TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER O DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

§353.1315. Rural Access to Primary and Preventive Services Program.

(a) Introduction. This section establishes the Rural Access to Primary and Preventive Services (RAPPS) program. RAPPS is designed to incentivize rural health clinics (RHCs) to improve quality, access, and innovation in the provision of medical services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Other terms used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1317 of this subchapter (relating to Quality Metrics for the Rural Access to Primary and Preventive Services Program).

(1) Freestanding rural health clinic (RHC)--A network RHC that is not affiliated with a hospital.

(2) Hospital-based RHC--A network RHC that is affiliated with a hospital.

(3) Network RHC--A RHC located in the state of Texas that has a contract with a managed care organization (MCO) for the delivery of Medicaid covered services to the MCO's enrollees.

(4) Program period--A period of time for which the Texas Health and Human Services Commission (HHSC) contracts with MCOs to pay increased capitation rates for the purpose of making RHC payments under this section. Each program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year. A RHC that is unable to participate in RAPPS beginning September 1 may apply to participate from March 1 until August 31 of the same program period. Participation during such a modified program period is subject to the application and intergovernmental transfer (IGT) deadlines described in subsection (g) of this section.

(5) Rural health clinic (RHC)--Has the meaning assigned by 42 U.S.C. Section 1396d(1)(2)(A).

(6) Total program value--The maximum amount available under the RAPPS program for a program period, as determined by HHSC.

(c) Classes of RHCs.

(1) HHSC may direct an MCO to provide an increased payment or percentage rate increase for certain services to all RAPPS-enrolled RHCs in one or more of the following classes of RHCs with which the MCO contracts for Medicaid services:

(A) hospital-based RHCs; and

(B) freestanding RHCs.

(2) If HHSC directs rate increases or payments to more than one RHC class in the service delivery area (SDA), the rate increases or payments may vary by RHC class. HHSC will consider the following factors in identifying the amount of the rate increase or payment for each class:

(A) the RHC class's contribution to the goals and objectives in the HHSC managed care quality strategy, as required in 42 C.F.R. §438.340, relative to other classes;

(B) the class or classes of RHC the sponsoring governmental entity wishes to support through IGTs of public funds, as indicated on the application described in subsection (f) of this section; and

(C) the actuarial soundness of the capitation payment needed to support the rate increase or payment.

(d) Eligibility. A RHC is eligible to participate in RAPPS if it meets the requirements described in this subsection.

(1) Location. The RHC must be located in a SDA with at least one sponsoring governmental entity.

(2) Minimum number of Medicaid managed care encounters. The RHC must have provided at least 30 Medicaid managed care encounters in the prior state fiscal year.

(e) Data sources for historical units of service and clients served. Historical units of service are used to determine a RHC's eligibility status and the estimated distribution of RAPPS funds across enrolled RHCs.

(1) HHSC will use encounter data and will identify encounters based upon the billing provider's national provider identification (NPI) number and provider type code.

(2) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine the eligibility status of a RHC.

(3) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine the distribution of RAPPS funds across

enrolled RHCs.

(4) In the event that the historical data are not deemed appropriate for use by actuarial standards, HHSC may utilize data from a different state fiscal year at HHSC's discretion.

(5) The data used to estimate eligibility and distribution of funds will align with the data used for purposes of setting the capitation rates for MCOs for the same period.

(6) To determine total program value, HHSC will calculate the estimated rate that Medicare would have paid for the same services using either each RHC's state fiscal year 2019 federal cost report or last submitted cost report. For RHCs where a filed cost report was not found, the RHC's Medicare payments will be estimated using the SDA weighted average ratio of Medicare encounter-based reimbursements divided by MCO reimbursement data.

(f) Participation requirements. As a condition of participation, all RHCs participating in RAPPS, as well as any entities billing on their behalf, must meet the following requirements.

(1) The RHC must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period will be no less than 21 calendar days, and the final date of the enrollment period will be at least nine calendar days prior to the IGT notification.

