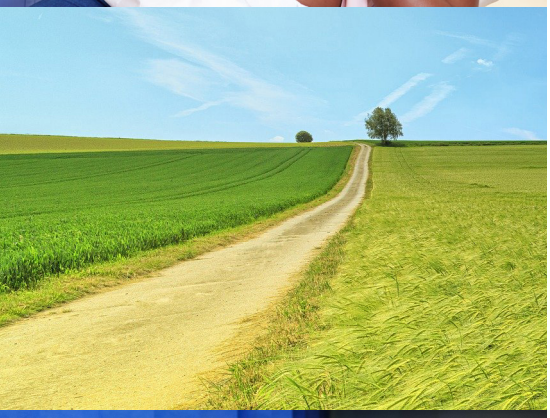

Centers for Medicare & Medicaid Services (CMS)

Rethinking Rural Health

FY 2020 Year in Review

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

From the Co-Chairs

As the co-chairs to the CMS Rural Health Council, we have a unique vantage point to see all of the work that CMS undertakes on a daily basis to ensure access, improve outcomes, and support the millions of individuals living in rural communities who benefit from CMS programs and activities.

Over the last few years, rural health has truly emerged as a key priority for CMS. Through the establishment of the CMS Rural Health Council, the release of the first formal CMS Rural Health Strategy, and culminating in the Rethinking Rural Health Strategic Initiative, it is evident that CMS is committed to providing patients in rural communities with access to more affordable, quality healthcare, and assisting rural communities in transforming their healthcare systems to more sustainable, value-based models.

Whether through rules and regulations, innovation models, or outreach and education, we know that all of us at CMS play a role in improving the lives of so many. We look forward to the work ahead and our continued collaboration and partnership to further improve healthcare in rural America.

We are pleased to present the CMS Rethinking Rural Health FY 2020 Year in Review, reflecting on much of what has been accomplished as part of our collective efforts to serve our rural communities.

Sincerely,

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

John T. Hammarlund
CMS Rural Health Council Co-Chair
Office of Program Operations & Local Engagement

Executive Summary

Rural communities are often at the forefront of healthcare innovation. Yet structural barriers, such as practitioner shortages, hospital closures, and healthcare disparities, present challenges to achieving equitable outcomes for people living in rural areas. The Centers for Medicare & Medicaid Services (CMS) is committed to working with rural communities to address these barriers and build on existing advancements to achieve optimal outcomes for all rural Americans.

CMS is working with its partners and key stakeholders to achieve equity in access to care, quality of care, and health outcomes for rural beneficiaries and enrollees.

Through its Rethinking Rural Health Initiative, CMS is working with its partners and key stakeholders to achieve equity in access to care, quality of care, and health outcomes for rural beneficiaries and enrollees. CMS is supporting beneficiaries, patients and providers by listening to stakeholders, and by developing and implementing innovative payment and policy solutions designed to meet the needs of rural communities and their most vulnerable populations. In this way, CMS is leading the way to facilitate transformation and improvement in the rural healthcare 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's commitment to the development and implementation of programs and policies through a rural lens in Fiscal Year (FY) 2020. They are presented across 9 priority focus areas: Coronavirus Disease 2019 (COVID-19), Maternal Health, Medicare Advantage (MA) and the Federally Facilitated Marketplace (FFM), Quality Improvement, Practitioner Engagement, Patient Empowerment, Medicare and Medicaid Payment and Policy, Models and Demonstrations, and Telehealth.

Highlights include the following:

Community Health Access and Rural Transformation (CHART) Model:
Launched an innovative new health care delivery model targeted to support rural providers in collaboratively transforming their health systems for high-quality, cost-effective care.

COVID-19 Telehealth Policies:
Expanded unprecedented access to telehealth through robust and comprehensive flexibilities and payment policies to cover more services and encourage remote visits during the COVID-19 public health emergency (PHE), resulting in an increase in telehealth utilization in both rural and urban areas.

Rural Maternal Health Request for Information (RFI):
Solicited information from the public to inform federal policy and build on previous rural maternal health access, quality, and outcomes improvement efforts, receiving comments from 135 rural and maternal health stakeholders.

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

COVID-19

The unprecedented challenges that COVID-19 presented to the U.S. healthcare system required a rapid and robust response. To effectively respond to the PHE, CMS implemented policies to support rural and other healthcare providers through increased flexibilities and advanced payments, easing or waiving requirements on rural facilities, and expanding use of vital services such as telehealth. CMS also provided specific guidance to its partners serving vulnerable populations and rural communities during the PHE, issued resources and requirements to enhance safety in nursing homes, and supported diagnostic testing and infection control efforts across the country.

Regulatory Activities

Regulatory efforts to promote flexibilities for providers and other partners were a large part of CMS's actions to improve rural health this year. Final rules that eliminated or reduced administrative burdens resulted in projected cost savings for many rural healthcare providers, and allowed them to spend more time with their patients. CMS also enabled rural patients to become more equal partners in their care through rules designed to encourage price and quality transparency, like the Hospital Price Transparency final rule, and patient-practitioner co-creation of goals during care transitions, like the Discharge Planning final rule.

Payment Policies

Enhanced payment and other CMS policies paved the way for rural health facilities and practitioners to implement innovative care practices. This year, CMS amended physician supervision requirements for non-physician practitioners in outpatient settings and rural hospitals through the Calendar Year (CY) 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center final rule, The CY 2020 Medicare Physician Fee Schedule final rule, outpatient therapeutic services supervision enforcement instructions, and other proposed regulatory changes. Additional CMS payment policies with the potential to bolster the financial well-being of rural facilities included wage index methodology updates and expanded access to telehealth payments to support remote services for geographically remote areas.

Tools and Publications

The research and tools CMS published this year sought to provide specific insights and guidance on rural health issues for patients, beneficiaries, caregivers, providers, policymakers, researchers, and other partners. These included the Care Compare website, partner toolkits and guidance for serving vulnerable populations, and a detailed rural-urban disparities report to highlight the unique health equity challenges of rural populations, including rural communities of color.

Stakeholder Engagement

Rural stakeholder engagement activities helped CMS identify opportunities and solutions to transform rural healthcare this year. These included issuing the RFI on rural maternal health, as well as an RFI on out-of-state care coordination for children with complex health needs. Working closely with states, issuers, and other partners, CMS was able to expand rural access to health insurance through new policies to support more plan options in rural areas. With its quality improvement initiatives, CMS encouraged rural engagement through rural and vulnerable population recruitment targets and technical support to small and rural providers.

Health Systems Innovations

Several payment and practice innovations moved forward this year to test and bolster improvements to the rural healthcare system. These included ongoing implementation, evaluations and updates to Center for Medicare & Medicaid Innovation models that focus on rural populations, continued support to rural practitioners through the Quality Payment Program, and models designed to address the needs of vulnerable beneficiaries and enrollees, such as mothers and children impacted by substance use disorders, including opioid use disorders.

This annual report on the Rethinking Rural Health Initiative describes CMS's FY 2020 actions across its various roles in improving rural health and healthcare. These actions provide a snapshot of CMS's ongoing commitment to rural communities, building on previous years' achievements, and laying the groundwork for future years' work. CMS looks forward to continuing its progress in helping to achieve rural health equity in collaboration with its federal partners and other stakeholders.

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Introduction

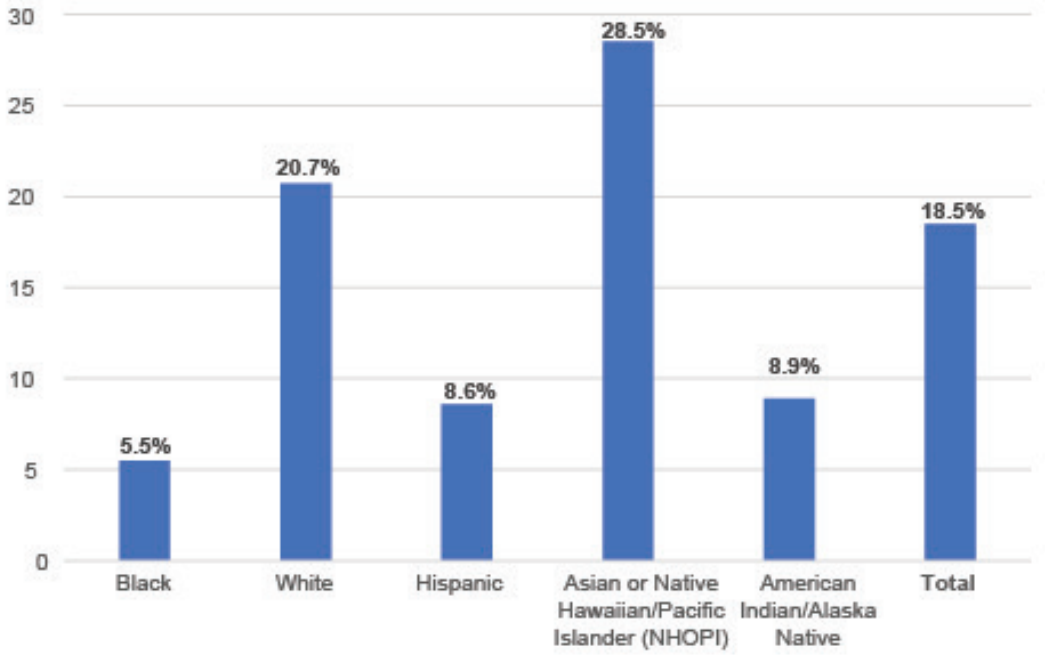
Why Rural Health?

