These actions span a wide breadth of the agency’s authorities and roles, including regulation, payment, coverage, tools and publications, partner engagement, health system innovations, quality of care, and regional coordination.

Across these actions, CMS maintains a focus on the goal of improving the lives of our enrollees and those who care for them. We eagerly anticipate our continued collaboration and partnership with all those CMS serves to advance health care in rural, tribal, and geographically isolated communities.

Sincerely,



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Executive Summary

Rural, tribalⁱ, and geographically isolated communitiesⁱⁱ are ethnically, culturally, socioeconomically, religiously, politically, linguistically, and economically diverse and important parts of the US population and economy.² These communities, which represent approximately 67 million Americans, contribute to the cultural diversity of our entire nation and play a vital role in the health and wellbeing of all Americans – for example, by producing food and energy, and providing outdoor recreation opportunities.^{3 4 5}

Despite this, many communities continue to face structural barriers to achieving equitable health outcomes, such as recruitment and retention of health workforces, access to specialty care or home and community-based services, and long distances to travel for care. The Centers for Medicare & Medicaid Services (CMS) is committed to working with impacted communities to address disparities and advance access to high-quality, affordable health care.

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. CMS is collaborating and consulting with national, state, tribal, and local partners to develop and implement innovative payment and policy solutions designed to meet the needs of rural, tribal, and geographically isolated communities.

In November 2022, CMS published the [CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities](#), which updates and builds upon the CMS Rural Health Strategy, released in 2018, to reflect changes in the health care landscape since its development. This new Framework supports CMS' overall efforts to advance health equity, expand access to quality, affordable health coverage, and improve health outcomes. In alignment with this Framework, this report focuses on how CMS serves various communities that share similar experiences in accessing health care based on geographical influences. 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. The priorities for rural, tribal, and geographically isolated communities are:

Priorities

1. Apply a Community-Informed Geographic Lens to CMS Programs and Policies
2. Increase Collection and Use of Standardized Data to Improve Health Care
3. Strengthen and Support Health Care Professionals
4. Optimize Medical and Communication Technology
5. Expand Access to Comprehensive Health Care Coverage, Benefits, and Services and Supports
6. Drive Innovation and Value-Based Care

i This report focuses on how CMS serves various communities that share similar experiences in accessing health care based on geographical influences, such as communities on tribal lands.

ii The term “geographically isolated” refers to frontier or remote communities, as well as the US territories and other island communities.

In this annual report, CMS highlights the following accomplishments towards meeting these priorities:

- **Rural Emergency Hospital Designation:** CMS finalized a rule establishing Conditions of Participation and enrollment processes for Rural Emergency Hospitals (REHs), new payment rates, and a new provider type established to allow Critical Access Hospitals and certain rural hospitals to continue providing essential health services.^{6 7}
- **Postpartum Coverage Expansion:** Medicaid and CHIP provide extended continuous postpartum coverage for 12 months after pregnancy to postpartum individuals in 37 states, the District of Columbia, and the US Virgin Islands.⁸
- **Innovative Models:** The Making Care Primary Model⁹ and the All-Payer Health Equity Approaches and Development (AHEAD) Model, which were announced this year, both aim to improve health care and advance health equity across diverse geographies through innovative model design.¹⁰
- **Extension of the “Four Walls” Requirement Grace Period:** CMS extended a grace period related to the Medicaid clinic services “four walls” requirement until February 11, 2025. This extension means that Indian Health Service (IHS) and tribal facilities can continue to claim Medicaid payment under the clinic services benefit (including at the IHS All Inclusive Rate) for services provided outside of the “four walls” of the facility until February 11, 2025.

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, tribal, and geographically diverse areas. These actions 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. A summary of the CMS activities is shown below.

- **REGULATORY ACTIVITIES:** Regulatory efforts that promote and extend flexibilities for providers and other partners were a large part of CMS’ actions to improve rural, tribal, and geographically isolated communities’ health this year. Through rulemaking in fiscal year (FY) 2023, CMS established the Conditions of Participation and enrollment processes for REHs, which began in January 2023. In addition, CMS established a policy that permits clinical staff of hospital outpatient departments to provide behavioral health services remotely to patients in their homes. In the Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Final Rule (42 CFR § 422.100(n)), CMS finalized requirements for Medicare Advantage organizations to develop and maintain procedures to offer digital health education to enrollees to improve access to medically necessary covered telehealth benefits.¹¹
- **PAYMENT POLICIES:** Enhanced payment and other CMS policies paved the way for rural, tribal, and geographically isolated health facilities and practitioners to implement innovative care practices. In late 2022, CMS finalized payment policies for clinical psychologists and licensed clinical social workers to furnish integrated behavioral health care as part of a primary care team. As of January 1, 2023, Medicare is also providing a new monthly payment for comprehensive treatment and management services for patients with chronic pain.¹²
- **COVERAGE EXPANSION:** Efforts to expand access to and enrollment in health care coverage across Medicare, Medicaid, CHIP, and the Affordable Care Act (ACA) Marketplaces allowed more individuals living in rural, tribal, and geographically isolated communities to obtain the care they need. For the ACA Marketplaces, CMS improved consumer choices by increasing health insurance issuer participation in single-issuer counties. For Medicare, CMS finalized the implementation of certain provisions of the Consolidated Appropriations Act, 2021 pertaining to Medicare enrollment and eligibility rules. The finalized rule adopted new special enrollment periods for exceptional circumstances that provide an opportunity for eligible individuals to enroll in Part B without a late enrollment penalty if they didn’t enroll in Medicare during their Initial Enrollment Period when they were first eligible.¹³ In July 2023, South Dakota expanded Medicaid eligibility to adults aged 19 to 64 with incomes under 138 percent of the federal poverty level. As a result, more than 52,000 South Dakotans, including many tribal members in South Dakota, are now eligible for comprehensive health care coverage through Medicaid. CMS continues

to offer resources about the end of the COVID-19 Public Health Emergency (PHE) for states and providers to assist with the transition, including outreach to people in rural areas, Medicare provider fact sheets, and [resources for states](#) on the end of the Medicaid continuous enrollment condition.

- **TOOLS AND PUBLICATIONS:** The research and tools CMS published this year sought to provide insights and guidance on health issues for diverse geographies. CMS continued to release tools and resources to support states, providers, and individuals in navigating the end of the COVID-19 PHE. In addition, CMS published a technical assistance document that provides information to ACA Marketplace Navigators and certified application counselors on the unique health coverage protections, needs, and programs for American Indian and Alaska Native (AI/AN) people. CMS also published a study on the use of telehealth visits for rural and urban fee-for-service Medicare enrollees, finding significant increases in utilization of telehealth services compared to a pre-COVID-19 PHE period.
- **HEALTH SYSTEMS INNOVATION:** CMS remains committed to developing and testing innovative health care payment and service delivery models, several of which moved forward this year to test and bolster improvements to the health care systems in rural, tribal, and geographically isolated communities. These included several provisions of the Shared Savings Program to advance equity and increase enrollee participation in rural, tribal, and geographically isolated areas. In addition, CMS established a supplemental payment for Indian Health Service and tribal hospitals, and for hospitals located in Puerto Rico. Finally, CMS announced an Innovation Center model, Making Care Primary, which aims to improve care for Medicare beneficiaries by supporting the delivery of advanced primary care services, which are foundational for a high-performing health system.
- **PARTNER ENGAGEMENT:** CMS engaged 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. CMS engaged in robust outreach efforts to assist individuals to enroll in insurance coverage across programs. Through the [Connecting Kids to Coverage Outreach and Enrollment](#) grants program, CMS awarded \$5.9 million in cooperative agreements to seven tribal and urban Indian health programs in six states to increase the participation of eligible, uninsured AI/AN children in Medicaid and CHIP.
- **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 ten US Department of Health and Human Services Regions, the Rural Health Coordinators conducted outreach to understand the issues that providers and individuals CMS serves face, and they offered information and resources to support health care coverage and services. Moreover, the CMS Division of Tribal Affairs worked closely with tribal communities and tribal leaders, including through the CMS Tribal Technical Advisory Group and All Tribes Consultation Webinars, to seek input and advice on proposed rules and initiatives, enhance access to CMS programs, and hold trainings on CMS and other federal programs.