(2) An entity that bills on behalf of the RHC must:

(A) certify, on a form prescribed by HHSC, that no part of any RAPPS payment will be used to pay a contingent fee, consulting fee, or legal fee associated with the RHC's receipt of RAPPS funds, and the certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection; and

(B) submit to HHSC, upon demand, copies of contracts it has with third parties that reference the administration of, or payments from, RAPPS.

(g) Non-federal share of RAPPS payments. The non-federal share of all RAPPS payments is funded with IGTs from sponsoring governmental entities. No state general revenue is available to support RAPPS.

(1) HHSC will communicate the following information for the program period to all RAPPS-enrolled hospital-based RHCs and sponsoring governmental entities at least 10 calendar days prior to the IGT declaration of intent deadline:

(A) suggested IGT responsibilities for the program period, which will be based on:

(i) the maximum funding amount available under RAPPS for the program period as determined by HHSC, plus ten percent;

(ii) forecasted member months for the program period as determined by HHSC; and

(iii) the distribution of historical Medicaid utilization across RHCs, plus the estimated utilization for enrolled RHCs within the same SDA, for the program period; and

(B) the estimated maximum revenues each enrolled RHC could earn under RAPPS for the program period, which will be based on HHSC's suggested IGT responsibilities and the assumption that all enrolled RHCs will meet 100 percent of their quality metrics.

(2) Sponsoring governmental entities will determine the amount of IGT they intend to transfer to HHSC for the entire program period and provide the declaration of intent to HHSC 15 business days before the first half of the IGT amount is transferred to HHSC. The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity intends to transfer to HHSC. It must be certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) HHSC will instruct sponsoring governmental entities as to the required IGT amounts. Required IGT amounts will include all costs associated with RHC payments and rate increases, including costs associated with MCO premium taxes, risk margin, and administration, plus ten percent.

(4) Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. Sponsoring governmental entities will transfer the second half of the IGT amount by a date determined by HHSC, but no later than December 1. HHSC will publish the IGT deadlines and all associated dates on the HHSC website by March 15 of each year.

(h) RAPPS capitation rate components. RAPPS funds will be paid to MCOs through two components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of RAPPS funds to the enrolled RHCs will be based on each RHC's performance related to the quality metrics as described in §353.1317 of this subchapter. The RHC must have had provided at least one Medicaid service to a Medicaid client for each reporting period to be eligible for payments.

(1) Component One.

(A) The total value of Component One will be equal to 75 percent of total program value.

(B) Allocation of funds across qualifying RHCs will be based upon historical Medicaid utilization and RHC class.

(C) Monthly payments to RHCs will be paid prospectively.

(D) HHSC will reconcile the interim allocation of funds across RAPPS-enrolled RHCs to the actual Medicaid utilization across these RHCs during the program period as captured by Medicaid MCOs contracted with HHSC for managed care 180 days after the last day of the program period. This reconciliation will be performed only if the weighted average (weighted by Medicaid utilization during the program period) of the absolute values of percentage changes between each RHC's proportion of historical Medicaid utilization and actual Medicaid utilization is greater than 10 percent.

(2) Component Two.

(A) The total value of Component Two will be equal to 25 percent of total program value.

(B) Allocation of funds across qualifying RHCs will be based upon actual Medicaid utilization of specific procedure codes as identified in the final quality metrics and performance requirements described in §353.1317 of this subchapter.

(C) A percent increase on all applicable services will begin when a RHC demonstrates achievement of performance requirements as described in §353.1317 of this subchapter during the reporting period.

(i) Distribution of RAPPS payments.

(1) Prior to the beginning of the program period, HHSC will calculate the portion of each monthly prospective payment associated with each RAPPS-enrolled RHC broken down by RAPPS capitation rate component, quality metric, and payment period. For example, for a RHC, HHSC will calculate the portion of each monthly prospective payment associated with that RHC that would be paid from the MCO to the RHC as follows.

(A) Monthly payments from Component One will be equal to the total value of Component One for the RHC divided by twelve.

