Rural Access to Primary and Preventive Services (RAPPS) Requirements
State Fiscal Year (SFY) 2025

Program Overview

RAPPS is a directed payment program that provides for increased Medicaid payments to rural health clinics (RHCs) for primary and preventive services provided to adults and children enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs.

Quality Goals

RAPPS aims to advance the goals of the Texas Managed Care Quality Strategy. Participating RHCs will report quality measures that tie to the following quality strategy goals.

1. Promoting optimal health for Texans at every stage of life through prevention and by engaging individuals, families, communities, and the healthcare system to address root causes of poor health.
2. Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate.
3. Promoting effective practices for people with chronic, complex and serious conditions to improve people's quality of life and independence, reduce mortality rates, and better manage the leading drivers of healthcare costs.
4. Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team-based, collaborative, and coordinated care.

Program Structure

RAPPS includes one component for SFY 2025. It provides a uniform dollar increase in the form of prospective, monthly payments to all qualifying RHCs.

RHCs apply to participate in the program. To be eligible to participate, an RHC must be located in a service delivery area with at least one sponsoring governmental entity and must have provided at least 30 Medicaid managed care encounters in the prior state fiscal year.

Component 1

Component 1 includes structure, process, and outcome measures. It requires annual submission of status updates for the structure measures and data for the process and outcome measures.

All measures in Component 1 must be reported as a condition of participation.

Reporting Requirements

RHCs must report data for all measures as a condition of participation in the program. Failure to meet any conditions of participation will result in removal of an RHC from RAPPS and recoupment of all funds previously paid during the program period.

SFY 2025 semiannual reporting is planned to take place during Reporting Period 1 (October 2024) and Reporting Period 2 (April 2025).

- Reporting Period 1 (October 2024): RHCs will report progress on structure measures.
- Reporting Period 2 (April 2025): RHCs will report data for outcome and process measures for January 1, 2024, to December 31, 2024.

Reporting will follow the detailed specifications for each measure as included in the SFY 2025 Measure Specifications.

For structure measures, RHCs must submit responses to qualitative reporting questions that summarize their progress toward implementing the structure measure. RHCs are not required to implement structure measures as a condition of reporting or program participation.

For outcome and process measures, an RHC must submit specified numerator and denominator data and respond to qualitative reporting questions as specified by HHSC. RHCs must report rates for most measures stratified by Medicaid Managed Care, Other Medicaid, Uninsured, and All-Payer.

Reported qualitative and numeric data will be used to monitor RHC-level progress toward state quality objectives.

Component 1 RHC-Reported Measures

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
R1-103	Preventive Care and Screening: Influenza Immunization	Process	0041e	NCQA	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer
R1-105	Health Information Exchange (HIE) Participation	Structure	NA	NA	NA
R1-119	Controlling High Blood Pressure	Outcome	0018	NCQA	- STAR/STAR+PLUS/STAR Kids - Other Medicaid - Uninsured - All-Payer
R1-163	Non-Medical Drivers of Health (NMDOH) Screening and Follow-up Plan Best Practices	Structure	NA	HHSC	NA
R1-166	Depression Screening and Follow-up Best Practices	Structure	NA	NA	NA

Attribution Methodology

RHCs must follow these steps to identify the specific population that should be included in the numerator and denominator for RHC-reported process and outcome measures.

Step 1: Determine the DPP-attributed population.

Step 2: Determine the measure-specific denominator population.

Step 3: Stratify the measure-specific denominator population by required reporting payer type.

Attribution Step	**Details**
Step 1: Attributed Population Definition	Using a retrospective attribution methodology, the RAPPS-attributed population includes the individuals that a participating RHC, as indicated in the enrollment application, must include in accordance with the "Attributed Population Inclusion Criteria."
Step 1: Attributed Population Inclusion Criteria	The RHC's attributed population includes any individual who has at least one encounter with the RHC during the measurement period.
Step 1: Allowable Exclusions	None
Step 2: Measure-Specific Denominator Population Definition	The measure-specific denominator population (Step 2) includes the individuals or encounters from the RAPPS-attributed population (Step 1) that meet all criteria in the Measure Specifications.