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Introduction

Applying a Geographic Lens to Health Care

Approximately 67 million Americans live across vast and varied landscapes that encompass rural and frontier regions, tribal lands, and US territories.^{14 15} Rurality exists on a spectrum, ranging from towns adjacent to a metropolitan area to towns that are more sparsely settled and remote. Common definitions often describe rural populations, areas, and structures as those that are not urban. However, this creates a dichotomy that focuses on urban spaces and overlooks the nuances among the types of rurality.^{16 17}

Rural, tribalⁱⁱⁱ, and geographically isolated^{iv} communities are diverse – ethnically, culturally, socioeconomically, religiously, politically, linguistically, and economically.¹⁸ The strengths and assets of rural, tribal, and geographically isolated communities vary depending on the sources of employment (e.g., agriculture, manufacturing, natural resources), recreation destinations (e.g., federal, state, and local parks, historic sites), and community capital (e.g., cultural organizations, community institutions, health facilities).^{19 20 21}

Communities that are rural, tribal, or geographically isolated face unique challenges accessing health care. Many communities face increased susceptibility to climate crises, such as extreme weather events (e.g., hurricanes, typhoons, droughts, wildfires) or environmental pollution, that may exacerbate the need to access health care.^{22 23 24 25} Residents of rural or remote areas, particularly remote tribal communities, face more obstacles in accessing care, such as fewer health facilities and providers, increased distance to care, or increased costs.^{26 27 28} In island areas, such as the US territories, residents may have to leave the island by boat or airplane to access care.²⁹ Within the US, American Indians and Alaska Natives (AI/AN) have limited access to health care and poorer health outcomes when compared to other groups. AI/AN people have higher avoidable hospitalizations compared to non-AI/AN people living in the same counties.³⁰

Telehealth is a key strategy for overcoming barriers to access to care.^{31 32 33 34} For example, health centers in the US territories increased telehealth services during the COVID-19 Public Health Emergency (PHE). However, rural areas tend to have decreased access to broadband compared to urban areas. Broadband access is further diminished in geographically isolated areas within rural communities, such as tribal lands, or in areas with larger Black populations, higher rates of poverty, or lower educational levels.^{35 36} While some US territories recently established broadband, many people face outages in adverse weather events or still lack internet access.^{37 38} As telehealth and health information technology have become increasingly important to health care delivery, lack of broadband access is another potential barrier.

iii This report focuses on how CMS serves various communities that share similar experiences in accessing health care based on geographical influences, such as communities on tribal lands.

iv The term “geographically isolated” refers to frontier or remote communities, as well as the US territories and other island communities.

Working alongside rural, tribal, and geographically isolated communities, the Centers for Medicare & Medicaid Services (CMS) strives to be a partner and a leader, amplifying and building on existing innovations, and advancing health care solutions to achieve health equity for all Americans. CMS is furthering the longstanding efforts that recognize how communities' conditions, such as social determinants of health (SDOH), impact individual outcomes, and how policies can address the needs and assets of communities in various geographies.^{39 40 41} Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally Facilitated Marketplaces offer important sources of health care coverage for millions of Americans living in rural, tribal, and geographically isolated areas. This report summarizes a variety of actions taken across CMS programs as part of CMS' commitment to ensuring that all Americans have access to high-quality, equitable, and affordable health care.

FY 2023 Transitions: The End of the COVID-19 Public Health Emergency

During the COVID-19 PHE, CMS used a combination of emergency authority waivers, regulations, and sub-regulatory guidance to ensure and expand access to care and to give health care providers the flexibilities they needed to deliver care.^{42 43 44} The Medicaid continuous enrollment^v ended on March 31, 2023 and the federal COVID-19 PHE ended on May 11, 2023.⁴⁵ Beginning April 1, 2023, states were able to begin terminating Medicaid and, in some cases, CHIP^{vi} enrollment for individuals who were determined no longer eligible.⁴⁶ With the end of the Medicaid continuous enrollment condition, CMS was cognizant that geographically isolated communities might face additional enrollment challenges, such as increased distance to eligibility offices or health care providers, lack of broadband or telephone connectivity for online eligibility and enrollment resources, or even unreliable mail delivery to receive eligibility notices. Recognizing that the end of the Medicaid continuous enrollment condition is a significant health coverage transition event, CMS has worked to ensure that people stay connected to coverage, whether through Medicaid, CHIP, or other coverage options (i.e., employer-sponsored, Affordable Care Act (ACA) Marketplace).

CMS began mitigation strategies during the COVID-19 PHE and ramped up these efforts by working with states to identify opportunities to improve compliance with federal redetermination requirements to promote coverage and protect enrollees. CMS has also been working with states on innovative Medicaid outreach and retention strategies, including approving state waivers for flexibility in eligibility requirements and systems. CMS released guidance to Medicare and Medicaid providers, including federally qualified health centers (FQHCs), Critical Access Hospitals (CAHs), and Indian Health Service (IHS) and tribal facilities, to encourage them to engage with enrollees on renewal processes. CMS continues to offer resources for states and providers to assist with the transition, such as guidance for [outreach to people living in rural areas](#), Medicare provider fact sheets, and Medicaid continuous enrollment frequently asked questions for states.^{47 48 49 50}

CMS Strategic Priorities Related to Health Care in Rural, Tribal, and Geographically Isolated Areas

In collaboration with states and rural partners, CMS sought to advance health equity for rural, tribal, and geographically isolated communities in alignment with broader CMS strategic priorities. The CMS strategic vision outlines 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.^{51 52}

- 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.

v Under the authority of the Families First Coronavirus Response Act (FFCRA), states received a temporary 6.2 percentage point Federal Medical Assistance Percentage increase and maintained enrollment of nearly all Medicaid enrollees during the COVID-19 PHE. The Consolidated Appropriations Act, 2023 delinked the end of the FFCRA's Medicaid continuous enrollment condition from the end of the COVID-19 PHE.

vi The FFCRA 6008(b)(3) continuous enrollment condition does not apply to individuals enrolled in a separate CHIP, but does apply to individuals enrolled in a "Medicaid expansion CHIP" program (wherein the state has expanded Medicaid eligibility to optional targeted low-income children and meets the requirements of the CHIP program, rather than operating the program separately from Medicaid). However, some states, using state-only funds, opted to maintain eligibility for individuals determined ineligible for separate CHIP.

- 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.

Since the release of the CMS Strategic Plan in September 2021, CMS has made considerable progress towards each of the six pillars. For example, the release of the [CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities](#) aims to advance health equity by identifying priorities specific to those communities.^{53 54}

The Rural Health Cross-Cutting Initiative connects staff and projects across CMS to promote access to high-quality, equitable care for all people in rural, tribal, and geographically isolated communities. 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

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.

Purpose of this Report

This report describes CMS actions, including programs, policies, and outreach, that have impacted health care for rural, tribal, and geographically isolated communities in FY 2023. These activities either have a specific focus related to rural, tribal, and geographically isolated populations, or they focus on all those participating in CMS programs, and thus will benefit these populations. In alignment with the CMS strategic vision and the CMS Framework for Health Equity, these activities represent steps to achieve high-quality, affordable care that improves health outcomes and promotes health equity for people in rural, tribal, and geographically isolated areas.

The report sections are based on the priorities from the [CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities](#):

Priorities

- | | |
|--|---|
| 1. Apply a Community-Informed Geographic Lens to CMS Programs and Policies | 4. Optimize Medical and Communication Technology |
| 2. Increase Collection and Use of Standardized Data to Improve Health Care | 5. Expand Access to Comprehensive Health Care Coverage, Benefits, and Services and Supports |
| 3. Strengthen and Support Health Care Professionals | 6. Drive Innovation and Value-Based Care |

These sections capture efforts under CMS programs (Medicaid and CHIP, Medicare, and the Health Insurance Marketplace®), Innovation Center models, and other 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. Although some CMS activities may span multiple priorities, each activity is highlighted in one section of the 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.



