Rural Access to Primary and Preventive Services Program Stakeholder Feedback on Measures and Performance Requirements

As Required by

Texas Administrative Code

§353.1317

Medicaid/CHIP

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TEXAS
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Contents

1. Overview

On January 25, 2021, HHSC released the draft measures and performance requirements for Rural Access to Primary and Preventive Services Program (RAPPS) for stakeholder feedback. The documents included measure specifications, attribution methodology, reporting requirements, achievement goals, and CPT codes for focused rate enhancements. HHSC hosted a webinar on January 29, 2021 to provide an overview of the proposed measures and performance requirements and to answer questions. Stakeholders submitted feedback through an online survey that closed on February 17, 2021.

This document summarizes the stakeholder feedback HHSC received through the three respondents to the survey and three letters received during the rules comment period that relate to feedback on the measures. The Healthcare Transformation Waiver team reviewed stakeholder comments, grouped similar comments together, drafted responses, and determined changes through internal discussion and guidance from leadership. Changes made based on stakeholder feedback are reflected in the updated *Measure Specifications*, *RAPPS Requirements,* and are noted in the responses herein.

HHSC will include the measures and performance requirements in the RAPPS state directed payment preprint submitted to the Centers for Medicare & Medicaid Services (CMS) in March 2021. All RAPPS requirements are subject to CMS approval. HHSC will post any changes requested by CMS as required in TAC §353.1317.

2. Component 1 and 2 Measures

R1-101: Telehealth to provide virtual medical appointments with a primary care or specialty care provider

1. Two stakeholders asked to clarify the goals and requirements for the measure.

   HHSC Response: There are not any prescribed requirements for R1-101. The measures in Component 1 require status reports only and do not include any achievement requirements to trigger payments. Moreover, the types of measures in Component 1 are all "structure measures", which help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. For example, to get a sense for integrating specialty care access through telehealth capacity and infrastructure (R1-101), RHCs may report on questions regarding telehealth best practices for specialty care needs; however, RHCs are not required to have implemented or be working towards implementing telehealth with specialty care providers.

R1-102: Advanced use of electronic health record (EHR)

2. One stakeholder suggested the measure be replaced by participation in a health information exchange.

   HHSC Response: HHSC has not replaced measures in Component 1 based on stakeholders' request for attainable measures. HHSC may consider such a measure for RAPPS Year 2 and will begin stakeholder engagement in fall 2021.

   To clarify the measure, HHSC has updated the measure name to "Use of electronic health record (EHR)."

R1-103: Care team includes personnel in a care coordination role not requiring clinical licensure

3. Stakeholders supported inclusion of the measure.

   HHSC Response: HHSC appreciates the support and has maintained the measure.

R2-104: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing

4. One stakeholder agreed to the inclusion of the measure although indicated there may be challenges with tracking lab results.

HHSC Response: In cases where a variance from a designated data source is required, providers should keep a record of such variances to ensure consistency or changes in reporting future performance years. Providers may also opt to use local or proprietary codes or values mapped to the standard codes included in the RAPPS measure specifications. Providers that opt to use local or proprietary codes or values must maintain documentation that includes a crosswalk of relevant codes, values, descriptions, and clinical information if applicable.

R2-105: Preventive Care and Screening: Influenza Immunization

5. One stakeholder agreed to the inclusion of the measure although indicated there may be challenges with tracking the measurement period.

   HHSC Response: The measure specifications identify the calendar year as the measurement period to establish the initial population. The denominator is determined by using the initial population AND if the individual had a specified encounter during the flu season. For RAPPS reporting purposes, RHCs will include encounters that occur January 2021 through March 2021 and October 2021 through December 2021 of the first measurement year.

General Components 1 and 2 Feedback

6. Two stakeholder groups recommended condensing the measures with one group proposing one structure measure and one process measure.