Rural communities are dynamic, experiencing population gains and demographic shifts in recent years

Approximately one in five Americans lives in a rural area, where populations are more widely dispersed across geographic expanses.[1] Americans living in rural areas tend to be older than those in urban areas, and rural communities are less racially and ethnically diverse, with nearly 78% of their populations identifying as non-Hispanic White.[2, 3] Yet, rural communities are dynamic, experiencing population gains and demographic shifts in recent years, including an increase in racial and ethnic diversity, increased urban-to-rural migration for recreation and retirement, and an aging population.[4, 5]

Rural residents may face socioeconomic and structural barriers to healthcare that can result in disparate outcomes compared to urban residents. Rural areas often have higher rates of poverty and unemployment than urban areas.[6] Rural Americans frequently experience longer travel times to reach their healthcare providers, and often lack access to public transportation, which can impede timely access to necessary care.[7, 8] Compared to urban areas, rural areas tend to have higher rates of uninsurance or underinsurance.[9] Rural residents may also have limited access to high-speed internet, which can limit their ability to leverage online healthcare information and participate in remote visits with their care practitioners.[10]

Rural Household Income by Race and Ethnicity: Percent of Rural Households with Annual Income Above $75,000[11]



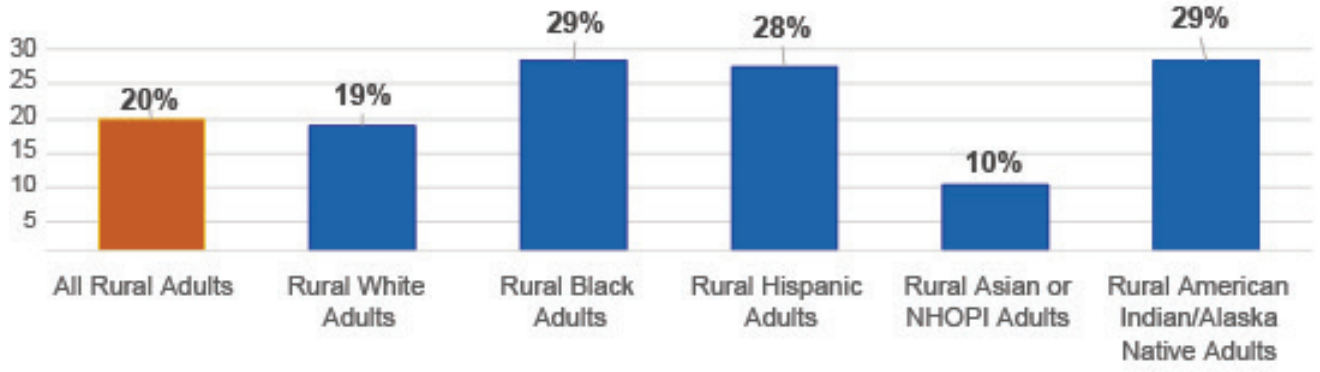
Rural residents may also experience barriers to care due to practitioner shortages and facility closures in rural areas. In general, rural areas have fewer practitioners per capita than urban areas, including shortages of primary care and behavioral health specialists.[12, 13] Since 2010, more than 133 rural hospitals have closed, limiting rural residents' ability to receive hospital

care near their homes.[14] Many other rural hospitals are at risk of closure, with nearly 47% of the country's 1,844 rural hospitals operating with negative margins, and many closing specific care units, such as obstetric units. [15] Between 2008 and 2018, an estimated 500 out of over 4,500 rural nursing homes closed or merged, impeding access to nursing home care for aging rural Americans.[16]

These challenges impact rural health outcomes. Compared with their urban counterparts, residents of rural counties have a higher prevalence of chronic conditions such as diabetes and obesity; higher rates of substance use including opioids, tobacco, and alcohol use; and higher rates of preventable death.[17, 18] People in rural areas have a higher prevalence of serious mental illness, which is often associated with chronic conditions and can lead to shortened lifespans.[19] Women in rural areas experience increased morbidity and mortality in maternal health compared to women in urban areas, and infant mortality is higher in rural areas.[20, 21] In general, all-cause mortality rates are higher in rural counties than in urban counties.[22]

Within rural areas, racial and ethnic minority populations experience greater barriers and outcomes disparities[23, 24] Compared to non-Hispanic Whites, racial and ethnic minorities who live in rural areas are more likely to report not having personal healthcare practitioners, not having accessed healthcare appointments due to cost, and fair or poor health status.[25] In general, Black and American Indian/ Alaska Native women experience disparities in maternal health outcomes compared to non-Hispanic White women, and these disparities are compounded by limited access to high quality care in rural communities.[26]

Rural Residents Reporting Fair or Poor Health by Race/Ethnicity[27]



Rural communities know what solutions are needed and how best to achieve them; they are well-positioned to develop creative and innovative solutions and continuously advance their systems of care to improve their populations' health. The Centers for Medicare & Medicaid Services (CMS) strives to be both a partner and a leader in this work, amplifying and building on existing rural innovation efforts, and advancing rural healthcare solutions to help achieve health equity for all rural Americans.

CMS Strategic Initiatives: Rethinking Rural Health and Health Equity

To address the challenges described above and build on the successes of rural communities, CMS has prioritized improving the health of rural Americans through its Rethinking Rural Health Initiative.[28] This strategic focus applies a rural lens to CMS's many programs and policies, resulting in Agency-wide efforts to empower rural patients and consumers, unleash

rural health innovations, and focus on rural results. The initiative supports CMS in better serving individuals in rural areas, and in developing policies and programs that address unique rural healthcare needs. To that end, CMS developed the Rural Health Strategy in 2018 to guide its own efforts in supporting the achievement of high quality, accessible healthcare and improved outcomes in rural areas.

Rethinking Rural Health is a vital part of CMS's effort to transform the health care delivery system

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

- Increase participation of rural providers and healthcare systems in alternative payment models.
- Expand the number of Medicare Advantage plan and Exchange plan offerings in rural areas.
- Increase the quality of rural healthcare by focusing on reducing readmissions, reducing hospital acquired conditions, and improving maternal healthcare.
- Promote and encourage the adoption of telehealth.
- Reduce administrative burdens that impact rural areas and remove policy barriers that disadvantage rural areas.

These rural health initiatives have been strengthened and amplified through CMS's focus on health equity for all beneficiaries and enrollees. Guiding these actions is the CMS Equity Plan for Improving Quality in Medicare.[29] Developed by the CMS Office of Minority Health, the Equity Plan identifies and lays out approaches for CMS to reduce health disparities among the vulnerable populations it serves, including racial and ethnic minorities, sexual and gender minorities, people with disabilities, and individuals living in rural areas. The CMS Equity Plan includes a core set of quality improvement and disparity reduction priorities that target the individual, interpersonal, organizational, community, and policy levels of the health system. These priorities are to:

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

Because these two strategic efforts guide approaches to rural health activities within CMS, the activities in this report are aligned to one or more Rethinking Rural Health objectives, or to the CMS Equity Plan. For a full list of activities and their evaluated alignment, please see Appendix B.

Purpose of this Report

This report looks at CMS's programs and policies to compile an account of activities that have affected rural health in Fiscal Year (FY) 2020. These include activities specifically designed to target rural populations, as well as impactful activities designed for all CMS beneficiaries and enrollees, but from which rural populations, in particular, stand to benefit.

The activities and accomplishments outlined in this report underscore CMS's commitment to improving rural health. They represent initial steps to realize the visions of the Rethinking Rural Health Initiative and the CMS Equity Plan: supporting the achievement of high quality, affordable care that improves health outcomes and promotes health equity for people in rural areas. Each of the report sections below details CMS activities relevant to focus areas of particular importance to rural health. These focus areas are: The coronavirus disease 2019 (COVID-19), Maternal Health, Medicare Advantage and the Federally Facilitated Marketplace, Quality Improvement, Practitioner Engagement, Patient Empowerment, Medicare and Medicaid Payment and Policy, Models and Demonstrations, and Telehealth.