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

CMS uses a community-informed geographic lens for its activities and processes to promote health equity and ensure that rural, tribal, and geographically isolated communities can meet their health and health care needs. Throughout fiscal year 2023, CMS took steps to deepen relationships with local rural, tribal, and geographically isolated communities to better understand their needs and the impacts of CMS programs and policies in their areas. CMS applied a community-informed geographic lens through activities such as: **engaging with geographically isolated communities, convening providers, examining existing policies, and providing geographically informed resources.** CMS worked to ensure that the voices of those most impacted and underserved are heard.

Engaging in Rural, Tribal, and Geographically Isolated Communities

Throughout FY 2023, CMS conducted listening sessions, townhalls, Open Door Forums, tribal consultations, All Tribes Calls, and other forms of public engagement to seek feedback and input from rural and tribal communities on new and existing CMS programs and policies. The CMS Office of Program Operations and Local Engagement conducted outreach across the ten CMS regions to engage with the public locally. For example, CMS Region II (New Jersey, New York, Puerto Rico, and USVI) visited rural New York to meet with various providers, including sole community hospitals, CAHs, Rural Health Clinics (RHCs), Accountable Care Organizations (ACOs), behavioral health providers, public health departments, and aging service providers, to strengthen its relationships across the health system in rural New York.

CMS engaged directly with communities living on tribal lands and in US territories, many of whom experience geographic isolation and have unique health and health care needs. In May 2023, the CMS Deputy Administrator and other CMS officials hosted a listening session in Anchorage, Alaska during the National Tribal Health Conference held by the National Indian Health Board. The CMS Listening Session provided an opportunity for CMS leadership to share updates and information about CMS initiatives, such as the CMS Health Equity Framework, CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities,¹ and the CMS Quality Improvement Work for Indian Health Services and tribal hospitals and facilities.⁵⁸ During the trip, CMS Region X (Alaska, Idaho, Oregon, and Washington) arranged health leader and enrollee listening sessions; meetings with four hospitals, two nursing facilities, two FQHCs, and inpatient and outpatient behavioral health facilities; a meeting with a pre-maternal home, and a meeting with itinerant nurses who serve 57 communities; and a meeting with state officials who oversee federal and state programs. The communities and facilities provided many opportunities for CMS staff to see the distinctions and similarities between tribal and non-tribal health delivery systems. In July 2023, CMS Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas) held a tribal listening session in New Mexico that was attended by over 40 participants representing 20 tribes, the IHS Albuquerque field office, and the state Medicaid Office. CMS shared the learnings from all of these engagements throughout the agency and incorporated key takeaways into future planning and program improvements. In September 2023, the CMS Administrator attended the Secretary’s Tribal Advisory Committee meeting in Rapid City, South Dakota and made site visits to health care facilities and community-based organizations serving the Oglala Lakota community.

In March 2023, the CMS Deputy Administrator and other CMS officials visited Puerto Rico to better understand how CMS policies affect people in the US territories and the health disparities that underlie their health care systems. During the three-day visit, CMS officials toured a hospital and an FQHC in Puerto Rico and hosted 13 different engagement events with stakeholders to hear more about the needs of the health care system in Puerto Rico and USVI.^{59 60 61} CMS leadership met with physicians, hospital administrators, advocacy groups, provider coalitions, Medicare Advantage plans, Medicaid programs, industry and thought leaders, and government officials from Puerto Rico and USVI, and heard about issues ranging from funding to program oversight. CMS expressed a commitment to interacting with the health care community in Puerto Rico and USVI throughout the policy and implementation processes to best achieve their shared goals.⁶² In August 2023, CMS hosted a Medicare Symposium in USVI and facilitated several discussions, roundtables, and presentations related to health care delivery and access in USVI, and heard from attendees about the challenges of providing health care.

Convening Providers from Diverse Geographies

CMS continued to advance improvements for maternal health care as laid out in the 2022 [Advancing Rural Maternal Health Equity](#) report, including through a new Birthing-Friendly Hospital designation for qualifying facilities. There has been a decline in the number of rural hospitals providing obstetric services, in addition to challenges recruiting and retaining maternal health providers.^{63 64} As a part of local outreach and engagements with the community in Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin), leadership from one CAH reported not offering obstetric delivery services, requiring patients to travel 1.5 hours for delivery. Leadership from another CAH reported that shortages and increased turnover in OB/GYN staff and providers is causing concerns over keeping their OB/GYN unit open. In December 2022, CMS convened a maternal health discussion on key actions to improve the health of pregnant and post-partum individuals – including the need for a robust and diverse maternity care workforce and the ability for consumers to easily identify health systems engaged in improving maternal care. More than 25 health plans have committed to displaying the Birthing-Friendly Hospital designation logo, which will go live in fall 2023, on their provider directories.⁶⁵



In June 2023, CMS held the inaugural CMS Health Equity Conference, which convened leaders in health equity from federal agencies, health provider organizations, academia, community-based organizations, and others, both in person and virtually. Conference attendees heard from CMS leadership on recent developments and updates on CMS programs; learned about health equity, tribal health disparities, and promoting health literacy in rural areas; discussed promising practices and innovative solutions; and collaborated on community engagement efforts.⁶⁶

Through the Partnership for Quality Measurement, CMS receives input from a variety of experts – clinicians, patients, measure experts, and health information technology specialists – in a consensus-based approach to ensure informed and thoughtful endorsement of qualified measures. In FY 2023, rural health experts were sought out for new committees, such as Pre-Rulemaking Measure Review, Measure Set Review, or Endorsement and Maintenance.^{67 68}

Examining Existing Policies with a Geographic Lens

CMS examined the impacts of new and existing CMS policies and initiatives to remove systemic barriers to accessing high-quality health care. Through the activities within this report, CMS advanced a three-pronged approach of supporting rural providers, making rural health care more effective, and transforming the rural health delivery system to improve access to high-quality, coordinated care in rural areas.⁶⁹ In November 2022, CMS published the [CMS Framework for Advancing Health Care in Rural, Tribal, and Geographically Isolated Communities](#), which updates and builds upon the CMS Rural Health Strategy, released in 2018, to reflect changes in the health care landscape since its development. This Framework supports CMS' overall efforts to advance health equity, expand access to quality, affordable health coverage, and improve health outcomes. CMS will inform the approach to operationalizing this Framework by ongoing public engagement as appropriate and will continue to

monitor trends in health and health care that uniquely impact rural, tribal, and geographically isolated areas.⁷⁰

CMS issued the Make Your Voices Heard Request for Information (RFI) to gather input on accessing health care and related challenges, understanding provider experiences, advancing health equity, and assessing the impact of waivers and flexibilities provided in response to the COVID-19 PHE. This RFI gathered feedback and perspectives, particularly from populations experiencing health disparities.⁷¹ CMS received more than 900 individual submissions, which included over 4,000 comments.⁷² Commenters shared feedback on rural access to health care, geographic distribution of providers, and recommendations for increased consideration of diverse populations such as tribal affiliation or geographic isolation.⁷³

Providing Geographically Informed Engagement Resources and Tools



CMS took steps to enable health care providers and individuals to easily navigate CMS programs and policies through direct communication and outreach that meets people where they are. As mentioned in the discussion of the transition to the end of the COVID-19 PHE, CMS conducted outreach and then created responsive guidance for states to increase access to Medicaid coverage during the unwinding period. CMS released information and resources to states about current language access requirements to ensure that information about the ending of the COVID-19 PHE is accessible for people who have limited English proficiency or disabilities.⁷⁴

CMS developed resources to help individuals better navigate care, aimed at both the consumer and provider levels. As a key contributor to health care coverage for AI/AN people, CMS published a technical assistance document providing information to ACA Marketplace Navigators and certified application counselors on the unique health coverage protections, needs, and programs for AI/AN people.^{75 76 77} Additionally, CMS released an updated Coverage to Care (C2C) Roadmap to Care resource in nine languages and a tribal version to help consumers understand and use their health coverage.⁷⁸

