NATIONAL ASSOCIATION OF RURAL HEALTH CLINICS

March 28, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS Limiting Participation in Value-Based Care for Safety-Net Providers

Dear Administrator Brooks-LaSure:

We are writing to you to identify a CMS policy that is currently limiting Rural Health Clinic (RHC) participation in value-based care models. Since January, we have been working with an excellent group of staff within CMS on this issue, but we have been unable to identify a resolution. Through this communication we hope that a positive policy outcome may be achieved.

The problem is simple: RHCs are currently unable to use CPT Category II codes on their claims because of a CMS edit. Specifically, if RHCs try to include these informational-only codes on any Medicare claim, the Medicare Administrative Contractors (MACs) reject the entire claim.

This policy prevents RHCs from being able to *easily* report quality measures. Instead, in order to calculate performance on certain quality measures, staff must go through each patient's medical record and manually check if the performance measure was achieved. In other clinical settings, the EMRs can quickly and automatically pull quality measure performance by scanning the records for CPT category II codes.

We appreciate that CMS's value-based care strategy discusses "lowering barriers to participation for practitioners treating underserved populations." In that spirit, we hope that this letter has clarified one of the key barriers to participation for our nation's 5,500 Rural Health Clinics. The ability to easily report quality measures is essential to successful participation in a wide variety of value-based care models and programs, but because of this policy, it is significantly easier for non-RHCs to report quality measures than it is for RHCs.

Earlier this year, we initiated a discussion with CMS staff on this issue to determine if a policy fix was attainable. **We believe that if CMS instructed the MACs to process claims with CPT Category II codes instead of rejecting those claims, the issue would be resolved.**

We initially thought that the issue may have something to do with the fact that we use the institutional claim form, but we have confirmed with the National Uniform Billing Committee (NUBC) that the CMS-1450 (or UB-04) claim form can handle CPT Category II codes. We have asked CMS staff if there is another operational reason (that perhaps we are unaware of) why RHCs are prevented from using

informational-only CPT Category II codes but have not received a concrete response thus far. Despite their best efforts to understand and address our concerns, to date, CMS staff have been unable to commit to fixing this issue.

It is our hope that together we can find a way to lower this particular barrier to safety-net provider participation in value-based care arrangements. As we move toward the goal of having all Medicare beneficiaries in a value-based arrangement by 2030, we believe it is imperative for RHCs to participate in value-based models and report quality metrics as easily as our traditional peers.

Sincerely,

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