Rural Rounds Summary

JULY 22, 2026

About Us

Rural Rounds was started as a way to connect rural health leaders across the nation in order to tackle the real-world issues facing rural healthcare today. You no longer have to feel isolated and you don't have to fight your battles alone!

We know that leading a clinic in Rural America brings it own challenges and it can often feel very isolating. So, every Wednesday from 9am to 10am CST, rural health leaders from across the United States come together virtually to discuss hot topics or challenges that are facing their clinics and organizations. This is a safe zone for leaders to ask questions, share ideas, and learn from their peers.

Summary of Today's Rural Rounds

Thank you to those who brought important topics to today's discussion. Below is a summary of what we discussed.

Proposed 2027 Physician Fee Schedule Final Rule

- Changes to who can perform Remote Physiological Monitoring/Remote Therapeutic Monitoring
  - Proposed to not allow for use of 3rd party contractors to perform RPM/RTM services when billing for these services. Staff would have to be the clinic's own staff (w-2 employee)
- Required in-person visit to initiate RPM/RTM Therapy
- Removal of G2211 and replace with modifier
  - If removed and replaced with modifier, this would increase the billed FFS E&M reimbursement by 16%
  - Unsure how RHCs would be able to receive this fee adjustment
- Addition of Diabetic Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) as stand-alone visits in an RHC
  - Proposed to allow RHCs to bill DSMT and MNT services as a stand-alone billable visit and receive the AIR
  - Proposed to allow for certified/licensed ancillary staff, such as Diabetic Educator, to perform these services under the direct supervision of an RHC provider
- Telehealth Flexibilities extended through 12/31/2027 (payment for non-behavioral health telehealth services furnished by RHCs and FQHCs)
- Mental health in-person requirement extended through 12/31/2027

Plus many other proposed changes or comments requested that don't directly affect RHCs, but do affect primary care and other healthcare services.

These are proposed changed for 2027 and not final. Final rule will be posted by 11/1/2026 and final changes in effect 1/1/2027 or otherwise specified date. Clinic should not implement any changes at this time. Clinic are encouraged to submit comments to CMS on any of the proposed changes or requests for comments **by 9/14/2026.** To submit a Public Comment visit https://www.federalregister.gov/documents/2026/07/16/2026-14327/medicare-and-medicaid-programs-cy-2027-payment-policies-under-the-physician-fee-schedule-and-other

You can also email your comments to Sarah Hohman with NARHC at Sarah.Hohman@narhc.org and she will review and include in NARHCs response to CMS.

NARHC is hosting a webinar on the proposed changes on Friday, 7/31/2026 at 12:00pm CST. Link to register is https://us06web.zoom.us/webinar/register/WN_FkRb334hQjefOmJWyalkeA#/registration

Lab Draw in the Clinic

- Patients Coming for Lab Draw Only (How do you bill Medicare?)
  - Patients coming in only for labs do not have to see a provider to have the labs drawn.
  - The venipuncture/lab draw (36415) performed by your clinic staff (not an outside lab staff member) can be billed with an allowable face-to-face encounter the same day or within 30 days before or after.
  - Billing for venipuncture will add to the patient's coinsurance, but will not gain you any extra reimbursement from Medicare directly.
  - The venipuncture should not be billed with the actual lab services to your Part B MAC if performed by your clinic staff. Your Point of Care labs (such as required RHC POC labs), as well as any other labs must be split billed to your Medicare Part B MAC under your clinic if Independent or under hospital if Provider-based.
  - Lab charges should NEVER be on an RHC claim to Medicare.
- Can you draw labs for patients who are not patients of your RHC?
  - Yes you can draw labs for patients for who are not patients of your RHC.
  - Patients should complete all necessary registration paperwork as any other patient
  - You will not have a qualifying visit to attach the venipuncture to. But you can bill for the labs themselves to your Part B MAC.
  - Make sure that your policies and procedures speak to who will address any lab results and communicate to patient or how any critical values will get reported to the ordering provider.
  - Make sure to have a valid order from the ordering provider
  - Important to also address who is responsible for checking diagnosis against the ordered labs if Medicare will cover prior to drawing the labs. Who is responsible for reaching to ordering provider to get updated order with approved diagnosis if not covered or obtaining an ABN should there not be a coverable diagnosis?