CMS provided geographically informed resources to health researchers as part of its commitment to ending health disparities. CMS' Minority Research Grant Program released the 2023 Notice of Funding Opportunity for researchers at minority-serving institutions (MSIs) who are investigating or addressing health care disparities affecting CMS focus populations, including people who live in rural areas and people otherwise adversely affected by persistent poverty or inequality. Eligible MSIs include Asian American and Native American Pacific Islander-Serving Institutions, Tribal Colleges and Universities, Native American Serving Non-Tribal Institutions, and Alaska Native and Native Hawaiian-Serving Institutions.⁷⁹

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

CMS worked closely with health care providers and other organizations and government entities to improve the collection and use of comprehensive, interoperable, standardized, individual-level demographic and social determinants of health, and health outcomes data. Evidence suggests that increasing the collection of standardized data, including geographic data, across health and health care systems is an important step towards improving population health.^{81 82 83} In fiscal year 2023, CMS

focused on: **increasing data collection for telehealth, improving disclosures of nursing home data, and sharing data for easier decision-making.**

Increasing Data Collection for Telehealth

Increasing available standardized data across settings and programs enables CMS to address changes in populations over time and leverage information to connect individuals living in rural, tribal, and geographically isolated communities with appropriate and needed health care services. Throughout the COVID-19 PHE, there was an increase in telehealth availability and utilization across the country. Locally in CMS Region VII (Iowa, Kansas, Missouri, and Nebraska) and Region IX (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee), providers noted that telehealth had increased access to care in their areas. For example, in California, providers shared that they saw improved health equity for their patients, many of whom are migrant farm workers and unable to travel for care. CMS is interested in collecting data to better understand telehealth use for Medicare enrollees receiving services from home health agencies. Beginning voluntarily in January 2023 and required as of July 2023, CMS is collecting data via cost-reporting on the use of telehealth during 30-day home health periods of care, which provides information around telecommunications use in home health agencies.^{84 85}

Improving Disclosure of Nursing Home Data for Transparency and Safety

Nursing homes are an important part of the health care delivery system for rural, tribal, and geographically isolated areas, in part due to the limited availability of home- and community-based services (HCBS).^{86 87} Rural nursing homes have challenges, such as greater distance to transitional care, longstanding staffing shortages, or capacity constraints due to lower population density.⁸⁸ For example, leadership at CAHs in CMS Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin) shared that there has been an increased length of stay in hospitals for lower acuity patients, due to lack of open beds, staffing issues, and COVID-19–related requirements at skilled nursing facilities. In FY 2023, CMS began offsite audits of documentation and assessments of individuals with schizophrenia diagnoses from Medicare-certified nursing homes to address the issue of erroneous coding of schizophrenia in residents. Nursing home residents erroneously diagnosed with schizophrenia are at risk of receiving poor care and inappropriately prescribed antipsychotic medications. Individuals in institutional care settings, such as nursing homes, may already be at a higher risk for safety concerns since they are often older, have chronic conditions, or have had a recent hospitalization that indicates more medically complex health care needs.^{89 90 91} Additionally, CMS began to publicly display survey noncompliance citations that nursing homes are currently informally disputing, in addition to those that are not in dispute, to assist in transparency and patient choice.⁹²

Sharing Data for Easier Decision-Making

CMS enacted several initiatives to analyze and share health data and information, as appropriate, to drive quality improvement and inform decision-making. CMS released data-informed research products, such as reports and data briefs, as part of ongoing efforts to measure disparities in access to care and make focused, evidence-based investments to improve health equity. CMS released a series of health equity data briefs, including a [Rural Data Brief](#), detailing various demographic characteristics of Medicaid and CHIP enrollees from all states, Puerto Rico, and USVI. The four data briefs use Transformed Medicaid Statistical Information System data to focus on the race and ethnicity, rural residency, primary language, and disability-related eligibility of the national Medicaid and CHIP populations.^{93 94} During community engagement and outreach in Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee), providers shared that improved data collection on race and ethnicity would assist clinics and states in understanding health equity and disparities. In addition, CMS released [Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility \(DE\) or Eligibility for Low-Income Subsidy \(LIS\) and Disability](#). This report presents summary information on the performance of Medicare Advantage (MA) plans on specific measures of quality of health care reported in 2021, which corresponds to care received in 2020.⁹⁵

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

Strengthening and supporting the rural, tribal, and geographically isolated health workforce in underserved and geographically isolated areas is of critical importance, given that rural and tribal areas comprise more than half of all Health Professional Shortage Area (HPSA) designations.^{96 97} CMS leveraged available authorities and resources to support the financial stability of health care professionals in rural, tribal, and geographically isolated communities through activities such as: **policies to support rural, tribal, and geographically isolated providers, resources and reports to support health care providers, incorporating health care professionals' perspectives, and health care professional recruitment and retention.**

Policies Supporting Rural, Tribal, and Geographically Isolated Providers

CMS took steps to support the full and growing array of health professional and provider types. CMS finalized the Conditions of Participation and enrollment processes for Rural Emergency Hospitals (REHs), a new provider type that addresses the ongoing concern over rural hospital closures. There were 146 rural hospital closures or converted closures between January 2010 and September 2022.⁹⁸ The REH designation provides an opportunity for CAHs and certain rural hospitals to avert complete closure and continue to provide essential services. REHs provide emergency services, observation care and, if elected by the REH, additional qualifying outpatient services.^{99 100 101} Since the designation process launched in January, 17 facilities have converted to REHs.¹⁰² During local engagements, CMS Region X (Alaska, Idaho, Oregon, and Washington) facilitated a discussion in Alaska about local interest in the new provider type, despite current ineligibility, by clinics that are far from any hospital and provide comparable services in their communities. Additionally, CMS Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas), along with colleagues from the Health Resources and Services Administration (HRSA) and the Office of Management and Budget, met with the first hospital in New Mexico to apply for the REH designation as part of a statewide tour.

CMS implemented a new policy to support health care professionals in rural and geographically isolated areas to improve access to behavioral health services. Rural residents often have additional challenges in availability and accessibility of behavioral health services, such that there are unmet needs across many rural communities.¹⁰³ In CMS Region III (Pennsylvania, Delaware, Maryland, District of Columbia, Virginia, and West Virginia), Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas), and Region VII (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming), providers, health care leaders, and other interested parties shared the impacts of the ongoing certified behavioral health provider and facility shortages in their areas. In the CY 2023 Hospital and Surgical Center Payment System Final Rule, CMS established a policy that permits clinical staff of hospital outpatient departments to provide behavioral health services remotely to patients in their homes.¹⁰⁴ By making this policy permanent, CMS will improve access to behavioral health services, particularly for rural and other underserved communities, furthering the agency's health equity goals.

In the FY 2024 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, CMS finalized a number of payment policies that may support rural, tribal, and geographically isolated providers and facilities. For example, CMS is continuing its policy to increase the wage index values for certain hospitals with low wage index values (the low-wage hospital policy), which includes many rural hospitals. In addition, CMS took recent public comments into consideration to determine that the best interpretation of section 1886(d)(8)© of the Social Security Act is that it instructs CMS to treat reclassified hospitals the same as geographically rural hospitals for purposes of calculating the wage index. Specifically, CMS will include hospitals with



§412.103 reclassification along with geographically rural hospitals in rural wage index calculations beginning with FY 2024, and will only exclude hospitals with simultaneous §412.103 and Medicare Geographic Classification Review Board reclassifications in accordance with the “hold harmless” provision at section 1886(d)(8)(C)(ii) of the Act.^{105 106} In addition, beginning with FY 2023, CMS has established a supplemental payment for IHS and tribal hospitals and hospitals located in Puerto Rico to help prevent undue long-term financial disruption due to the decision to discontinue use of the low-income insured days proxy in the uncompensated care payment methodology for these hospitals.