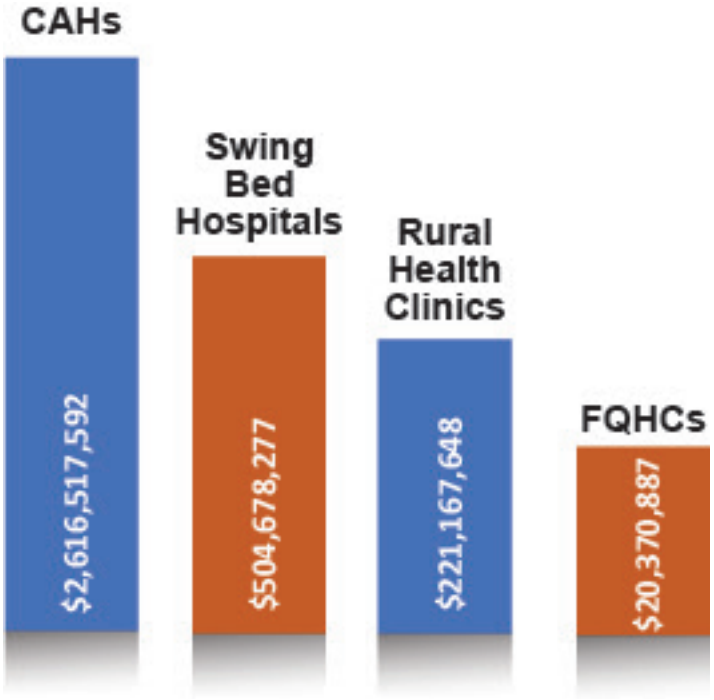
The activities and accomplishments outlined in this report underscore CMS's commitment to improving rural health

COVID-19

The outbreak of COVID-19 introduced new and unique challenges to the U.S. healthcare system in early 2020. CMS quickly took action to support healthcare workers, strengthen the public health response, and protect the nation's health.[30] The initiatives described below specifically focus on steps the Agency took to help safeguard rural communities and rural providers.

A large part of CMS's response to COVID-19 in rural areas involved leveraging its authority to increase workforce flexibilities and alleviate administrative burden during the COVID-19 Public Health Emergency (PHE), thereby allowing rural healthcare providers to focus additional resources on caring for patients and consumers, and responding in other ways to the PHE.[31] CMS actions included temporarily waiving certification, training, supervision, local licensure, and federal limitations on scope of practice requirements, such as physician supervision and staffing requirements in Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs). [32] CMS also provided enhanced financial support for rural facilities, including a higher accelerated payment (125%) available to CAHs through the expanded Accelerated and Advance Payments Program, as required by the Coronavirus Aid, Relief, and Economic Security Act.[33] Through CMS, rural facilities such as CAHs, FQHCs, RHCs, and hospital swing-bed units received over $3 billion in accelerated payments, which are intended to provide necessary funds when there is a disruption in claims submission and/or claims processing, and these payments must be repaid.[34, 35]

CMS Accelerated and Advance Payments Amounts to Rural Facilities[36]



CMS's Hospitals Without Walls initiative temporarily allowed hospital services to be provided in more settings to facilitate surge capacity during COVID-19. This included allowing CAHs to establish surge site locations, waiving certain geographic requirements for CAHs, allowing ambulance transport to RHCs and FQHCs, and waiving certain requirements for Medicare-Dependent Small Rural Hospitals and Sole Community Hospitals.[37] Other CMS efforts to help maintain the financial viability of rural facilities during the PHE included additional options for hospitals to establish swing beds, and continuation of pre-PHE payment determinations for provider-based RHCs that allow for increased capacity without affecting payment rates.[38]

To ensure the safety of its beneficiaries and enrollees during the COVID-19 PHE, CMS took several actions, including promotion of remote services to avoid transmission risk during in-person visits. CMS temporarily removed many barriers to accessing healthcare services and medications remotely, such as permitting states to waive cost-sharing requirements under Medicaid and the Children's Health Insurance Program (CHIP) and allowing Medicare Part D sponsors to relax policies around home delivery for medications.[39, 40] During the PHE, CMS allowed RHCs and FQHCs to provide visiting nursing services to a beneficiary's home with fewer requirements, making it easier for beneficiaries to receive care in their homes. In addition to its existing efforts to expand telehealth access, CMS took dramatic steps to increase telehealth flexibilities using additional statutory authorities enacted by Congress for the PHE, expanding rural beneficiaries' and enrollees' opportunities to access care remotely. These telehealth flexibilities included allowing RHCs and FQHCs to furnish distant site telehealth services, and implementing waivers to allow patients to receive telehealth services in any location, including in their homes. These flexibilities resulted in an increase of rural telehealth utilization during the PHE.[41, 42] Trends in rural telehealth utilization are further discussed in the Telehealth section of this report.

CMS published specific safety and testing requirements, developed trainings, published toolkits and other guidance, and offered technical assistance to support nursing homes' responses to COVID-19. These efforts included the informational Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes, which highlighted resources and best practices to address COVID-19 safety and prevention in nursing homes, including in rural areas.[43] CMS also supported direct technical assistance to rural nursing homes through its Quality Improvement Organization (QIO) contractors.[44] To comprehensively assess the nursing home response to the COVID-19 PHE, CMS engaged the operator of the CMS

Alliance to Modernize Healthcare Federally Funded Research and Development Center (Health FFRDC), which convened a new Independent Nursing Home Commission that included representatives of rural communities among its participants.[45, 46] The findings of this commission will help inform immediate and future responses to COVID-19 in nursing homes.

CMS took steps to strengthen the public health response to the disease outbreak, including releasing infection control guidance documents with recommendations to rural facilities for how to mitigate COVID-19 spread, expanding access to testing, and supporting coverage for vaccinations. [47, 48] Per the requirements of the Families First Coronavirus Response Act, Medicare, Medicaid, CHIP, and group health plans and health insurance issuers covered COVID-19 diagnostic testing and certain COVID-19 testing-related services with no cost sharing during the PHE, and CMS allowed COVID-19 tests to be covered by Medicare and Medicaid when ordered by any pharmacist or other healthcare professional authorized to do so under state law.[49] CMS also expedited processing of Clinical Laboratory Improvement Amendments of 1988 applications, allowed Medicare-enrolled suppliers such as pharmacies to enroll temporarily as independent clinical diagnostic laboratories, and offered specimen collection and travel allowance payment for laboratories to send trained technicians to collect samples from homebound beneficiaries or non-hospital inpatients for COVID-19 diagnostic testing. [50, 51, 52] Under the Families First Coronavirus Response Act, states' and territories' Medicaid programs may receive a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage if they cover COVID-19 vaccines and their administration for Medicaid enrollees without cost sharing, and the Coronavirus Aid, Relief, and Economic Security Act required Medicare and group health plans and health insurance issuers to cover certain COVID-19 immunizations.[53]

CMS published several resources to keep stakeholders and the general public informed during the PHE, including monthly Medicare COVID-19 data snapshots, beginning in June 2020, showing data on COVID-19 cases and hospitalizations among Medicare beneficiaries, and breaking down those data by demographic factors such as rurality, race, ethnicity, gender, and age.[54] The CMS Office of Minority Health also compiled and published a rural crosswalk to highlight COVID-19 flexibilities relevant to rural providers, and a set of resources to support providers working with vulnerable populations, such as older adults, racial and ethnic minorities, and rural communities.[55, 56] CMS also issued the CMS Coronavirus Partner Toolkit, with a specific section for rural areas; distributed toolkits and resources for specific topics like telehealth and workforce issues; and published guidance and Medicare Learning Network Matters articles targeted to specific providers such as RHCs and FQHCs. [57, 58, 59, 60]

To promote the sharing of lessons learned and best practices, CMS held regularly occurring COVID-19 stakeholder engagement calls with a variety of practitioners and facility types. [61] Throughout the PHE, CMS regional outreach teams engaged regularly with local stakeholders across the country, including rural providers, to ensure they were aware of CMS's COVID-19-related flexibilities and waivers, provide technical assistance and training where necessary, and explain how health care providers could access additional informational resources and get their questions addressed. In addition, CMS held weekly calls with state Medicaid Directors, and published a State Medicaid & CHIP Telehealth Toolkit to assist states in broadening Medicaid & CHIP telehealth coverage policies during the PHE.[62]

