Program	Rural Access to Primary and Preventive Services (RAPPS)
Target Beneficiaries	Adults and children enrolled in STAR, STAR+PLUS, and STAR Kids

Quality Goals

1. Promote 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. Promote 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 health care costs.

Program Overview

- RAPPS is a directed payment program (DPP) that incentivizes the provision of primary and preventive services for individuals enrolled in Medicaid managed care in rural areas of the state. The program also focuses on management of chronic conditions.
- Two classes of Rural Health Clinics (RHCs) are eligible for RAPPS:
  - Hospital-based RHCs, which include non-state government owned and private RHCs, and
  - Freestanding RHCs.
- RHCs apply to participate in the program and must have provided at least 30 Medicaid managed care encounters in the prior state fiscal year (SFY) to be eligible for participation.
- RAPPS includes two components:
  - Component 1 provides a uniform dollar increase in the form of prospective, monthly payments to all qualifying RHCs.
  - Component 2 is a uniform percent rate increase for certain services to incentivize preventive care and services to manage individuals' chronic conditions. Component 2 rate enhancements will be applied to the following codes: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99244, 99381, 99382, 99383, 99384, 99385, 99386, 99391, 99392, 99393, 99394, 99395, 99396, 99429, G0444, T1015.

Reporting Requirements

- RHCs must report data for all measures as a condition of participation in the program. RHCs that fail to submit the required data by the deadlines communicated by HHSC will be determined to be out of compliance with program eligibility requirements, will be removed from the program, and will have all funds they received recouped.
- SFY 2022 (Year [Y] 1) reporting will begin on April 29, 2022, and will be on data for calendar year 2021.
- For structure measures, RHCs must submit responses to qualitative reporting questions that summarize their progress towards 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 rates and respond to qualitative reporting questions as specified by HHSC. RHCs must report measure rates stratified by the following payer types: Medicaid Managed Care, Other Medicaid, Uninsured, and All Payer.[1]
- Reported qualitative and numeric data will be used to monitor RHC-level progress toward state quality objectives.

RAPPS Measures by Program Component

Program Component	Measure ID	Measure Name	Measure Type	NQF #	Measure Steward
R1 - Dollar Increase	R1-101	Care team includes personnel in a care coordination role not requiring clinical licensure	Structure	NA	NA
	R1-143	Telehealth to provide virtual medical appointments with a primary care or specialty care provider	Structure	NA	NA
	R1-144	Use of electronic health record (EHR)	Structure	NA	NA
R2 – Percent Increase	R2-102	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Outcome	0059	NCQA
	R2-103	Preventive Care and Screening: Influenza Immunization	Process	0041e	NCQA

[1] In the reporting template, providers will indicate whether the provider's system can report the required reporting payer type of "Medicaid Managed Care" as outlined above to include STAR, STAR+PLUS, and STAR Kids. If provider's system cannot report "Medicaid Managed Care" as outlined above, then the provider may alternatively report the "Medicaid Managed Care" payer type as "Medicaid" (includes all Medicaid Managed Care programs and Medicaid FFS). This alternative will only be available during Y1 of the DPP. As a result of using this alternative, the required reporting payer types would be: Medicaid, Uninsured, and All Payer.