Resources and Reports to Support Health Care Providers in Diverse Geographies

CMS developed and disseminated resources and tools that support health and health care professionals. CMS released a [State Health Official letter on interprofessional consultation](#), which provides guidance to states on policy for Medicaid and CHIP to allow a treating practitioner to discuss a Medicaid or CHIP enrollee’s case with a specialist, with or without the enrollee present, and allow the specialist to receive payment for their services directly.¹⁰⁷ Interprofessional consultation can be an effective component of expanding access to specialty care for physical and behavioral health needs, particularly in rural and remote areas with limited availability of specialists. In addition, CMS released an [Informational Bulletin](#) to announce an extension of a grace period related to the Medicaid clinic services “four walls” requirement until February 11, 2025. This extension means that IHS and tribal facilities can continue to claim Medicaid reimbursement under the clinic services benefit at 42 C.F.R. § 440.90 (including at the IHS All Inclusive Rate) for services provided outside of the “four walls” of the facility until February 11, 2025.¹⁰⁸

In consultation with the US Department of Education, CMS released [Delivering Service in School-Based Settings](#), which outlines how schools can leverage existing school-based service structures to receive payment for delivering Medicaid-covered services. By making it easier for schools to bill Medicaid and CHIP, small, rural, and under-resourced schools can provide more services, thereby improving health care access for children with Medicaid and CHIP coverage.¹⁰⁹ States can adopt flexibilities outlined in the guide to reduce the administrative burden for schools significantly, making it easier for them to get paid for covered health services delivered to children enrolled in Medicaid and CHIP.¹¹⁰ Working with the Department of Education, CMS launched a school-based services Technical Assistance Center for Medicaid agencies, local education agencies, and school-based entities.¹¹¹ CMS approved school-based service expansions in New Mexico, Oregon, and Virginia, joining 12 other states that have already expanded.^{112 113}

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act demonstration is a 54-month project to increase the capacity of Medicaid providers to deliver substance use disorder treatment and recovery services. The demonstration project included planning grants awarded to 15 states for 18 months, and 36-month demonstrations with five states that received planning grants. In FY 2023, CMS released the Initial Report to Congress, which contained findings from the planning grant selection criteria, states selected to participate, and state activities during the initial period of the planning phase.¹¹⁴ When conducting the needs assessment activities, many states investigated the capacity among rural providers to gain a better understanding of geographic areas of need.¹¹⁵

Incorporating Health Care Professionals’ Perspectives

CMS conducted outreach to providers serving rural, tribal, and geographically isolated communities. As a part of the CY 2023 Physician Fee Schedule, CMS requested comment from the public on how payments between health care provider organizations and community-based organizations, local governments, and social service organizations account for the costs of services provided by community health workers (CHWs). CMS also sought comment on whether and to what extent CHW services are provided in association with preventive services, including those covered by Medicare.^{116 117} As a part of the FY 2024 Hospital IPPS and LTCH PPS proposed rule, CMS requested comment on the unique challenges faced by safety-net hospitals, and potential approaches to meet those challenges. Safety-net hospitals play a crucial role in the advancement of health equity by making essential services available to populations that face barriers to accessing health care, including people from racial and ethnic minority groups, the LGBTQ+ community, rural communities, and members of other historically

underserved groups.^{118 119} CMS received thoughtful and wide-ranging responses, including from safety-net hospitals, state hospital associations, industry trade groups, health systems, and other interested parties. CMS is continuing to review these comments to inform and guide future rulemaking.¹²⁰

Health Care Professional Recruitment and Retention

CMS collaborated with federal, state, tribal, territorial, and local entities to promote the recruitment and retention of health and health care professionals. CMS Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont) hosted rural listening sessions where providers, administrators, and community members shared ongoing challenges to recruit a sufficient workforce. CMS Region II (New Jersey, New York, Puerto Rico, and USVI) visited rural New York, where partners shared concerns about increased demand for behavioral health services, challenges with workforce and staffing, and lack of transportation, including a shortage of qualified emergency medical technicians for ambulances. Many rural communities experience health workforce shortages that limit access to essential care for residents.¹²¹ CMS responded to this need by awarding the first 200 of 1,200 Medicare-funded physician residency slots to 100 teaching hospitals across 30 states, the District of Columbia, and Puerto Rico.¹²² In allocating these new residency slots, CMS prioritized hospitals with training programs in geographic areas demonstrating the greatest need for additional providers, as determined by HPSAs.¹²³ The slots will enhance the health care workforce and fund additional positions in hospitals serving underserved communities.

As a part of the FY 2024 IPPS Final Rule, CMS determined that REHs can be designated as graduate medical education (GME) training sites. This change supports GME training in rural areas by allowing rural hospitals to serve as training sites for Medicare GME payment purposes after they become REHs. As a result, more medical residents will be able to train in rural settings, which can help address workforce shortages in these communities.^{124 125}

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

CMS collaborated with health care organizations and government entities to optimize and increase use of medical and communication technology across CMS programs. As advancements continue in telehealth, patient portals, and other medical and communication technology, it is vital to ensure those residing in underserved and technologically under-resourced areas, such as geographically isolated areas without broadband, are not left behind. Telehealth is an essential tool for expanding access to care in rural, tribal, and geographically isolated areas.¹²⁶ Building on lessons learned during the COVID-19 pandemic, CMS collaborated with health care organizations and government entities to optimize and increase use of medical and communication technology across CMS programs for people living in rural, tribal, and geographically isolated communities. CMS conducted supportive activities that included: **developing policies to increase telehealth coverage, encouraging health information technologies, and analysis and reporting of telehealth use.**

Developing Policies to Increase Telehealth Access and Coverage

CMS explored opportunities to enhance uptake and coverage of telehealth and other virtual services where appropriate to deliver high-quality care. During the COVID-19 PHE, CMS used its authority under section 1135 of the Social Security Act, along with regulatory authority, to implement a variety of temporary waivers and flexibilities for Medicare telehealth and other virtual services. Through the CY 2023 Medicare Physician Fee Schedule, CMS



extended several telehealth services that had been temporarily available to allow additional time for the collection of data that may support their inclusion as permanent additions to the Medicare Telehealth Services List.¹²⁷ The Consolidated Appropriations Act, 2023 further extended many Medicare telehealth flexibilities through December 31, 2024. For Medicaid and CHIP, telehealth flexibilities are not tied to the COVID-19 PHE and have been offered by many state Medicaid programs since long before the pandemic. CMS encourages states to continue to cover Medicaid and CHIP services when delivered via telehealth.¹²⁸

As part of the CY 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Final Rule (42 CFR § 422.100(n)), CMS finalized requirements for MA organizations to develop and maintain procedures to offer digital health education to enrollees to improve access to medically necessary covered telehealth benefits. Studies demonstrate that low digital health literacy, especially among populations experiencing health disparities, continues to impede telehealth access and worsen care gaps, particularly among older adults.¹²⁹

Encouraging Health Information Technologies

CMS continued to encourage uptake of telehealth and virtual services by promoting their availability to consumers. CMS added a new telehealth indicator to clinician profile pages on Medicare Care Compare and in the Provider Data Catalog. CMS research shows that, historically, website users search for information about telehealth, and the new indicator helps enrollees and caregivers more easily find clinicians who provide telehealth services. Additionally, user testing indicates that users understand the meaning of a telehealth indicator, and some also want to know the specific telehealth services clinicians offer. Most users found the telehealth indicator to be important and useful when selecting a clinician. Telehealth is also one of enrollees' primary service requests the Medicare Call Center receives monthly.¹³⁰

Analysis and Reporting of Telehealth Use

By conducting detailed analyses and releasing summative reports, CMS supported health care providers' efforts to harness health information technology to improve access to high-quality, equitable care. The Medicare Telehealth Trends dataset and report provide information about Medicare enrollees who used telehealth services between January 1, 2020, and December 31, 2022.¹³¹ In 2020, 48 percent of Medicare enrollees had a telehealth service. In 2021, 34 percent of Medicare enrollees had a telehealth service. Between 2020 and 2022, urban Medicare enrollees used telehealth services at a higher percentage than rural enrollees.¹³² In addition, CMS published [a study on telehealth visits](#) for rural and urban fee-for-service Medicare enrollees during January 2018 – June 2021. The study found significant increases in Medicare enrollees' utilization of telehealth services from pre-COVID (2018–2019) to COVID (2020–June 2021). Emergency waiver authorities and flexibilities enacted by Congress allowed for the expansion of provider types that could provide Medicare telehealth services and allowed Medicare enrollees to receive telehealth services from their homes and in any geographic area. The findings indicate that uptake of telehealth visits differed across the country, by diagnosis, and by location of Medicare enrollees' residences.¹³³