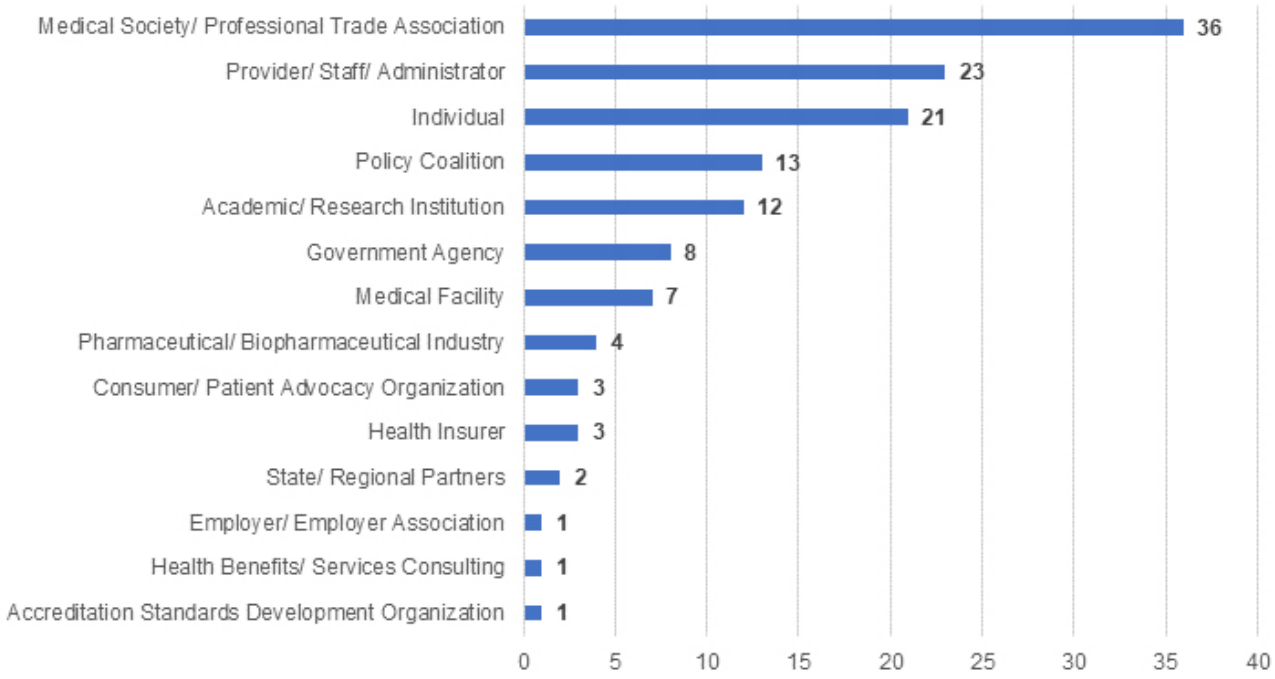
Maternal Health

One objective of the CMS Rural Health Strategy is to work closely with national, regional, and local partners and stakeholders to improve maternal health outcomes in rural communities.[63] This year, CMS leveraged stakeholder input to continue to inform its approach to rural maternal health policies. Many of the Agency's FY 2020 activities were built on stakeholder recommendations from the June 2019 Maternal Health Forum, an event that convened stakeholders from across the country to gain a better understanding of the challenges, opportunities, and priorities in maternal healthcare in the U.S.[64]

CMS received 135 responses and 3,183 unique comments in response to its rural maternal health RFI

A key follow-up action to the forum was a Request for Information (RFI) to seek public comments on rural maternal and infant healthcare. [65] In February 2020, the CMS Office of Minority Health issued the RFI, seeking information related to improving rural access, quality, and outcomes across pregnancy stages. CMS received 135 submissions, resulting in 3,183 unique comments from providers, advocacy organizations, Medicaid enrollees, and other key rural and maternal health stakeholders. Commenters offered diverse perspectives on barriers and opportunities for maternal and infant healthcare improvement, provided examples of impactful initiatives, and offered recommendations to CMS and the U.S. Department of Health and Human Services (HHS). Most responses focused on rural workforce shortages and training, provider and facility reimbursement, hospital closures, transportation challenges, insurance coverage, and data collection for measurement and understanding of rural maternal health outcomes. These responses will inform future work by CMS and HHS on programs and policies to ensure women living in rural areas have access to high-quality, equitable care and better maternal health outcomes.

RFI Submissions by Stakeholder Type (135 Total Submissions)[66]



Feedback on this RFI underscored the importance of provider payment as a key issue facing the rural maternal healthcare workforce. Consistent with its focus on improving maternal health, CMS took steps this year to reevaluate how maternal healthcare providers are paid through the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (PFS) proposed rule. If finalized, the rule will address a key concern highlighted by rural maternal health stakeholders, making increases for maternity payments commensurate with increases to other types of office visits paid for under the Medicare PFS.[67]

Recognizing that facilities in rural areas sometimes struggle to have the capacity and readiness to address emergent obstetric cases, CMS partnered with the Health FFRDC to convene an Obstetric Readiness Workgroup in June 2020, whose activities are ongoing. The Workgroup comprises 26 rural health, maternal health, pediatric, emergency services, and public health experts from across the country. Its purpose is to discuss priorities and next steps to improve the readiness of rural providers, including emergency medical services providers and hospital emergency departments that do not typically provide obstetric services, to manage obstetric cases in rural areas, and to develop ideas and solutions for rural providers to increase their obstetric readiness.

Because the opioid epidemic is affecting women in rural areas at higher rates than in urban areas,[68] CMS continued to include a rural focus in its efforts this year to improve access and quality for pregnant and postpartum women with opioid use disorder (OUD). These initiatives include the CMS Center for Medicare and Medicaid Innovation (CMS Innovation Center) Maternal Opioid Misuse (MOM) Model for pregnant women and infants, which specifically seeks to address the shortage of maternity care and substance use treatment practitioners in rural areas, and the Integrated Care for Kids (InCK) Model for children, which intentionally includes rural service areas, and puts mothers, children, and their families at the center of behavioral and substance use care. [69, 70, 71]

Medicare Advantage and the Federally Facilitated Marketplace

Supporting Rural Beneficiaries through Medicare Advantage

Medicare Advantage (MA) is an important option for many Medicare beneficiaries. MA plans cover all items and services under Parts A and B of original Medicare, and may choose to offer supplemental health benefits or prescription drug coverage.[72, 73] About a quarter of Medicare beneficiaries in rural areas are enrolled in MA plans, with enrollment increasing in recent years.[74]

Recognizing the importance of this coverage for rural beneficiaries, CMS took several steps this year to increase access to MA plans. The Contract Year 2021 MA and Part D final rule addressed MA network adequacy by reducing beneficiary thresholds on time and distance standards, which could expand plan options by helping MA organizations build networks in rural areas.[75] CMS also encouraged more benefit flexibilities offered by MA organizations, including additional telehealth benefits and cost-sharing flexibilities in 2020 for beneficiaries impacted by the PHE. [76, 77] The growing penetration of MA plans in rural areas is evidenced

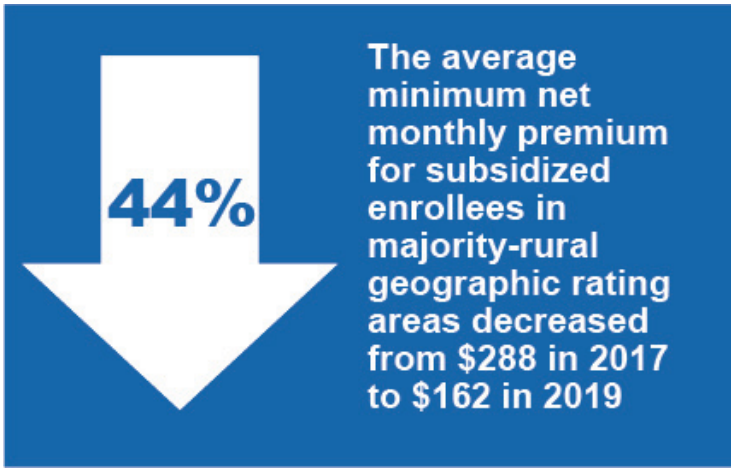
by the introduction of nearly 1,200 new MA plans in recent years, with the number of plan options in rural counties increasing about 18% from 2,450 in 2020 to 2,900 in 2021 as a result of plan flexibilities on benefit coverage and provider networks. [78, 79, 80, 81] This increase in MA plan choice contributed to greater competition and lower premiums, with 2021 MA premiums at their lowest level in 14 years. [82]

