TO: Medical Care Advisory Committee

DATE: February 11, 2021

FROM: Emily Sentilles, Director, Healthcare Transformation Waiver

SUBJECT: Rural Health Clinic Directed Payment Program

Agenda Item No.: 13

New Rules: §353.1315, Rural Access to Primary and Preventive Services Program; and §353.1317, Quality Metrics for Rural Access to Primary and Preventive Services Program

BACKGROUND: ☐ Federal Requirement ☐ Legislative Requirement ☒ Other: Delivery System Reform Incentive Payment Program Transition Plan

The Texas Health and Human Services Commission (HHSC) proposes new §353.1315, concerning Rural Access to Primary and Preventive Services Program, and new §353.1317, concerning Quality Metrics for Rural Access to Primary and Preventive Services Program, in Texas Administrative Code Title 1, Part 15, Chapter 353, Subchapter O.

The purpose of the proposed new rules is to describe the circumstances under which HHSC will direct a Medicaid managed care organization (MCO) to provide a uniform dollar amount in the form of prospective monthly payments and rate increases for certain services tied to quality measurement to rural health clinics (RHCs) in the MCO's network in a participating service delivery area (SDA) for the provision of general medical services. The proposed rules also describe the methodology used by HHSC to determine the amounts of the payments and rate increases.

HHSC is proposing these new rules as part of the new program proposals developed under the Delivery System Reform Incentive Payment (DSRIP) program Transition Plan. HHSC anticipates that the increased payments to RHCs will support access to services, promote better health outcomes, and increase focus on improving quality goals of the Texas Medicaid program. RHCs provide access to primary and preventive care and chronic disease management to rural residents and help to avoid potentially preventable emergency departments visits and hospitalizations, which increase Medicaid costs. The program’s quality objectives are supported by the results from the DSRIP Transition Best Practices Workgroup.

In May 2016, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that allows a state to direct expenditures under its contract with an MCO under certain limited circumstances. Under the federal rule, a state may direct an MCO to raise rates for a class of providers of a particular service by a uniform dollar amount or percentage, or as a performance incentive, subject to approval of the contract

arrangements by CMS. To obtain approval, the arrangements must be based on the utilization and delivery of services; direct expenditures equally, and using the same terms of performance, for a class of providers of a particular service; advance at least one of the goals and objectives of the state's managed care quality strategy and have an evaluation plan to measure the effectiveness of the arrangements at doing so; not condition provider participation on an intergovernmental transfer (IGT); and not be automatically renewed.

These proposed rules authorize HHSC to use IGTs from non-state governmental entities to support capitation payment increases in one or more SDAs. Each MCO within the SDA would then be contractually required by the state to provide a uniform dollar amount in the form of a prospective monthly payment and a percentage rate increase for certain services for RHCs.

Conceptual Framework

Eligibility:

HHSC determines eligibility for payments by RHC class. The SDA must have at least one governmental entity willing to provide IGT to support increased payments. Also, to be eligible for the reimbursement increase, a RHC must be within a class designated by HHSC to receive the increase.

HHSC proposes classifying RHCs into two classes: hospital-based RHCs and freestanding RHCs. The classifications allow HHSC to direct reimbursement increases where they are most needed and to align with the quality goals of the program. The reimbursement increases will be uniform for all RHCs within each class; but if HHSC directs rate increases to both classes, the reimbursement increase may vary between classes.

Services subject to rate increase:

HHSC may direct rate increases for all or a subset of RHC services. The services subject to the rate increase will focus on those codes most frequently billed by RHCs for the provision of preventive and primary care services in an effort to advance the goals and objectives of HHSC's managed care quality strategy and continue best practices of DSRIP.

Determination of rate increase:

HHSC will consider several factors in determining the percentage rate increase that will be directed for one or more classes of RHCs, including the amount of available funding; the class or classes of RHCs eligible to receive the increase; the type of service subject to the increase; budget neutrality; and the actuarial soundness of the capitation payment needed to support the increase.

Reconciliation and recoupment:

HHSC will follow the methodology described in Texas Administrative Code Title 1 §353.1301 to reconcile the amount of non-federal funds expended under this section and to authorize recoupments of overpayment or disallowance amounts.

ISSUES AND ALTERNATIVES:

HHSC currently operates DSRIP, which provides incentive payments to participating providers to support their efforts to enhance access to health care, the quality of care, and the health of patients and families served. DSRIP has impacted health care delivery in rural areas by improving access to care via increased primary and specialty care capacity (direct staff or telemedicine). However, access to necessary services in rural areas continues to be a challenge. There are 112 rural hospitals participating in DSRIP with a total demonstration year (DY) 8 valuation of $183 million. Rural hospitals often work closely with RHCs that support the continuum of care for residents in rural areas. RHCs are not performing providers in DSRIP, but they are often the extension of rural hospitals that deliver the outpatient care, which is the basis for rural hospitals reporting on outpatient quality measures as part of the Rural Measure Bundle in DSRIP.