CMS published [data releases](#) on the use of services, including telehealth, for Medicaid and CHIP enrollees during the COVID-19 PHE. The data releases provide findings based on claims data and encounter records analysis. Preliminary findings show that services delivered through telehealth peaked in April 2020, stabilized from June 2020 – March 2021, and then decreased through July 2022. Additionally, telehealth services increased for enrollees of all age groups during the COVID-19 PHE but were highest among the 19 to 64 age group.¹³⁴





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

Evidence suggests that health care coverage affects an individual's ability to access needed health care services and can contribute to disparities in health outcomes.¹³⁵ CMS has undertaken varied actions to increase access to health care coverage and services, particularly for rural, tribal, and geographically isolated people: **increasing access and coverage through new services and programs, increasing access through coverage expansion for enrollees, and addressing social determinants of health.**

Increasing Access and Coverage through New Services and Programs

CMS explored opportunities to expand health coverage and benefits that improve access to and delivery of a broad array of services and supports. CMS significantly expanded access to behavioral health services, cancer screening, and dental care, particularly in rural and underserved areas, through the CY 2023 Medicare Physician Fee Schedule Final Rule. Some of the key provisions include modifying supervision requirements for behavioral health services provided by auxiliary staff such as licensed professional counselors and licensed marriage and family counselors working with physicians and practitioners, bundling certain chronic pain management and treatment services into new monthly payments, and covering opioid use disorder treatment services furnished via an opioid treatment program mobile unit for Medicare beneficiaries.¹³⁶ In addition, CMS has approved proposals from eight states (California, Kentucky, Wisconsin, Arizona, Oregon, Maryland, Virginia, West Virginia) and the District of Columbia to expand mental health and substance use care through community-based mobile crisis intervention teams providing Medicaid services.^{137 138 139} CMS had previously awarded 20 states with planning grants to develop a state plan amendment, 1115 demonstration application, or section 1915(b) or 1915(c) waiver request to provide qualifying community-based mobile crisis intervention services.¹⁴⁰ Lastly, CMS released a National Coverage Determination decision that finds that power seat elevation equipment on Medicare-covered power wheelchairs falls within the benefit category for durable medical equipment.^{141 142}

In FY 2023, CMS both expanded and invested in future policy advancements in ambulance services. The Ground Ambulance and Patient Billing Advisory Committee members were announced in December 2022. Committee recommendations are expected to help inform policy changes that will improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, prevent balance billing to consumers, and evaluate the feasibility of implementing proposals for legislation and enforcement at the state and federal levels.¹⁴³ REHs will also be an allowed destination for ambulance service coverage.¹⁴⁴

CMS focused on reducing the cost of prescription drugs through the implementation of two new programs established by the Inflation Reduction Act of 2022. Under the Medicare Prescription Drug Inflation Rebate Program, which addresses drug prices that increase faster than the rate of inflation, CMS announced 43 prescription drugs that would have lower Part B coinsurance starting in July 2023. Pharmaceutical manufacturers that increase the price for a Part D rebatable drug faster than the rate of inflation are required to pay Part D drug inflation rebates to the Medicare Prescription Drug Program.¹⁴⁵ CMS released



guidance for the Medicare Drug Price Negotiation Program, which authorizes CMS to directly negotiate the prices of certain prescription drugs, detailing how Medicare will negotiate with participating drug companies. The first round of negotiations will occur during 2023 and 2024, with any negotiated prices effective beginning in 2026.¹⁴⁶

Increasing Access through Coverage Expansion for Enrollees

CMS increased health care coverage through opportunities in eligibility and enrollment across its programs. Under the authority of the ACA, South Dakota expanded Medicaid eligibility to a new adult group starting July 1, 2023. More than 52,000 South Dakotans – including many tribal members in South Dakota – are newly eligible for comprehensive health care coverage. For Medicare, CMS finalized a rule implementing certain provisions of the Consolidated Appropriations Act, 2021 related to Medicare enrollment and eligibility.¹⁴⁷ This final rule adopted new special enrollment periods for certain exceptional circumstances to provide an opportunity for eligible individuals to enroll in Part B without a late enrollment penalty if they didn't enroll in Medicare during their Initial Enrollment Period when they were first eligible.¹⁴⁸

In the Federally-Facilitated Marketplaces, CMS improved consumer choices by engaging with health insurance issuers to increase their participation across the country.¹⁴⁹ Rural counties have had lower issuer participation, which decreased consumer choices and increased costs to consumers.¹⁵⁰ CMS' efforts decreased the number of single-issuer counties during the 2023 Open Enrollment period to three percent, compared to five percent for the 2022 Open Enrollment period.^{151 152} CMS Region IX (Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, and American Samoa) hosted a listening session for the University of Hawaii's John A. Burns School of Medicine (JABSOM), the Healthcare Association of Hawaii, and rural providers from Hawaii. In response to community comments about challenges during Open Enrollment, CMS Region IX connected JABSOM with San Francisco's University of the Pacific, where students partner with CMS during Marketplace Open Enrollment to hold events assisting enrollees in choosing a plan, in the hopes of establishing similar events in Hawaii. Through the 2024 Notice of Benefit and Payment Parameters Final Rule, CMS finalized standards for issuers and Marketplaces, as well as requirements for agents, brokers, web-brokers, and Assistors who help consumers with enrollment through Marketplaces that use the federal platform. By allowing unsolicited direct help to consumers for enrollment, this policy aims to improve health literacy in rural and underserved communities and reduce burden on consumers, especially for consumers with a lack of access to transportation, inflexible job schedules, and those who are immunocompromised.¹⁵³

For Medicaid and CHIP, CMS continued to support states in expanding health care coverage for enrolled postpartum individuals. Medicaid and CHIP provide extended continuous postpartum coverage for 12 months after pregnancy to postpartum individuals in 37 states, the District of Columbia, and USVI.^{154 155 156} In FY 2023, Oklahoma, Alabama, North Dakota, Arizona, New Jersey, Georgia, Pennsylvania, Delaware, New York, and South Dakota were approved for the extended coverage made possible by provisions in the American Rescue Plan, signed into law by President Biden in March 2021.^{157 158} In addition, USVI received approval to extend postpartum coverage for a full year after pregnancy for persons enrolled in Medicaid.¹⁵⁹ CMS released a Medicaid and CHIP Postpartum Care Toolkit, which provides practical information for states to maximize the use of existing authorities, including a strategy checklist with suggestions for partnering with managed care plans to implement quality improvement strategies. States can use the toolkit to increase access, quality, and equity in postpartum care in their communities.¹⁶⁰

CMS supported outreach and awareness of health care coverage availability for AI/AN people. The [Connecting Kids to Coverage Outreach and Enrollment](#) grants program works to connect families with children and pregnant people to health coverage opportunities, such as Medicaid, CHIP, or affordability programs. CMS awarded \$5.9 million in cooperative agreements to seven tribal and urban Indian health programs in six states to increase the participation of eligible, uninsured AI/AN children in Medicaid and CHIP.¹⁶¹ CMS also released the [Tribal Protections in Medicaid and CHIP Managed Care Oversight toolkit](#), which provides resources for states, managed care plans, and Indian Health Care Providers to maximize the benefits of Medicaid and CHIP managed care for AI/AN enrollees and the providers, consistent with the statutory and regulatory managed care protections.