MA plans with prescription drug coverage (MA-PDs) and standalone Medicare Part D prescription drug plans (PDPs) had the opportunity to apply this year to offer enhanced alternative Part D plan options with predicable out-of-pocket costs for insulin through the Part D Senior Savings Model, which will be launched in 2021. For CY 2021, 1,635 prescription drug plans (including MA-PDs and PDPs) are participating in the model.[83] This model stands to benefit rural Americans, who experience higher rates of diabetes compared to urban Americans, as well as higher rates of poverty and lower incomes that can make access to diabetes treatment more of a challenge.[84, 85]

Expanding Access through the Federally Facilitated Marketplace

Access to health insurance is critical to rural residents' ability to obtain needed care.[86] In FY 2020, the CMS Center for Consumer Information and Insurance Oversight continued to make great strides in expanding access to health insurance coverage through the Federally Facilitated Marketplace (FFM), achieving the CMS goal of ensuring access to coverage in every county in the country. All rural counties now have at least one qualified health plan issuer offering coverage on the Health Insurance Marketplace.[87, 88] This success was fueled in part by CMS's outreach to states and issuers, as well as guidance and flexibilities over the years to increase choice and lower costs.[89, 90]

Average FFM Premium Decrease for Rural Communities: 2017 to 2019[91]



Having more issuers participating in the Marketplace in each county increases competition and reduces premiums, further ensuring access and affordability for rural Americans. The increased choice of issuers, combined with enhanced direct enrollment, which generates savings that can be used to lower user fees, have contributed directly to premium reductions for coverage offered on the FFM. The average minimum net monthly premium for subsidized enrollees in majority-rural geographic rating areas decreased from $288 in 2017 to $162 in 2019.[92, 93]

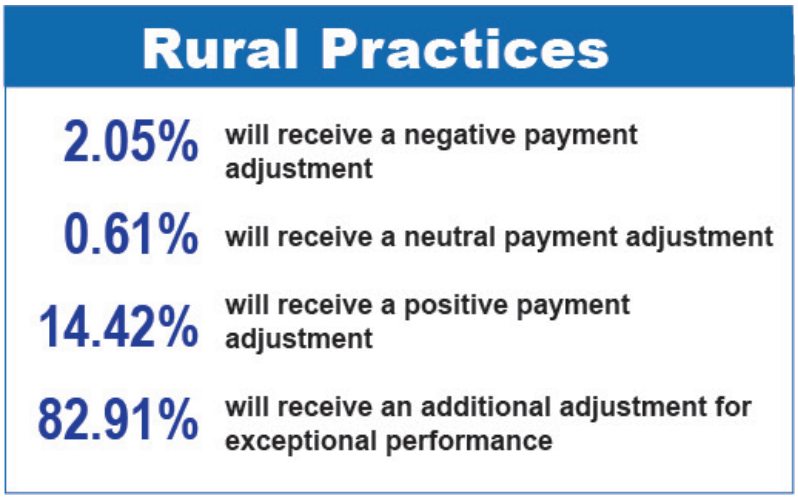
In 2020, with all counties now covered by at least one issuer, CMS worked to further increase competition by reducing the number of counties with a single issuer and continuing to increase the number of health plans available in counties across the country. The number of single issuer counties decreased from 1,124 in the 2019 plan year to 755 in the 2020 plan year (24% of all counties); 68% of these are rural counties.[94]

Quality Improvement

CMS maintains a focus on the unique opportunities for quality improvement in rural communities. In November 2019, CMS released its annual Rural-Urban Disparities in Health Care in Medicare Report, which assessed rural health equity according to patient experience and clinical care measures in both Fee-For-Service (FFS) Medicare and MA plans. The report summarized quality measures that show outcomes disparities for rural residents, regardless of race or ethnicity, with the most pronounced disparities among Hispanic beneficiaries.[95] This report provides CMS with insights on how and where to target initiatives to address healthcare disparities in rural communities, and helps to inform how the Agency includes rural and vulnerable populations in its quality improvement initiatives.

The Quality Payment Program (QPP) is an example of CMS's commitment to quality improvement in rural communities. Publication of QPP Performance Year 2018 results in January 2020 showed 97% of eligible clinicians in rural practices achieved a positive payment adjustment, compared to 93% in 2017.[96] In addition, the QPP's Merit-based Incentive Payment System Value Pathways (MVP) initiative, proposed for application in 2022, has the potential to further facilitate clinicians' successes by focusing on meaningful and aligned quality measures emphasizing outcomes.[97] In an RFI issued in late 2019, CMS specifically sought responses on the impact to small and rural providers in shaping the MVP.[98]

2018 QPP Performance Year Data: Rural Practice Payment Adjustments[99]



Through the efforts of the CMS Center for Clinical Standards and Quality, the QIO program set specific recruitment targets this year for the Quality Improvement Network QIOs to focus on rural and vulnerable populations (e.g., based on race, gender, socio-economic factors, complex chronic conditions and/or behavioral health needs, dual enrollment in Medicare/Medicaid, living in a medically underserved area or a health professional shortage area).[100] These recruitment priorities were announced at the 2020 CMS Quality Conference, the Agency's annual learning and stakeholder engagement event that convenes healthcare and quality leaders from across the country. This year's conference, attended by more than 3,000 stakeholders, featured a track titled "Targeted Focus on Rural Health and Under-Served Populations," which included 11 rural health breakout sessions and one grand plenary session on the CMS Rural Health Strategy. Five additional sessions from other conference tracks also focused on rural issues.[101]

Practitioner Engagement

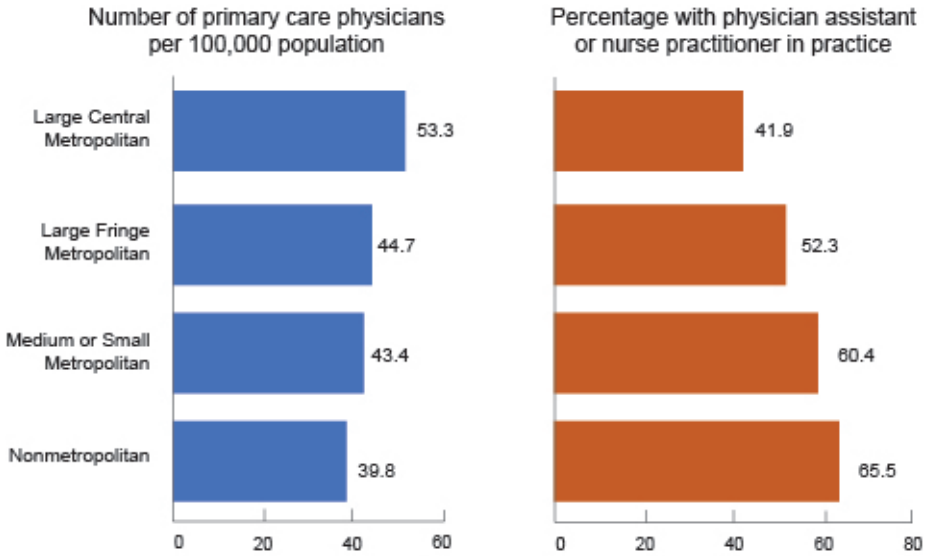
CMS's Patients Over Paperwork initiative focuses on the CMS priority of alleviating unnecessary administrative burdens to allow for more meaningful interactions between

patients and their practitioners. Since its inception in October 2017, this initiative has taken steps to incorporate the specific and unique challenges faced in rural areas.

Following Patients Over Paperwork rural listening sessions and building on previous Patients over Paperwork accomplishments, CMS took several actions in FY 2020 to reduce burdens on rural practitioners. These actions included continuing the moratorium on requirements for direct physician supervision of hospital outpatient services for small and rural hospitals through the end of 2019, and a change from direct to general supervision for hospital outpatient therapeutic services furnished by CAHs and other hospitals in CY 2020 and future years in the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System Final Rule. [102, 103] Other actions included publication of the Omnibus Burden Reduction (Conditions of Participation) final rule, which eased burdens on CAHs by reducing the frequency of required policy and procedure reviews, removing duplicative disclosure requirements, and allowing registered dieticians to practice to the fullest extent of their credentials.[104]

CMS also eased burdens for non-physician practitioners (NPPs), who are vital members of the rural health workforce.[105] This included amending Medicare physician supervision requirements for Physician Assistants (PAs) in the CY 2020 Medicare PFS to describe that in the absence of state rules, supervision is evidenced by documenting the PA's scope of practice and working relationship with the supervising physician, giving PAs greater flexibility to practice more broadly.[106] Other Medicare actions included a proposal to allow PAs, nurse practitioners, clinical nurse specialists, and certified nurse-midwives to supervise the performance of diagnostic tests; and a final rule to allow NPPs to perform face-to-face visits during a patient's stay in an inpatient rehabilitation facility.[107, 108]

Primary Care PA and NPs in Metropolitan and Nonmetropolitan Areas[109]



CMS estimates that final and proposed burden reduction regulations will result in cost savings to rural facilities of around $100 million between 2018 and 2021. It also estimates projected time savings for rural practitioners of around 950,000 hours, giving them back valuable time to spend with their patients.[110] The Agency is committed to continuing its work to alleviate practitioner burdens, formalizing these efforts through the creation this year of the CMS Office of Burden Reduction and Health Informatics.