Attribution Step	Details
Step 3: Reporting Payer Types	Measures must be stratified by the required reporting payer as outlined below. • Medicaid Managed Care: exclusive to STAR, STAR+PLUS, and STAR Kids • Other Medicaid: STAR Health, and Medicaid Fee-For-Service • Uninsured: includes No insurance; County-based or other public medical assistance • All Payer: includes Medicaid Managed Care, Other Medicaid, Uninsured, and all other payer types such as CHIP, Medicare, Medicare/Medicaid Dual Eligibles, Commercial Insurance, Qualified Medicare Beneficiaries, and Non-Texas Medicaid individuals/encounters
Step 3: Payer-Type Assignment Methodology	The payer-type assignment methodology depends on the unit of measurement for the denominator. The unit of measurement is defined in the Measure Specifications file. 1. Individual: If a person can be counted once in the denominator, then the unit of measurement is an individual. The payer type assignment will be determined by either the most recent payer type on record at the end of the measurement period OR as any individual with a Medicaid Managed Care-enrolled service at any point in the measurement period, even if their most recent payer type of record is not Medicaid Managed Care. The same assignment methodology for determining Medicaid Managed Care must be applied consistently across the measurement period. 2. Encounter: If a person can be counted in the denominator more than once, then the unit of measurement is an encounter. The payer type assignment will be determined by the payer type on record for the qualifying encounter (e.g., visit or admission).

Additional Reporting Information

Data Sources and Data Elements

Depending on the measure steward and the publicly available measure specifications source, the measure specifications may have been written based on electronic health record (E.H.R.) and claims data sources available to healthcare providers or health plans. For any measures where the measure specifications were originally written based on data sources available to health plans, HHSC has adapted the measure specifications for DPP participating providers.

For DPP reporting purposes, DPP participating providers are responsible for complying with measure specifications and should use the most complete data available to ensure that the data reported are representative of the entire population served. In cases where a variance from a designated measure specification is required due to variances in data sources, DPP participating providers may opt to use local or proprietary data elements (codes or values) mapped to the standard data elements (codes or values) included in the measure specifications.

DPP participating providers that use local or proprietary data elements must maintain documentation of the relevant clinical concepts, definitions, or other information as applicable that crosswalks to the standard data elements. DPP participating providers should keep a record of such variances to make note of and ensure consistency of such variances when reporting each measurement year.

Data Measurement Periods

The data measurement period required for a given reporting period is identified under Data Measurement Period in the Measure Specifications file. Additionally, measure-specific denominator specifications may place additional limitations on the measurement period used for denominator inclusion. This may include using only a portion of the measurement period for denominator inclusion or identifying encounters and/or diagnosis that occur before the measurement period for denominator inclusion (a lookback period).

All measures are specified for a 12-month data Measurement Period, unless otherwise specified under Measurement Period.

Sampling Methodology Requirements

DPP participating providers should use the most complete data available to ensure that the rates reported are representative of the entire population served. All cases that meet the eligible population requirements for the measure must be included.

For measures where all required data elements are not available electronically (E.H.R., claims data, or registry) or are of poor quality, providers may conduct a sample to determine rate for a given measurement year. DPP participating providers should follow the sampling methodology included in the measure specifications, or if no sampling methodology is specified, providers should follow the HHSC sampling methodology identified below:

HHSC Sampling Methodology

DPP participating providers should use available administrative data to determine the denominator population. Sampling should be systematic and random to ensure that all eligible individuals have an equal chance of inclusion. The resulting sample should be representative of the entire eligible population for the measure. At the time of reporting, DPP participating providers will indicate if a sampling methodology is used. DPP participating providers should maintain records of sampling methodology and random selection.

HHSC Minimum Sample Size for All-Payer

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.

- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases.

- For a measurement period where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 411 cases.

It is recommended to select an oversample of 10-15% of the sample size for substitution in the event that cases in the original sample are excluded from the measure.

Appendix A: Summary of Program Changes

The requirements document now includes technical instructions that were previously included in the measure specifications Excel file including the attribution methodology and additional reporting information. This content was not changed as compared to SFY 2024, unless otherwise noted below.

Component 1 and Component 2 were combined into Component 1. Measure IDs for the following measures have changed.

SFY 2024 Measure ID	SFY 2025 Measure ID
R2-103 Preventive Care and Screening: Influenza Immunization	R1-103 Preventive Care and Screening: Influenza Immunization
R2-119 Controlling High Blood Pressure	R1-119 Controlling High Blood Pressure