Addressing Social Determinants of Health

CMS worked to address social determinants of health, including risk factors and unmet health-related social needs, by providing guidance to promote state-level solutions. CMS provided guidance to states on an innovative opportunity to address health-related social needs for people with Medicaid coverage using “[in lieu of services and settings](#)” in Medicaid managed care. This option helps states offer alternative benefits that take aim at a range of unmet health-related social needs, such as housing instability and food insecurity, to help enrollees maintain their coverage and to improve their health outcomes.^{162 163 164} CMS also released a [Medicaid Transportation Coverage Guide](#), to provide a one-stop transportation resource for states on federal requirements and state flexibilities. The guide highlights existing and new policies to address scenarios for extended wait times, long-distance trips to health care facilities, and other scenarios. CMS is committed to equity and ensuring that individuals who rely on Medicaid, including those living in rural areas, can access the care they need to stay healthy.¹⁶⁵

In addition to state-level solutions, CMS provided guidance for MA organizations, expanding the example list of populations that must receive services in a culturally competent manner. The list now includes people who live in rural areas and other areas with elevated levels of deprivation. In addition, CMS amended its rules to incorporate, beginning with 2024 coverage, current best practices by requiring MA organizations to include providers’ cultural and linguistic capabilities in provider directories. This change will improve the quality and usability of provider directories, particularly for non-English speakers, individuals with limited English proficiency, and enrollees who use American Sign Language.¹⁶⁶

In the FY 2024 IPPS/LTCH PPS final rule, CMS finalized a change to the severity-level designation for the three ICD-10-CM diagnosis codes describing homelessness (i.e., unspecified, sheltered, and unsheltered) to recognize the higher costs that hospitals incur when treating people experiencing homelessness.¹⁶⁷



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

CMS continued to leverage its existing authorities to test demonstrations and models of care that meet the needs of rural, tribal, and geographically isolated communities. New payment models supported states, health care organizations, and health care professionals as they addressed the unique needs of underserved communities and strived to respond to public health emergencies and disasters with agility and resilience. Activities included: **state-based innovation models and demonstrations, national Innovation Center models and other demonstrations, investing in accountable care organizations and relationships, and supporting states and providers experiencing public health emergencies.**

State-Based Innovation Models and Demonstrations

CMS continued to partner with states in developing, implementing, and iterating on innovative models for health care services and delivery. Building off a 2021 [State Health Official Letter about addressing Social Determinants of Health \(SDOH\)](#), CMS encouraged states to utilize authority under section 1115(a) of the Social Security Act to test options to more effectively address enrollees’ unmet health-related social needs and related health impacts.^{168 169}

CMS approved section 1115 demonstrations in several states, including Arizona, Oregon, Arkansas, and Massachusetts, to test interventions to address housing and food insecurity, as well as other essential health-related social needs. For example, the Arkansas Health and Opportunity for Me (ARHOME) demonstration is expected to drive better health and wellbeing outcomes by providing medically necessary support services to those dealing with mental illness and substance use diagnoses. The Rural Life360 HOMEs will provide care coordination services to individuals with serious mental illness and/or substance use diagnoses who live in rural areas.^{170 171 172}

For formerly incarcerated enrollees, CMS announced the [Medicaid Reentry Section 1115](#)

[Demonstration Opportunity](#), which allows state Medicaid programs to address various health concerns, including substance use disorders and other chronic health conditions. States should, at minimum, include services for case management, medication-assisted treatment, and a 30-day supply of prescriptions.^{173 174} Community re-entry has many challenges, particularly in rural areas that may offer limited post-release resources and face barriers to health care access. Investments in data quality and infrastructure at the local, state, and federal levels have supported data sharing between the justice system and Medicaid that assists with community re-entry in rural areas.¹⁷⁵ Finally, CMS approved a first-of-its-kind section 1115 demonstration amendment in California that will provide integral pre-release services and improve access to care for people transitioning home.¹⁷⁶

In addition to supporting Medicaid innovation, CMS supported ongoing implementation of federal and state partnership models and demonstrations aimed at people in diverse geographies. 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.¹⁷⁷ In FY 2023, CMS released the [second annual evaluation report](#), which discusses the first two years of implementation.^{178 179} The Vermont All-Payer Accountable Care Organization model continues to test whether coordinating care across payers and providers throughout the state in a joint-ACO model can improve care quality and limit all-payer statewide cost growth.¹⁸⁰ CMS released the [second annual evaluation report](#), which provides implementation findings for 2018–2020, and the [third annual evaluation report](#), which provides findings through 2021.^{181 182} In addition, fourteen states in FY 2023 had active Section 1332 waivers,^{vii} aimed at lowering individual market premiums and improving access in rural areas.¹⁸³ This year, Rhode Island received pass-through funding for its approved Section 1332 waiver.¹⁸⁴

National Innovation Center Models and Other Demonstrations



CMS continued to incorporate equity principles in the design of models and demonstrations to test and scale innovations in health care payment and delivery. Historically, interested parties in rural and geographically isolated areas have faced challenges in participating in value-based care models, and CMS is dedicated to reducing barriers and challenges to foster innovation in diverse geographies. CMS Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming) spoke with states about these barriers, such as achieving the minimum number of covered lives because of their sparse population density. CMS continues to engage with stakeholders to better understand the needs of rural, tribal, and geographically isolated communities regarding innovation. For example, based on feedback received from stakeholders, as well as a lack of hospital participation, the Community Health Access and Rural Transformation (CHART) Model ended early on

September 30, 2023. CMS believes that the lessons learned from the CHART Model will continue to aid in the development of a potential future rural health care model at the CMS Innovation Center. Supporting rural health remains a key priority, and CMS is actively examining additional ways to expand access to high-quality health care and address the unique needs and challenges in rural areas.¹⁸⁵

vii Under Section 1332 of the Patient Protection and Affordable Care Act (PPACA), states can apply for a Section 1332 Waiver for State Innovation (also referred to as a “Section 1332 waiver” or “1332 waiver”) from the Department of Health and Human Services and the Department of the Treasury (collectively, the Departments). If approved, the waiver allows states to implement innovative programs to provide access to quality healthcare. Through Section 1332 waivers, the Departments aim to assist states with developing health insurance markets that offer expanded coverage, lower costs, and ensure healthcare is truly accessible for all. State innovation waivers became available January 1, 2017, and can be approved for up to a five-year period and can be extended. Waivers must not increase the federal deficit. CMS, along with the Department of the Treasury, have approved 19 Section 1332 waivers, some of which have reduced premiums 4 to 40% compared to without the waiver and increased consumer coverage options.

CMS announced the Making Care Primary (MCP) Model, which seeks to improve care for patients by expanding and enhancing care management and care coordination, equipping primary care clinicians with tools to form partnerships with health care specialists, and leveraging community-based connections to address patients' health needs and health-related social needs. MCP is the first advanced primary care model to operate in multiple states and include FQHCs as a provider type.¹⁸⁶ Other eligible provider types include IHS facilities and tribal clinics. CMS will work with the participants to address priorities specific to their communities, including care management for chronic conditions, behavioral health services, and health care access for rural residents.¹⁸⁷ CMS Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) met with and shared information about MCP with the North Carolina Primary Care Advisory Committee. Region IV has continued to assist the North Carolina State Office of Rural Health with the model.