Patient Empowerment and Person-Centered Care

Informed decision-making is one of the foundational principles of CMS's Person and Family Engagement Strategy, a guiding document for incorporating the voices of beneficiaries, enrollees, and their families and caregivers into CMS programs and policies. The principle of informed decision-making calls for empowering patients to choose providers based on reliable cost and quality information, and allowing them to participate more fully as equal partners in their care.[111]

CMS Person and Family Engagement Foundational Principles[112]

This principle of empowered patients was supported this year by the launch of the Care Compare website, which streamlined information on facilities, providers, and services in one user-friendly interface. Pulling together cost, quality of care, volume of services, and other data, CMS built on its existing quality compare tools to make quality information more accessible and useful for patients, caregivers, and other consumers.[113]

To enhance choice and informed decision-making, CMS issued several rules this year, including the CY 2021 Outpatient Prospective Payment System & Ambulatory Surgical Center proposed rule, which proposes to remove regulatory barriers to give patients more choices in where they receive care; and the Hospital Price Transparency final rule, which requires hospitals to publicly post standard charge information, enabling patients to compare those charge across hospitals.[114, 115] Discussing this rule's impact on rural communities, CMS Administrator Seema Verma stated that it contributes to "the foundation for a patient-driven healthcare system by making prices for items and services provided by all hospitals in the United States more transparent for patients," and specified that it will provide rural patients with more information for decision-making.[116]

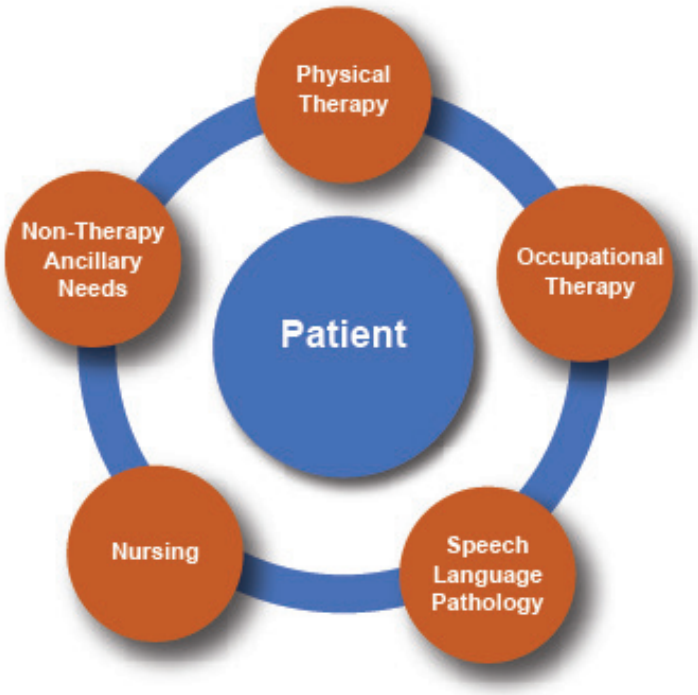
CMS is committed to beneficiaries and enrollees participating as equal partners in their care and co-creating goals with their practitioners. To empower rural patients to participate more fully in their care, CMS published the Discharge Planning final rule. It requires CAHs and other hospitals to focus more on patients' goals and treatment preferences during discharge planning from acute to post-acute care, allowing rural patients and others to direct their care more effectively.[117, 118, 119]

Medicare and Medicaid Payment and Policy

Supporting Beneficiaries through Medicare Payment and Policy

Building on previous changes to the wage index that address disparities in Medicare payments between some rural and urban facilities, CMS continued to make strides this year to improve the accuracy of wage index calculations, including a methodology to increase the wage index for certain low wage index hospitals.[120, 121] Using the 2019 Wage Index Quartiles, at least 60% of the hospitals set to receive a payment increase this year are rural.[122, 123]

PDPM Focus on Individualized Patient Needs, Characteristics, and Goals[124]



Additional Medicare payment and policy activities included proposals for rural dialysis facility wage index adjustments and an add-on payment for certain innovative home dialysis equipment through the End Stage Renal Disease Prospective Payment System (PPS); and additional principal care management codes in RHCs and FQHCs through the Medicare PFS.[125, 126] These activities also included improved payment accuracy and appropriateness for swing bed services provided in rural hospitals through the Patient Driven Payment Model (PDPM) which was implemented beginning in FY 2020 under the Skilled Nursing Facility PPS. The PDPM is a case-mix classification system that aims to reduce administrative burden and better account for each patient's unique characteristics and care needs in placing patients in payment groups.[127]

Moving forward, CMS will continue to examine and make Medicare payment adjustments to support the financial strength of rural facilities. To that end, the FY 2021 Inpatient Prospective Payment System (IPPS) Final Rule includes the continued application of a frontier state floor, details on the implementation of the Rural Community Hospital Demonstration Program in FY 2021, and continuation of the low wage index hospital policy.[128]

Supporting Enrollees Through Medicaid Policy

Rooted in partnership with states, Medicaid is a vital resource for many CMS beneficiaries, including children, pregnant and post-partum women, low-income enrollees, people with disabilities, and dual-eligible beneficiaries.[129] Advancing rural health strategies through the CMS Center for Medicaid and CHIP Services is central to CMS's goal of fostering increased flexibility and innovation toward improved outcomes for Medicaid enrollees.

To help state Medicaid agencies and other state and local entities understand what federal resources are available to help improve health and housing outcomes for older adults and those with disabilities in rural America, CMS and several other agencies issued an informational bulletin this year. Together with the U.S. Department of Housing and Urban Development, the U.S. Department of Agriculture, and three other HHS agencies, CMS published Living at Home in Rural America: Improving Accessibility for Older Adults and People with a Disability. This Joint Informational Bulletin can help state and local entities address physical environmental barriers in the home, increase safety, minimize fall risks, and support rural Americans' ability and desire to remain in their own homes.[130]

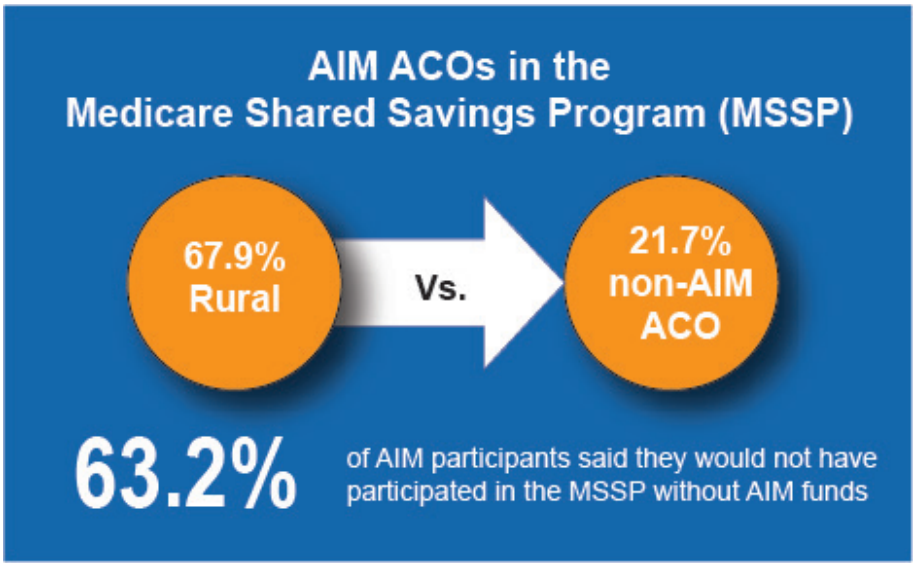
Also this year, CMS announced an RFI to seek public comments regarding the coordination of care from out-of-state providers for Medicaid-eligible children with medically complex conditions. CMS specifically sought input related to urban, rural, tribal, and medically underserved populations, as barriers and successful strategies may vary by geography. CMS intends to use the information received in response to this RFI to issue guidance to state Medicaid directors on the coordination of care from out-of-state providers for children with medically complex conditions.[131, 132]

Models and Demonstrations

To support the Rethinking Rural Health Initiative's focus on innovation for rural patients and providers, CMS is designing and testing new models of care to evaluate new approaches and improve the rural healthcare delivery system through the CMS Innovation Center.