DSRIP funding is ending September 30, 2021. As part of DSRIP Transition, HHSC reviewed data and best practices from DSRIP in the development of new programs or policies to be incorporated into the Medicaid program when DSRIP funding ends. The RAPPS program is one of the proposed programs and continues the focus areas of rural healthcare, access to care, preventive and primary care, and chronic disease management. The DPP will work to continue the improvements made under DSRIP by ensuring Medicaid members have access to the right care, in the right place, at the right time and ensuring providers continue incremental improvements in the quality of care.

STAKEHOLDER INVOLVEMENT:

HHSC convened a group of rural stakeholders to discuss the program design, quality objectives, feasibility, and structure. When discussing potential options for each topic, the workgroup considered the design of the current DSRIP program. Stakeholders agreed on a RHC class structure that comprises two classes and that a RHC must be within one of the designated classes to be eligible for a payment increase. The workgroup discussed different options for a payment methodology and agreed on a two-component structure to allocate funds across qualifying RHCs. The stakeholder group considered the quality measurement and structure of the program, which includes a monthly prospective payment to stabilize funding, in addition to payments earned through quality metric achievement.

Stakeholders agreed that quality goals should focus on primary and preventive care and chronic disease management. HHSC will publish a notice of the proposed metrics and their associated performance requirements for public comment on the HHSC web site.

The proposed rules were presented to the Hospital Payment Advisory Committee on February 4, 2021, as an informational item. The proposal will be presented to the HHSC Executive Council meeting on February 18, 2021. Additionally, HHSC held a public hearing to receive public comments following the publication of the proposed rules.

FISCAL IMPACT:

HHSC anticipates there will be no fiscal impact to state government because the non-federal share of the increase in capitation rates will be funded with IGTs from non-state governmental entities. There may be a fiscal impact to local governments, but there is insufficient information to provide an estimate because participation is optional.

RULE DEVELOPMENT SCHEDULE:

January 2021	Publish proposed rules in *Texas Register*
February 4, 2021	Present to the Hospital Payment Advisory Committee
February 11, 2021	Present to the Medical Care Advisory Committee
February 18, 2021	Present to HHSC Executive Council
March 2021	Publish adopted rules in *Texas Register*
March 2021	Effective date

REQUESTED ACTION: (Check appropriate box)

☐ The MCAC recommends approval of the proposed rules for publication.

☒ Information Only

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

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes new §353.1315, concerning Rural Access to Primary and Preventive Services Program; and new §353.1317, concerning Quality Metrics for Rural Access to Primary and Preventive Services Program.

BACKGROUND AND PURPOSE

The purpose of the proposed new rules is to describe the circumstances under which HHSC will direct a Medicaid managed care organization (MCO) to provide a uniform dollar amount in the form of prospective monthly payments and rate increases for certain services tied to quality measurement to rural health clinics (RHCs) in the MCO's network in a participating service delivery area (SDA) for the provision of general medical services. The proposed rules also describe the methodology used by HHSC to determine the amounts of the payments and rate increases.

HHSC is proposing these new rules as part of the new programs developed to transition from the Delivery System Reform Incentive Payment (DSRIP) program. HHSC anticipates that the increased payments to RHCs will support access to services, promote better health outcomes, and increase focus on improving quality goals of the Texas Medicaid program.

RHCs provide access to primary and preventive care and chronic disease management to rural residents and help to avoid potentially preventable emergency departments visits and hospitalizations, which increase Medicaid costs. The program’s quality objectives are supported by the results from the DSRIP Transition Best Practices Workgroup, particularly related to measures tracking improvement in primary care related services..

In May 2016, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that allows a state to direct expenditures under its contract with an MCO under certain limited circumstances. Under the federal rule, a state may direct an MCO to raise rates for a class of providers of a particular service by a uniform dollar amount or percentage, or as a performance incentive, subject to approval of the contract arrangements by CMS. To obtain approval, the arrangements must be based on the utilization and delivery of services; direct expenditures equally, and using the same terms of performance, for a class of providers of a particular service; advance at least one of the goals and objectives of the state's managed care quality strategy and have an evaluation plan to measure the effectiveness of the arrangements at doing so; not condition provider participation on an intergovernmental transfer (IGT); and not be automatically renewed.

These proposed rules authorize HHSC to use IGTs from non-state governmental entities to support managed care capitation payment increases in one or more SDAs. Each MCO within the SDA would then be contractually required by the state to provide a uniform dollar amount in the form of a prospective monthly payment and a percentage rate increase for certain services for RHCs.

Conceptual Framework

Eligibility:

HHSC determines eligibility for payments by RHC class. The SDA must have at least one governmental entity willing to provide IGT to support increased payments. Also, to be eligible for the reimbursement increase, an RHC must be within a class designated by HHSC to receive the increase.

HHSC proposes classifying RHCs into two classes: hospital-based RHCs and freestanding RHCs. The classifications allow HHSC to direct reimbursement increases where they are most needed and to align with the quality goals of the program. The reimbursement increases will be uniform for all RHCs within each class; but if HHSC directs rate increases to both classes, the reimbursement increase may vary between classes.

