National Advisory Committee on Rural Health & Human Services

Recommends Provisions to Modernize the RHC Program

The National Advisory Committee on Rural Health and Human Services (the Committee) is a nationally recognized panel of rural health experts that provides recommendations on rural issues to the Secretary of the Department of Health and Human Services. Recently, they released their report on how to "modernize rural health clinics" that you can read here.

This report creates an opportunity for NARHC and the broader RHC community to press policymakers for RHC modernization. Generated by an unbiased panel of health experts, this report confirms many of the policies we were already advocating for, and provides additional evidence to help make the case.

There were six main recommendations to the Secretary regarding improvements to the rural health clinic program:

1. **Increase the RHC Payment Cap to Cover Costs**

The Committee found that the RHC payment cap as updated by the Medical Economic Index (MEI) has not kept pace with the cost of providing service. They noted that RHCs subject to the payment cap had costs from $25 to $81 greater above their capped All Inclusive Rate. The Committee asks the Secretary to work with Congress to obtain a statutory change to the payment cap that better covers average costs.

2. **Technical Assistance on Quality Reporting**

The Committee noted that a long-term challenge for RHCs will be finding a way to participate in value-based care. They noted that other entities such as FQHCs may be further along than RHCs because they receive 330 grants that allow them to collect better data. As a result, the Committee recommended that Congress provide grants to the State Offices of Rural Health to provide technical assistance on quality reporting.

3. **Allowing RHCs to be Distance Site Providers**

The Committee recommended that RHCs be allowed to participate in telehealth services as the distant site provider. This would allow an RHC practitioner to receive the AIR for a telehealth service as if the patient was in the room face to face. We believe that if RHCs were able to participate as distant sites in the Medicare telehealth benefit, they could achieve the patient volume necessary to recruit health professionals, particularly mental health professionals to rural areas.

4. **Allowing RHC Providers to Order Hospice and Home Care**

As the law stands today, RHC practitioners cannot be the attending clinician for hospice services. This often forces long-time patients of an RHC into picking a different attending clinician for their time in hospice. The Committee recommended that all RHC providers be allowed to be the attending clinician for hospice services.

5. **Allowing Masters Trained Behavioral Health Providers to be RHC Practitioners**

The Committee recommended that masters trained behavioral health providers be recognized as RHC practitioners to increase access to mental health care in rural areas. They argued that licensed professional counselors, mental health counselors, and marital and family therapists all be recognized as RHC practitioners for the purposes of Medicare reimbursement.

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6. Modernize lab requirements

Last but certainly not least, the Committee recommended that the Secretary modernize the lab requirements. They noted that the current regulations can lead to inefficient allocation of resources. The Committee suggested that the Secretary publish a Request for Information (RFI) to RHC providers on current RHC laboratory needs and then use that RFI to inform a decision on how best to modernize the lab requirements.

While not formal recommendations, the report did highlight a few other issues for modernization. The committee argued that these "other considerations" merit further consideration by HHS and include: the ability to contract with PAs or NPs to meet the 50% requirement, a request that HHS generate faster survey and certification turnarounds, and a suggestion that HHS explore regulatory flexibility for grandfathered-in RHCs looking to relocate.

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