   HHSC Response: HHSC has maintained the list of measures; however, there are no longer benchmark measures. In Year 1, RHCs will submit responses to qualitative reporting questions for Component 1 and report baselines for Component 2. HHSC may consider changes to measures for RAPPS Year 2 and will begin stakeholder engagement in fall 2021.

7. Two stakeholders recommended adding or aligning with MCO P4Q metrics such as well child visits, childhood immunizations, and PPVs. Another stakeholder suggested adding a governance structure that ensures responsiveness to local community needs.

   HHSC Response: HHSC has not added requirements or measures in Component 1 based on stakeholders' request for fewer and attainable measures. HHSC may consider such a requirement or measures for RAPPS Year 2 and will begin stakeholder engagement in fall 2021.

3. Quality Requirements

Attribution Methodology

8. One stakeholder requested that a minimum enrollment period be used for attributing Medicaid managed care.

   HHSC Response: Based on stakeholder feedback regarding the challenges of stratifying by Medicaid managed care vs. Medicaid, HHSC has updated the requirements for reporting and performance achievement to be based on all Medicaid patients. Providers will also be required to report measures stratified by uninsured and other payer types.

   In addition, HHSC has updated the Payer Type Assignment Methodology under Step 3 of the RAPPS Attribution Methodology. Providers must apply the same methodology for determining Medicaid across the measurement period.

   The payer type is determined based on the unit of measurement (e.g., "individual" or "encounter") of the measure-specific denominator (Step 2) as defined in the RAPPS Measure Specifications.

   1. Individual: A unit of measurement is an "individual" if a person can only be counted once in the denominator in a given measurement period. Physician groups may choose to determine payer type by the most recent payer type on record for the individual at the end of the measurement period OR any individual with a Medicaid-enrolled service at any point in the measurement period, even if their most recent payer type of record is not Medicaid.

   2. Encounter: A unit of measurement is an "encounter" if a person can be counted in the denominator more than once in a given measurement period. Payer type will be determined by the payer type on record for the qualifying encounter (visit or admission).

Improvement Over Self (IOS) Measures

9. One stakeholder suggested goals and aggregation of data for IOS measures. Two stakeholder groups recommended a one-year allowance to prepare for reporting.

   HHSC Response: In Year 1, RAPPS IOS measures are reporting on baselines. RHCs may report a rate of 0% for the measurement period, if it is accurate that the RHC has not implemented the measure during the measurement period. Goals for future years have not been determined. HHSC will begin engaging stakeholders in fall 2021 on measures and goals for Year 2.

10. One stakeholder asked how the COVID-19 pandemic will be taken into account and whether CY2021 is an appropriate baseline.

    HHSC Response: HHSC will continue to work with CMS to align COVID-19 impacts on quality measurement and will inform stakeholders of any changes.

Benchmark Measures

11. Multiple stakeholders expressed concern regarding achieving benchmark goals and comparison to national benchmarks.

    HHSC Response: HHSC has updated benchmark measure R2-104: *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing* to be an IOS measure. There are no benchmark measures for RAPPS in Year 1.

Minimum Denominator Volume

12. One stakeholder indicated that Medicaid is not stratified in their system by program and many are dual eligible with Medicaid secondary.

    HHSC Response: Based on stakeholder feedback regarding the challenges of stratifying by Medicaid managed care vs. Medicaid, HHSC has updated the requirements for reporting and performance achievement to be based on Medicaid patients. Providers will also be required to report measures stratified by uninsured and other payer types.

    Dual eligible individuals should be included under Medicaid reporting.

Reporting Requirements

13. One stakeholder requested that reporting be once a year and align deadlines with other programs to reduce administrative burden.

    HHSC Response: HHSC did not make any changes in response to this comment. The twice per year reporting also provides an opportunity for HHSC to track progress and collect data for evaluation purposes.

Targeted CPT Codes for Component 2

14. Stakeholders indicated that CPT code 99201 has been discontinued for CY2021.

    HHSC Response: HHSC has removed 99201 from the list of targeted CPT codes for rate enhancements.