CMMI continued to administer and evaluate several national models in rural areas this year, publishing evaluation reports for models that encourage and support rural participation. This work included the second annual evaluation report for the Accountable Care Organization (ACO) Investment Model (AIM). This model targets ACO participants in rural and underserved areas that may otherwise have limited ACO uptake, requiring that participating AIM ACOs serve small populations, or rural or underserved markets. [133] The evaluation report found that the model was associated with increased annual wellness visits for its beneficiaries, reductions in readmissions and emergency room utilization rates, Medicare spending reductions, and a greater likelihood of ACO formation in small and rural communities.[134] Also published this year was the second annual evaluation report for the Million Hearts® Cardiovascular Disease Risk Reduction Model, for which half of the participating organizations are rural. [135] This report described outcomes for the intervention group across both rural and urban areas, including an increased likelihood of patients beginning or intensifying hypertension treatment, a greater likelihood of providers using risk scores to identify patients at risk for cardiovascular disease, a decline in cardiovascular disease risk scores for high-risk beneficiaries, and a lower all-cause mortality rate for beneficiaries.[136]

Select AIM Performance Year 2 Results[137]



Building on the successes of initiatives such as the ACO Investment Model, this year CMS announced the Community Health Access and Rural Transformation (CHART) Model, a focused innovation effort targeting rural health system improvements. Through this model, CMS aims to continue addressing rural health disparities by leveraging coalitions and collaborations among rural communities to transform their healthcare delivery systems. The model provides two options through which rural providers can leverage innovative financial arrangements and operational and regulatory flexibilities: the Community Transformation Track, and the ACO Transformation Track. Key facets of both tracks are the continuation of expanded telehealth coverage, and opportunities to use telehealth for home health visits, remote patient monitoring programs, and in skilled nursing facilities.[138]

New and ongoing national models to promote innovation in rural areas also made progress in participant recruitment and model launches this year. The Direct Contracting Model opened participant applications to launch its implementation period and first performance year for the Global and Professional Options. This model, which includes CAH, RHC, and FQHC participants, provides flexibilities that will allow participants to support care transformation in rural areas. [139] The Emergency Triage, Treat, and Transport (ET3) Model, which will launch in January 2021 to support people living in both rural and non-rural areas to access emergency care while potentially avoiding expensive, unnecessary ambulance transports, announced its initial performance year participants in May 2020. [140] The Primary Care First Initiative, which supports innovative payment solutions in support of primary care providers, including those in rural states, announced its practice and payer selections for its initial performance year. [141] And the Bundled Payments for Care Improvement (BPCI) Advanced Model, which includes rural practitioners and waivers to allow enhanced telehealth services to be furnished to beneficiaries during certain episodes of care, announced its participant list, episode initiators, and clinical episode documents for model year three, as well as new Clinical Episode Service Line Groups (CESLGs) and an option to use a new Alternate Quality Measure Set for each Clinical Episode in a CESLG for model year four.[142]

CMS and states are testing innovative payment models and engaging providers to improve care delivery and population health in rural areas. This year, CMS announced the hospitals and payers that would be participating in the Pennsylvania Rural Health Model for Performance Year two.[143] This model tests whether care delivery transformation and global budgets can increase rural Pennsylvanians' access to high-quality care and improve their health, while also reducing the growth of hospital expenditures. Two other state models, the Vermont All-Payer ACO Model and the Maryland All-Payer Model, had reports published on their progress, including a final evaluation for the Maryland All-Payer Model. This model exempted Maryland hospitals from Medicare's inpatient and outpatient prospective payment systems and shifted the state's hospital payment structure to an all-payer, annual global budget with an all-payer rate-setting system. From 2014-2018, the state saw fewer admissions and emergency department visits and reduced hospital and Medicare expenditures for both rural and non-rural beneficiaries.[144] In May 2020, CMS posted a request for applications for the Maryland Total Cost of Care Model's Maryland Primary Care Program. The Maryland Total Cost of Care Model builds on the previous Maryland All-Payer Model to set a per capita limit on Medicare total cost of care in that state.[145] The ongoing Vermont All-Payer ACO Model tests an all-payer payment system in which the state's most significant payers (Medicare, Medicaid, and commercial health plans) incentivize value-based care for the majority of providers, with a focus on health outcomes in a state whose population is 65% rural.[146, 147]

Telehealth and Other Virtual Services

According to the American Telemedicine Association, more than 50% of healthcare services will be consumed virtually by 2030.[148] Driving factors include increases in chronic diseases, the aging population, healthcare professional shortages, developments in telecommunication infrastructure, and innovative technological advancements.[149] For rural patients whose access can be impeded by distance and practitioner shortages, access to remote provision of care is becoming increasingly critical.[150] CMS is committed to staying ahead of this curve, modernizing its programs by leveraging technologies to help beneficiaries and enrollees access quality services in ways that are convenient to them.[151]

In the first few months of the COVID-19 PHE, the number of Medicare beneficiaries with telehealth visits grew from 13,000 weekly to nearly 1.7 million.[152] In rural areas, 22% of Medicare beneficiaries used telehealth services in the first few months of the PHE.[153] Acknowledging this success, CMS is reviewing and evaluating the temporary flexibilities provided during the PHE to determine whether some should be extended.[154] For example, CMS proposed, and has since finalized, regulatory changes to make permanent beyond the PHE some of the expanded list of telehealth services covered by Medicare, including home visits for the evaluation and management of a patient (in the case where the law allows telehealth services in the patient's home), and certain types of visits for patients with cognitive impairments.[155, 156, 157]

Prior to its unprecedented expansion of telehealth services in response to the COVID-19 PHE, CMS had already taken considerable action in increasing access to care through telehealth and other virtual services. This year, telehealth policy advancements outside of the COVID-19

provisions included new opportunities in Medicare to allow telehealth services for OUD. In the 2020 Medicare PFS final rule established separate payment for several billing codes for office-based treatment of OUD and added the services to the list of covered telehealth services. These bundled payments include services such as treatment plan development, care coordination, individual therapy, group therapy, and counseling.[158] Additionally, the Medicaid Substance Use Disorder Treatment via Telehealth, and Rural Health Care and Medicaid Telehealth Flexibilities Informational Bulletin published this year identified options for states to leverage existing telehealth policies in Medicaid to increase access to care, and described federal reimbursement for substance use disorder treatment delivered via telehealth.[159]

Prior to the COVID-19 PHE, CMS was already taking action to increase telehealth access

In response to stakeholder feedback, and in addition to Medicare telehealth services, CMS continued to make updates this year to improve access to care management services that are furnished virtually, such as remote physiologic monitoring (RPM). In the 2020 Medicare PFS final rule, CMS established an add-on code for RPM services, allowing healthcare providers to bill additional treatment management services during the month. In this rule, CMS made changes to the care plan requirements and added a new code for Principal Care Management services that is similar to chronic care management, but only involves treatment of a single chronic condition. In addition, CMS eliminated the concurrent billing restriction between chronic care management and Transitional Care Management (TCM) services when TCM is relevant and medically necessary.[160, 161]

Other actions to expand telehealth services this year included additional flexibilities for how MA plans may include telehealth coverage of certain Part B benefits in their bids (which encourages MA Plans to offer telehealth options that are not available in the Medicare FFS program) and guidance for reporting on telehealth services in CMS's quality programs. In the MA and Part D Contract Year 2021 final rule, CMS finalized policies that gave MA plans additional support to offer telehealth benefits in rural areas, instituting policies to further increase telehealth access for beneficiaries enrolled in MA plans.[162] For its quality reporting programs, CMS issued detailed guidance on documenting and reporting electronic clinical quality measures for telehealth encounters in certain instances, providing supplemental information for clinicians to incorporate telehealth services into quality improvement efforts.[163] CMS is enthusiastic about the growth in telehealth, including expansion of broadband services to enable greater access to remote technologies in rural areas. Initiatives like the CMS Innovation Center Colorado State Innovation Model, which surpassed its goal of expanding broadband to 300 practice sites by 27% through a successful partnership with the Colorado Telehealth Network, offer insights and best practices to help CMS carry this work forward. Building on successes like this, CMS can continue to support the expansion of emerging technologies, and help to increase equitable access to high quality remote care for rural residents.[164]

The Way Forward

The activities and initiatives described in this report are part of an ongoing commitment to improving the health and well-being of CMS beneficiaries and healthcare consumers living in rural communities. Going forward, CMS will continue to develop and implement programs and policies that foster access to high quality care for rural patients and consumers, support rural providers, address unique rural healthcare economics, and reduce unnecessary burdens in the healthcare system. CMS is committed to supporting advancements and transformations of the rural healthcare system to improve outcomes for Americans living in rural areas.