Biennial Program Evaluation (Who has to participate?)

- Per 42 CFR 491.11 the clinic's Medical Director, one NP or PA, and one outside member (not part of your clinic staff).
- Medical Director and NP need to participate in the development and review of policies, as well as participate and sign off on the biennial program evaluation.

- The only responsibility of your your "outside member" is to review and approve your RHC patient care policies and other RHC regulatory policies. They do not have to sign off on non-patient care policies (example HR policies that your hospital or organization has in place).
- The "outside member" should be someone with clinical knowledge and can be a consultant, pharmacist, director of a department at hospital, another clinic's staff member, other anyone else that is not on your clinic's payroll. If provider-based it can be someone who works at hospital, but shouldn't be someone who the clinic staff may report up through.
- You are not required to have a formal meeting to conduct the program evaluation. You can do a summary with all the required elements and have the required parties sign off on. But it is the recommendation of some consultants to have meeting to review and discuss the information. It is a perfect time to discuss and reflect how the RHC is doing (# of patients served, services offered, changes in policies made or need to be made, quality metrics, patient satisfaction), and if there should be any modification, changes, or improvements made.
- Make sure your policy reflects how often you perform the program evaluation. You are required to conduct at least biennially, but if you policy states you conduct annually you will be subject to doing annually. Recommendation is to have your policy state that your clinic will conduct "at least biennially." Not conducting a program evaluation is a Conditional Deficiency.

Information on how the All-Inclusive Rate (AIR) Works

- When you become an RHC you are opting out of the fee-for-service reimbursement for Medicare and are accepting a cost-based reimbursement (All-Inclusive Rate).
- Your AIR is based on your annual cost report. The AIR calculations is:

Total Allowable Costs/Total Allowable Visits = All Inclusive Rate

- RHCs are subject to an annual "cap" or Upper Payment Limit (UPL). If you are an Independent RHC or became a Provider-Based RHC 2020 or after you are subject to an Upper Payment Limit that is increasing each year by $13.00 until it reaches $190.00 in 2028, when it will then go up by the Medicare Economic Index (MEI). The UPL for 2026 is $165.00. If you are Provider-based RHC prior to 2020, your clinic has a grandfathered UPL at your filed 2020 cost per visit.
- If your cost per visit is at or above the current UPL you will receive the UPL as your AIR. If it is below the UPL then your AIR will be your actual cost per visit filed on your cost report.
- Medicare will then pay you based on your AIR for any qualifying visit that is medically-necessary, and face-to-face visit with an allowable RHC provider. Medicare will pay your clinic 80% of your current AIR (minus the 2% Sequestration).
- The 20% coinsurance is based off your total charges reported in the line with CG modifier.
- Certain Medicare preventative services (such as the Annual Wellness Visit) are paid at 100% of your AIR (minus the 2% sequestration). When there is no cost-sharing with the patient, then there will be no additional 20% coinsurance.

Policy and Procedure Manual

- Patient care policies must be reviewed by your Medical Director, NP or PA, and "outside member" biennially.
- To support your clinic's policies you will then have an "evidence" binder to show how you are complying with your policies and procedures.
- Watch for a future dedicated session on managing your policies and procedures, along with supporting evidence.

Helping a New Rural Health Manager

- There are training resources available through NARHC such as Billing, Finance, and Compliance. To sign up for these courses visit. https://www.narhc.org/narhc/NARHC-Academy-Courses.asp
- Best advice is to "give yourself some grace", as RHC's are complex and complicated.
- Educate yourself with the resources that are available to you, such as NARHC's forum, the Rural Health Clinic Information Exchange Facebook page, and RHC conferences at National and State levels.
- Tara Adams, Clinic Administrator with the Pillow Clinic in Arkansas, offered for clinic managers to reach out to her directly for advise and assistance from an administrator in the trenches. Her email is tadams@pillowclinic.net.