In July 2023, CMS launched the Enhancing Oncology Model (EOM) and announced the Guiding an Improved Dementia Experience (GUIDE) Model. EOM is intended to transform care for cancer patients, reduce spending, and improve quality of care by incorporating many of the lessons that CMS learned from the Oncology Care Model (OCM) and feedback from the oncology community, including from OCM participants, patient advocacy groups, oncology professional associations, and others. EOM has a national scope and approximately 15 percent of EOM participants' sites of care are in rural or micropolitan areas.¹⁸⁸ The GUIDE model aims to support people living with dementia and their unpaid caregivers. The model will launch in July 2024.¹⁸⁹

In September 2023, CMS announced the States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD Model), which aims to better address chronic disease, behavioral health, and other medical conditions. The AHEAD Model represents the next iteration of the [CMS Innovation Center's multi-payer total cost of care models](#). CMS will partner with states to redesign statewide and regionwide health care delivery to improve the total population health of a participating area by improving the quality and efficacy of care delivery, reducing health disparities, and improving health outcomes. There are specific payment models for participating hospitals and primary care practices as a tool to achieve model goals. The pre-implementation period will begin in 2024, and the performance period in 2026.¹⁹⁰

CMS is developing new payment model tests, including the Medicare High Value Drug List Model and the Cell and Gene Therapy Access Model, to lower the cost of prescription drugs and lifesaving therapies.¹⁹¹ ¹⁹² Adults living in rural areas are more likely than urban adults to experience challenges paying for medical bills, and are more likely to engage in cost-savings measures for prescription drugs, such as skipping doses, delaying refills, or taking less medication than prescribed.¹⁹³ The Medicare High Value Drug List Model is designed to facilitate \$2 enrollee cost-sharing for a list of high-value generic drugs covered under the Medicare Part D program. In addition, the Cell and Gene Therapy Access Model would test a CMS-led approach to administering outcomes-based agreements with participating manufacturers to lower the cost of, and increase access to, emerging cell and gene therapies for participating state Medicaid and CHIP programs.¹⁹⁴ ¹⁹⁵ ¹⁹⁶

CMS has continued to implement and evaluate numerous other national innovative models and demonstrations that aim to increase access to care, improve quality of care, and decrease costs. For example, 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.¹⁹⁷ In FY 2023, CMS released the second interim evaluation report, which found positive impacts on some financial outcomes for new participating hospitals.¹⁹⁸ In addition, the Maternal Opioid Misuse (MOM) model addresses fragmentation in the care of pregnant and postpartum Medicaid enrollees with opioid use disorder through state-driven transformation of the delivery system surrounding this vulnerable population.¹⁹⁹ The eight participating states are currently in the full implementation phase. In FY 2023, CMS released the [second annual evaluation report](#), which covers the 2021–2022 implementation year.²⁰⁰ ²⁰¹

Investing in Accountable Care Organizations and Relationships

CMS continued to make progress on the CMS goal of having all people with Traditional Medicare in an accountable care relationship with their health provider by 2030.²⁰² One of the key accountable care programs is the Medicare Shared Savings Program, which saved Medicare \$1.8 billion in 2022.²⁰³ In FY 2023, CMS advanced equity and supported increased participation the Medicare Shared Savings

Program in rural, tribal, and geographically isolated areas. CMS established advance shared savings payments (referred to as advance investment payments (AIP)) for low-revenue ACOs that do not have experience with performance-based risk Medicare ACO initiatives and serve underserved populations.^{204 205 206} AIP is intended to support investments in population health management tools for these newer program participants. CMS expects that AIP will drive growth in ACOs and advance health equity, particularly in rural and underserved areas.²⁰⁷

To assist ACOs participating in the Shared Savings Program long term and increase the number of enrollees participating in accountable care relationships, CMS adjusted components of the payment methodology. Changes included reducing the impact of the negative regional adjustment, which had previously been challenging for rural ACOs. In addition, CMS established a health equity adjustment to an ACO's quality performance category score to recognize high-quality performance by ACOs with a high proportion of underserved enrollees. Finally, CMS implemented changes based on provider feedback that will allow new, inexperienced ACOs, which are often providers serving rural or underserved populations, to participate in a one-sided risk model (i.e., be eligible to share in savings with the Medicare program, but not be required to share in losses) for the five-year contract cycle.²⁰⁸ In the CY 2024 Medicare Physician Fee Schedule proposed rule, CMS continued efforts to address SDOH within the Shared Savings Program by seeking comment on ways to improve and incentivize collaboration between ACOs and interested parties in the community or community-based organizations.²⁰⁹

The ACO REACH (Realizing Equity, Access, and Community Health) Model aims to improve the quality of care for people with Traditional Medicare through better care coordination and by increasing access to accountable care in underserved communities. For 2023, the ACO REACH Model had 132 ACOs with 131,772 health care providers and organizations providing care to an estimated 2.1 million enrollees. Importantly, in 2023, ACO REACH increased access to accountable care in underserved populations. The ACO REACH Model had 824 FQHCs, RHCs, and CAHs participating in 2023, which is more than twice the number than in 2022. Increasing the number and reach of ACOs in underserved communities will help close racial and ethnic disparities among people with Traditional Medicare in accountable care relationships.^{210 211} In response to feedback from the public, CMS announced changes for performance year 2024 that will increase predictability for participants, protect against inappropriate risk score growth and maintain consistency across CMS programs, and further advance health equity. The revised Health Equity Benchmark Adjustment will better identify underserved enrollees living in high cost-of-living areas by incorporating two new variables: Low-Income Subsidy Status and State-based Area Deprivation Index.²¹²

Supporting States and Providers Experiencing Public Health Emergencies

CMS supported state Medicaid and CHIP agencies and other state and local agencies to prepare for and respond to PHEs, disasters, and threats. After determining that a PHE existed, CMS provided additional resources and flexibilities available in response to Hurricane Idalia in Georgia and Florida, severe storms in Mississippi, Typhoon Mawar in Guam, and wildfires in Hawaii.^{213 214 215 216 217} CMS worked closely with Mississippi, Guam, and Hawaii to put these flexibilities in place to ensure those affected by natural disasters had access to care.²¹⁸ In addition, CMS Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) met with Appalachian Leadership Institute fellows to understand the needs of rural health leaders during an emergency, such as a protocol that will allow leadership to ensure patients receive care while also coordinating with the Federal Emergency Management Agency and local officials.

CMS published and updated guidance on changes to Medicare, Medicaid, CHIP, and Marketplaces at the conclusion of the COVID-19 PHE. CMS also helped health care providers, including RHCs and CAHs, prepare for the end of the COVID-19 PHE on May 11, 2023 by publishing and continuing to update provider guidance.^{219 220} For example, CMS released guidance to state Medicaid directors updating the end date of flexibilities for HCBS programs approved through Appendix K amendments, which would extend COVID-19 PHE flexibilities beyond the expiration of the PHE based on actions by the state.²²¹ CMS is taking steps to keep health care providers informed as standards for compliance with CMS requirements are restored and other provider waivers will conclude as described in the updates. CMS' approach aligns with the Biden-Harris Administration's priority for an orderly, predictable transition leading into the close of the COVID-19 PHE.²²²

The Way Forward

The activities and initiatives described in this report are part of an ongoing commitment to improve 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, tribal, and geographically isolated communities, support health care professionals, and address the unique economics of delivering health care in rural, tribal, and geographically isolated areas. CMS Rural Health Coordinators in the ten CMS regions 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 in geographically isolated areas. 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 2023. CMS anticipates expanding promising programs; implementing rules, such as those advancing equity and inclusivity in the Shared Savings Program; 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. CMS will continue this important work in collaboration with its partners to ensure that all individuals in rural, tribal, and geographically isolated communities have access to high-quality, affordable, and equitable health care.



Acronyms

Acronym	Full Term
ACA	Affordable Care Act
ACO	Accountable Care Organization
AI/AN	American Indian/Alaska Native
AIP	Advance Investment Payments
CAH	Critical Access Hospital
CHART	Community Health Access and Rural Transformation
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CY	Calendar Year
D.C.	District of Columbia
EOM	Enhancing Oncology Model
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GME	Graduate Medical Education
GUIDE	Guiding an Improved Dementia Experience
HCBS	Home- and Community-Based Services
HEDAP	Health Equity Data Access Program
HHS	US Department of Health and Human Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IPPS	Inpatient Prospective Payment System
JABSOM	John A. Burns School of Medicine
LTCH PPS	Long-Term Care Hospital Prospective Payment System
MA	Medicare Advantage
MCP	Making Care Primary
MIPS	Merit-based Incentive Payment System
MSI	Minority-Serving Institutions
OCM	Oncology Care Model
PHE	Public Health Emergency
PPACA	Patient Protection and Affordable Care Act
REACH	Realizing Equity, Access, and Community Health
REH	Rural Emergency Hospital
RFI	Request for Information
RHC	Rural Health Clinic
SDOH	Social Determinants of Health
SUPPORT Act	Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act
USVI	US Virgin Islands

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