Services subject to rate increase:

HHSC may direct rate increases for all or a subset of RHC services. The services subject to the rate increase will focus on those codes most frequently billed by RHCs for the provision of preventive and primary care services, in an effort to advance the goals and objectives of HHSC's managed care quality strategy and continue best practices of DSRIP.

Determination of rate increase:

HHSC will consider several factors in determining the percentage rate increase that will be directed for one or both classes of RHCs, including the amount of available funding; the class or classes of RHCs eligible to receive the increase; the type of service subject to the increase; budget neutrality; and the actuarial soundness of the capitation payment needed to support the increase.

Reconciliation and recoupment:

HHSC will follow the methodology described in Texas Administrative Code Title 1 §353.1301 to reconcile the amount of non-federal funds expended under this section and to authorize recoupments of overpayment or disallowance amounts.

SECTION-BY-SECTION SUMMARY

Proposed new §353.1315(a) establishes the Rural Access to Primary and Preventive Services (RAPPS) program and describes the goals of the program. Subsection (b) defines key terms used in the section. Subsection (c) describes the RHC classes. Subsection (d) describes the eligibility requirements for the program. Subsection (e) describes the data sources that will be used to determine a RHC's eligibility status and the estimated distribution of RAPPS funds. Subsection (f) describes the requirements for participating in the program, including the application process and timing. Subsection (g) describes the process for collecting the non-federal share of the program funding. No state general revenue funds are available for the program and the non-federal share will be comprised of IGTs. Subsection (h) describes the value and allocation of RAPPS capitation rate components. Subsection (i) describes the timing and basis for the distribution of RAPPS payments. Subsection (j) describes the notice requirements if there are changes in operation of the RHC. Subsection (k) refers to 1 TAC §353.1301(g) for the description of the reconciliation authority. Subsection (l) refers to 1 TAC §353.1301(j) and (k) for the description of the recoupment authority.

Proposed new §353.1317 describes the quality metrics associated with the RAPPS program. Subsection (a) establishes the purpose of the section. Subsection (b) defines key terms used in the section. Subsection (c) describes the quality metrics HHSC can designate for each RAPPS capitation rate component. Subsection (d) discusses the performance requirements that will be associated with the designated quality metrics. Subsection (e) provides for publication of the proposed metrics and their associated performance requirements. The notice will be published on HHSC's website. Subsection (f) provides that final quality metrics and performance requirements will be provided on HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period.

FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer, has determined that for each year of the first five years the proposed rules are in effect, there will be no fiscal impact to state government because the non-federal share of the increase in capitation rates will be funded with IGTs from non-state governmental entities. There may be a fiscal impact to local governments, but there is insufficient information to provide an estimate because participation is optional.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

(1) the proposed rules will create a government program;
(2) implementation of the proposed rules will not affect the number of HHSC employee positions;
(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;
(4) the proposed rules will not affect fees paid to HHSC;
(5) the proposed rules will create a new rule;

(6) the proposed rules will not expand, limit, or repeal existing rules;
(7) the proposed rules will increase the number of individuals subject to the rules; and
(8) the proposed rules will positively affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro businesses, or rural communities to comply with the proposed rules because RHCs eligible for the reimbursement increases will not be required to alter their current business practices.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules. The anticipated public benefit will be improved quality and stability in access to rural providers as a result of funding flowing through the MCOs.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the rules do not impose any additional fees or costs on those who are required to comply.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC HEARING

A public hearing is scheduled for February 5, 2021, at 9:30 a.m. (Central Standard Time) to receive public comments on the proposal. Persons requiring further information, special assistance, or accommodations should email TXHealthcareTransformation@hhsc.state.tx.us.

Due to the declared state of disaster stemming from COVID-19, the hearing will be conducted online only. No physical entry to the hearing will be permitted.

Persons interested in attending may register for the public hearing at:

https://attendee.gotowebinar.com/register/1125419832365365264

After registering, a confirmation email will be sent with information about joining the webinar.

HHSC will broadcast the public hearing. The broadcast will be archived for access on demand and can be accessed at https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or emailed to Kimberly Tucker, Senior Analyst, Medicaid and CHIP Services, Healthcare Transformation Waiver Unit, at TXHealthcareTransformation@hhsc.state.tx.us.

During the current state of disaster due to COVID-19, physical forms of communication are checked with less frequency than during normal business operations. Therefore, please submit comments by email if possible.

To be considered, comments must be submitted no later than 15 days after the date of this issue of the *Texas Register*. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be post-marked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 21R040" in the subject line.

STATUTORY AUTHORITY

The new rules are proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code, Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The proposed new rules implement Texas Human Resources Code, Chapter 32; Texas Government Code, Chapter 531; and Texas Government Code Chapter 533. No other statutes, articles, or codes are affected by this proposal.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 923-0644.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language
(No change.) = No changes are being considered for the designated subdivision

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.