Emergency Preparedness Exercises

- RHCs are required to provide training for emergency preparedness for their employees at least biennially and is recommended annually.
- RHCs must conduct a Hazard Vulnerability Assessment every two years to determine your clinic and community's top risks. You HVA and EPP, should include Emerging Communicable Diseases.
- RHCs are required to participate in a live (actual) emergency event or full scale community exercise every two years. In subsequent years, they can conduct a tabletop exercise or participate in another live (actual) emergency event or full scale community exercise.
- If it is your clinic's year to participate in a full scale community exercise, you cannot replace it with a tabletop.
- It is recommended to try to capture your exercises through real life events, such as clinic closing for no provider, utility failure, internet failure, winter storms, tornados, or lock downs.
- Make sure to document all events and exercises with an After-Action Report, review with your staff, get staff signatures and keep on file.
- At least annually review to see if you have met the exercise requirements for the year and if not, schedule a full-scale exercise or tabletop (if it is a tabletop year for your clinic).
- It is recommended that you should not use same event/activity type every year. If you notice you are having the same event multiple years, you may want to do a different exercise that is relevant to your clinic. Still document all events.

Beyond the Rounds

Every Friday, we will dive deeper into one of the topics discussed that week during Rural Rounds.

- Written by trusted RHC consultants or RHC leaders
- Available in your inbox every Friday morning
- All articles will be published on Facebook and available at www.empowerruralhs.com/ruralrounds
- If you are interested in writing an article, please email Cassie at cbeesley@empowerruralhs.com.

Upcoming Conferences

National Rural Health Association (NRHA), RHC Conference | Sept. 15-16, 2026 | Kansas City, MO
To Register: **https://www.ruralhealth.us/events/schedule/rural-health-clinic-conference**

National Association of Rural Health Clinics (NARHC) Fall Institute | Sept 29-Oct. 1, 2026 | Louisville, KY. To Register: **https://www.narhc.org/narhc/Conferences.asp**

If you have an RHC conference that you would like to spotlight here, please email Cassie at cbeesley@empowerruralhs.com.

Grant Opportunities

Small Health Care Provider Quality Improvement Program

- Eligible applicants must be a rural domestic public or nonprofit private health care provider or provider of health care services, such as a critical access hospital, a rural health clinic, or be another rural provider or network of small rural providers identified by the Secretary as a key source of local or regional care; and not previously have received an award under this subsection for the same or similar project. Applicant's organization must be located in a rural area.
- 20 Awardees; up to $250,000 per year over 4-year project period
- The purpose of the grant is to improve the delivery of cost-effective, coordinate, high-quality care services in rural primary care settings. (Care Coordination, enhancing chronic disease management, & improving health outcomes)
- Deadline is 8/6/2026 (11:59pm), with expected award date of 9/1/2026
- For more information, **https://www.grants.gov/search-results-details/362831**

Topic Suggestions

If you would like to suggest a topic for upcoming Rural Round sessions, please visit www.empowerruralhs.com/ruralrounds to submit your topic. Submissions should be submitted each week by Tuesday at 3:00pm CST to be added to discussion for that week.

Invitation to Rural Rounds

If you know of someone who would benefit from attending Rural Rounds, please direct them to sign up at www.empowerruralhs.com/ruralrounds and click on "Get Your Spot at the Table." Attendees must now complete a Zoom registration request in order to receive the recurring Zoom invite. You only have to complete this registration once.

Recording of Past Rural Rounds

Rural Rounds, starting 7/15/2026 will be recorded for those unable to attend. To access the recordings please visit www.empowerruralhs.com/ruralrounds. The videos will be posted within 24 hours after the session. A summary of the session will be emailed to all invitees, as well.

Contact

If you need further information on any topics discussed today or need further assistance, please email info@empowerruralhs.com

If you would like speak with any consultants participating in Rural Rounds, please contact them directly. No one participating in Rural Rounds will be directly solicited to purchase services. If you have any concerns, please email info@empowerruralhs.com to discuss.