(B) Payments from Component Two associated with each quality metric will be equal to the total value of Component Two attributed as a rate increase for specific services based upon historical utilization.

(C) For purposes of the calculation described in subparagraph (B) of this paragraph, a RHC must achieve quality metrics to be eligible for full payment as determined by performance requirements described in §353.1317(d) of this subchapter.

(2) A MCO will distribute payments to an enrolled RHC based on criteria established under subsection (1) of this section.

(3) Funds that are non-disbursed due to failure of one or more RHCs to meet performance requirements will be distributed across all qualifying RHCs in the SDA based on each RHC's proportion of total earned RAPPS funds from Components One and Two combined after each payment period.

(j) Changes in operation. If a RAPPS-enrolled RHC closes voluntarily or ceases to provide Medicaid services, the RHC must notify the HHSC Provider Finance Department by electronic mail to an address designated by HHSC, by hand delivery, United States (U.S.) mail, or by special mail delivery within 10 business days of closing or ceasing to provide Medicaid services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

(k) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter and, as applicable, subsection (h)(1)(D) of this section.

(l) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) and §353.1301(k) of this subchapter.

§353.1317. Quality Metrics for Rural Access to Primary and Preventive Services Program.

(a) Introduction. This section establishes the quality metrics that may be used in the Rural Access to Primary and Preventive Services (RAPPS) program.

(b) Definitions. The following definitions apply when the terms are used in this section. Other terms used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1315 of this subchapter (relating to Rural Access to Primary and Preventive Services Program).

(1) Baseline--An initial standard used as a comparison against performance in each metric throughout the program period to determine progress in a RAPPS quality metric.

(2) Benchmark--A metric-specific initial standard set prior to the start of the program period and used as a comparision against a rural health clinic's (RHC's) progress throughout the program period.

(3) Measurement period--The time period used to measure achievement of a quality metric.

(c) Quality metrics. For each program period, the Texas Health and Human Services

Commission (HHSC) will designate quality metrics for each RAPPS capitation rate component as described in §353.1315(h) of this subchapter.

(1) Each quality metric will be identified as a structure measure, a pay-for-reporting (P4R) measure, or a pay-for-performance (P4P) measure.

(2) Each quality metric will be evidence-based.

(d) Performance requirements. For each program period, HHSC will specify the performance requirement that will be associated with the designated quality metric. Achievement of performance requirements will trigger payments for the RAPPS capitation rate components as described in §353.1315(h) of this subchapter. The following performance requirements are associated with the quality metrics described in subsection (c) of this section.

(1) Reporting of quality metrics. A RHC must report all quality metrics for which it is eligible, as defined in §353.1315 of this subchapter, to be eligible for payment.

(2) Achievement of quality metrics.

(A) The achievement of a structure measure is tested on whether a RHC meets the established requirement.

(B) The achievement of a P4R measure is based on the RHC reporting data for a specified measurement period.

(C) The achievement of a P4P measure is based on the RHC meeting or exceeding the P4P measure’s goal for a measurement period. Goals will be established as either a target percentage improvement over self or performance above a benchmark as specified by the metric and determined by HHSC.

(3) Reporting frequency. Achievement will be reported semi-annually unless otherwise specified by the metric.

(e) Notice and hearing.

(1) HHSC will publish notice of the proposed quality metrics and their associated performance requirements no later than January 31 preceding the first month of the program period. The notice must be published either by publication on HHSC's website or in the *Texas Register*. The notice required under this section will include the following:

(A) instructions for interested parties to submit written comments to HHSC regarding the proposed metrics and performance requirements; and

(B) the date, time, and location of a public hearing.

(2) Written comments will be accepted for 15 business days following publication. There will also be a public hearing within that 15-day period to allow interested persons to present comments on the proposed metrics and performance requirements.

(f) Final quality metrics and performance requirements will be provided through HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period. If Centers for Medicare and Medicaid Services requires changes to quality metrics or performance requirements after February 28 but before the first month of the program period, HHSC will provide notice of the changes through HHSC's website.