Just as in previous years, CMS will continue its ongoing work to help improve access to care and quality in rural areas through FY 2021 initiatives that will build on the developments and achievements of FY 2020. Proposed rules will be updated based on public comment and feedback, announced policies and initiatives will become effective, and current research and stakeholder engagement will inform policy and practice transformation. In addition, lessons learned from the COVID-19 PHE will be examined and applied to CMS's work. Temporary policies that benefited rural communities may be made permanent; studies may be launched to provide important information about access, quality, and outcomes related to COVID-19, particularly in settings such as nursing homes; and COVID-19-related economic impacts to rural communities will be important to consider as CMS plans for FY 2021.

CMS looks forward to continuing this work in partnership with its stakeholders and partners in Rethinking Rural Health to expand value-based care, ensure access, improve outcomes, and provide all individuals in rural communities with access to quality, more affordable, and equitable healthcare.

Appendix A: Acronym List

Acronym	Full Term
ACO	Accountable Care Organization
AIM	ACO Investment Model
BPCI	Bundled Payments for Care Improvement
CAH	Critical Access Hospital
CELGs	Clinical Episode Service Line Groups
CHART	Community Health Access and Rural Transformation
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CY	Calendar Year
ET3	Emergency Triage, Treat, and Transport
FFM	Federally Facilitated Marketplace
FFRDC	Federally Funded Research and Development Center
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HHS	U.S. Department of Health & Human Services
InCK	Integrated Care for Kids Model
IPPS	Inpatient Prospective Payment System
MA	Medicare Advantage
MA-PDs	MA Plans with prescription drug coverage
MOM	Maternal Opioid Misuse Model
MVP	Merit-based Incentive Payment System Value Pathways
NHOPI	Native Hawaiian and Other Pacific Islanders
NPP	Non-Physician Practitioner
OPPS	Outpatient Prospective Payment System
OUD	Opioid Use Disorder
PA	Physician Assistant
PDP	Prescription Drug Plan
PDPM	Patient Driven Payment Model
PFS	Physician Fee Schedule
PHE	Public Health Emergency
PPS	Prospective Payment System
QIO	Quality Improvement Organization
QPP	Quality Payment Program
RFI	Request for Information
RHC	Rural Health Clinic
RPM	Remote Physiologic Monitoring
RRH	Rethinking Rural Health
TCM	Transitional Care Management

Appendix B: Alignment of Rural Health Activities to CMS Priorities

The activities in this report are aligned to one or more Rethinking Rural Health (RRH) objectives, or to the CMS Equity Plan. The table below outlines alignment of activities from this report to these priority initiatives. Alignment to the Equity Plan was evaluated based on an activity's demonstrated adherence to the Equity Plan's overall approach to program development and implementation. Alignment to The Rethinking Rural Health Initiative was evaluated based on an activity's demonstrated support for one or more of the following objectives:

- RRH Objective 1- APMs: Increase participation of rural providers and healthcare systems in alternative payment models
- RRH Objective 2- Coverage: Expand the number of Medicare Advantage plan and Exchange plan offerings in rural areas
- RRH Objective 3- Quality: Increase quality of rural healthcare by focusing on reducing readmissions, reducing hospital acquired conditions, and improving maternal healthcare
- RRH Objective 4- Telehealth: Promote and encourage the adoption of telehealth, especially in rural areas
- RRH Objective 5- Burden: Reduce administrative burdens that impact rural areas and remove policy barriers that disadvantage rural areas

Activity	RRH Objective 1- APMs	RRH Objective 2- Coverage	RRH Objective 3- Quality	RRH Objective 4- Telehealth	RRH Objective 5- Burden	CMS Equity Plan
COVID-19 Workforce Flexibilities	No	No	No	Yes	Yes	Yes
COVID-19 Accelerated Advance Payments	No	No	No	No	Yes	Yes
COVID-19 Hospitals Without Walls	No	No	Yes	Yes	Yes	Yes
COVID-19 Telehealth and Remote Care Flexibilities	No	Yes	No	Yes	No	Yes
COVID-19 Infection Control Guidance	No	No	Yes	No	No	Yes
COVID-19 Nursing Home Support	No	No	Yes	No	No	No
COVID-19 Public Health Response	No	Yes	No	No	Yes	Yes
COVID-19 Published Resources	No	No	Yes	Yes	No	Yes

Activity	RRH Objective 1- APMs	RRH Objective 2- Coverage	RRH Objective 3- Quality	RRH Objective 4- Telehealth	RRH Objective 5- Burden	CMS Equity Plan
COVID-19 Stakeholder Engagement	No	No	Yes	No	No	Yes
Rural Maternal Health RFI	No	Yes	Yes	Yes	Yes	Yes
Obstetric Readiness Workgroup	No	No	Yes	No	Yes	No
MoM Model	Yes	No	Yes	No	Yes	Yes
InCK Model	Yes	No	Yes	No	No	Yes
MA and Part D Contract Year 2021-2022 final rule	No	Yes	No	Yes	No	No
MA and Part D Insulin Pricing Model	No	Yes	No	No	No	Yes
FFM Enhanced Direct Enrollment	No	Yes	Yes	No	No	No
FFM Reduction of Zero-Issuer Counties	No	Yes	No	No	No	Yes
Rural-Urban Disparities Report	No	No	Yes	No	No	Yes
QPP Support to Small and Rural Practices	Yes	No	Yes	No	Yes	Yes
QIO Recruitment Targets	No	No	Yes	No	Yes	Yes
CMS Quality Conference Rural Track	No	No	Yes	No	No	Yes
Omnibus Burden Reduction final rule	No	No	Yes	No	Yes	No
Instruction on CAH and Small Rural Outpatient Therapeutic Services Supervision Requirements	No	No	Yes	No	Yes	Yes
Hospital OPPS and ASC Payment System final rule- Direct Supervision Requirements	No	No	Yes	No	Yes	Yes
Medicare 2020 PFS- Amended PA Physician Supervision Requirements	No	No	Yes	No	Yes	Yes
Compare Tool	No	No	Yes	No	No	Yes

Activity	RRH Objective 1- APMs	RRH Objective 2- Coverage	RRH Objective 3- Quality	RRH Objective 4- Telehealth	RRH Objective 5- Burden	CMS Equity Plan
OPPS and Hospital Price Transparency rules	No	No	No	No	No	Yes
Discharge Planning final rule	No	No	No	No	No	Yes
Wage Index Calculation Accuracy Improvements	No	No	No	No	No	Yes
ESRD PPS Rural Wage Index and Home Dialysis	No	No	Yes	No	No	Yes
Medicare PFS rural care management codes	No	No	No	No	Yes	Yes
PDPM in the 2019 SNF PPS Prospective Payment System	No	No	Yes	No	Yes	Yes
FY 2021 IPPS proposed rule- Frontier State Floor	No	No	No	No	No	Yes
FY 2021 IPPS Final Rule- Rural Community Hospital Demonstration Program	Yes	No	No	No	No	Yes
HHS Information Bulletin: Housing Resources	No	No	No	No	No	Yes
Out-of-State Care Coordination RFI	No	Yes	No	No	No	No
ACO Investment Model	Yes	No	Yes	No	No	Yes
BPCI Advanced Model	Yes	No	No	Yes	No	No
Comprehensive Care for Joint Replacement Model	Yes	No	No	No	No	No
CHART Model	Yes	No	Yes	Yes	No	Yes
Direct Contracting Model	Yes	No	Yes	No	No	No
ET3 Model	Yes	No	No	No	No	No
Maryland All-Payer Model	Yes	No	Yes	No	No	No

Activity	RRH Objective 1- APMs	RRH Objective 2- Coverage	RRH Objective 3- Quality	RRH Objective 4- Telehealth	RRH Objective 5- Burden	CMS Equity Plan
Million Hearts® Cardiovascular Disease Risk Reduction Model	No	No	Yes	No	No	Yes
Pennsylvania Rural Health Model	Yes	No	Yes	No	No	Yes
Primary Care First Model Options	Yes	No	Yes	No	No	Yes
Vermont All-Payer ACO Model	Yes	No	Yes	No	No	No
Colorado State Innovation Model	Yes	No	Yes	Yes	No	Yes

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