Rural Access to Primary and Preventive Services Program Stakeholder Feedback on Proposed Year 3 (State Fiscal Year 2024) Quality Measures and Reporting Requirements

As Required by

Texas Administrative Code

§353.1317

Texas Health and Human Services

Commission

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Overview

On January 4, 2023, HHSC released the quality measures and reporting requirements proposed for Year 3 (State Fiscal Year 2024) of the Rural Access to Primary and Preventive Services (RAPPS) program for stakeholder feedback. On January 12, 2023, HHSC hosted a webinar to provide an overview of the RAPPS Year 3 proposed measures and requirements and answer stakeholder questions. The RAPPS Year 3 proposal documents included requirements (such as a program overview, measures, and reporting requirements) and measure specifications (such as detailed information on measure specifications, attribution methodology, and payer type reporting stratification).

Stakeholders were able to submit feedback through an online survey that closed on January 27, 2023. This document summarizes the stakeholder feedback HHSC received through the three respondents to the survey, on behalf of three organizations. HHSC reviewed and considered stakeholder comments and is not making any changes to the proposed Year 3 *RAPPS Measure Specifications* or *RAPPS Requirements*. However, updated file versions of the Year 3 *RAPPS Measure Specifications* and *RAPPS Requirements* have been published to the RAPPS Quality webpage. A new *RAPPS Measure Specifications FAQ* file for the proposed Year 3 measures has also been published to the RAPPS Quality webpage.

HHSC will include the proposed measures and requirements in the RAPPS Year 3 state-directed payment pre-print submission to the Centers for Medicare & Medicaid Services (CMS) in March 2023. All RAPPS Year 3 measures and requirements are subject to CMS approval. HHSC will post any changes required by CMS as described in TAC §353.1317.

1. Stakeholder Comments

Based on stakeholder questions to clarify measure specifications for the proposed Year 3 measures, HHSC has published a new *RAPPS Measure Specifications FAQ* file for the proposed Year 3 measures to the RAPPS Quality webpage. HHSC will also continue to clarify any detailed measure specifications questions via email at DPPQuality@hhs.texas.gov.

Component 1

Component 1 General Feedback

1. One respondent shared a concern about structure measures (specifically R1-105: Health Information Exchange (HIE) Participation and R1-163: Non-Medical Drivers of Health (NMDOH) Screening and Follow-up Plan Best Practices) becoming outcome measures in the future. Concerns include the increased costs for hospitals to alter their electronic health record (EHR) systems and workflows.

   HHSC Response: Structure measures are a type of measure (as opposed to "Process Measures" and "Clinical Outcome Measures") that help provide a sense of a provider's capacity, infrastructure, and strategy for delivering evidence-based best practices for high quality care. At this time, there are not any prescribed implementation or achievement requirements tied to a structure measure in any of the DPPs; the proposed structure measures require status reports only.

R1-163: Non-Medical Drivers of Health (NMDOH) Screening and Follow-up Plan Best Practices

2. One respondent requested additional information on required documentation for the NMDOH Screening and Follow-up Plan structure measure.

   HHSC Response: HHSC will provide additional information regarding reporting once the questions have been developed. Providers are only required to satisfy complete reporting on structure measures. At this time for all DPPs, reporting on structure measures will primarily be formatted as multiple-choice selections with some qualitative questions.

R1-166: Depression Screening and Follow-up Best Practices

3. One respondent requested additional information on the requirements of a follow-up plan as access to psychiatry and counseling can be difficult in rural areas.

HHSC Response: HHSC will provide additional information regarding reporting once the questions have been developed. Providers are only required to satisfy complete reporting on structure measures. At this time for all DPPs, reporting on structure measures will primarily be formatted as multiple-choice selections with some qualitative questions.

Component 2

Component 2 General Feedback

HHSC did not receive any general feedback on Component 2.

R2-103: Preventive Care and Screening: Influenza Immunization

4. One respondent stated that the measure has been retired as an eCQM for MIPS reporting in 2023 and that continuing the measure may create obstacles in data mining.

   HHSC Response: HHSC did not make changes in response to this comment. The measure continues to be used in MIPS Value Pathways (MVP) reporting. The approved eCQM measure specifications for the 2023 Performance Period can be found at this link.

R2-119: Controlling High Blood Pressure

5. One respondent stated that the previous outcome measure was preferred but did not offer any additional details.

   HHSC Response: HHSC did not make changes in response to this comment. This measure is proposed as a replacement for the year 1 and year 2 measure *Comprehensive Diabetes Care: Hemoglobin A1c Poor Control*. In review of data and during RAPPS Year 3 Workgroup discussions, the measure was identified as one for which many rural health clinics (RHCs) had a low volume of Medicaid clients during reporting. This indicates poor alignment between the population being measured and encounters that receive RAPPS payment. During workgroup discussions, the *Controlling High Blood Pressure* measure was identified as a better measure for RHCs to report.

Attribution Methodology

Attribution Methodology General Feedback

HHSC did not receive any general feedback on the RAPPS Attribution Methodology.

Reporting Requirements

Quality Reporting Requirements General Feedback

6. One respondent stated that the current timeline of program years being approved after the reporting period begins does not provide enough opportunity for participating providers to set up data systems for reporting and improve outcomes before the next program year requirements are in place.

   HHSC Response: HHSC understands providers would like more notice and time for measure changes. CMS requires annual approval of these programs as they are currently structured. HHSC will continue to look for opportunities to involve stakeholders earlier in the process to gather feedback on proposed changes.

7. One respondent suggested that reporting should occur annually instead of twice per year to decrease the burden on participating providers.

   HHSC Response: HHSC did not make changes in response to this comment. Due to evaluation cycles, including preliminary evaluation data required by CMS, HHSC uses two reporting periods in order to assess the preliminary six months of data for process and outcome measures. Additionally, having an initial reporting round for six months of data allows HHSC to provide feedback on any quality concerns that may affect accuracy of the data being reported.