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

ADOPTION PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), adopts an amendment to §353.1315, concerning the Rural Access to Primary and Preventive Services Program.

Section 353.1315 is adopted without change to the proposed text as published in the November 17, 2023, issue of the *Texas Register* (48 TexReg 6688), and therefore will not be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the adoption is to pursue modifications to the Rural Access to Primary and Preventive Services (RAPPS) to simplify the program structure, provide additional details concerning certain enrollment-related processes and procedures, and reduce the administrative burden of operating the program for HHSC and participating providers.

HHSC sought and received authorization from the Centers for Medicare & Medicaid Services to create RAPPS for state fiscal year (SFY) 2022 as part of the financial and quality transition from the Delivery System Reform Incentive Payment program (DSRIP). HHSC has not made significant modifications to RAPPS since its inception in SFY 2022. Directed payment programs authorized under 42 C.F.R. §438.6(c), including RAPPS, are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact.

HHSC has determined that RAPPS contains certain provisions that pose administrative complexity that may impede HHSC's and the participating providers' ability to use the program to advance a quality goal or strategy. HHSC, therefore, adopts certain clarifying amendments and other modifications with the intention of reducing administrative complexity and burden for participants.

The adopted amendment also consolidates RAPPS into a single component paid via Component 1 only for SFY 2025 and after. All payments will be directed to be paid by the managed care organization (MCO) as a lump sum payment based on a scorecard issued by HHSC. This adopted rule amendment reduces the administrative burden on providers and MCOs, as the payments will no longer be made via the claim adjudication process and will be exclusively made via the monthly scorecard outside of the claims process.

The adopted amendment determines the network status of an enrolling provider for an entire program period based on the submission of supporting documentation at the time of enrollment.

HHSC adopts several other minor clarifying or grammatical amendments to improve the readability of the rule text.

COMMENTS

The 31-day comment period ended December 18, 2023.

During this period, HHSC did not receive any comments regarding the proposed rule.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner 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 medical assistance payments under the Texas Human Resources Code Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The amendment affects Texas Government Code, Chapters 531 and 533, and Texas Human Resources Code, Chapter 32.

This agency hereby certifies that the adoption 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 contact PFD_Hospitals@hhsc.state.tx.us or (512) 487-3480.

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§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 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) Intergovernmental transfer (IGT) notification--Notice and directions regarding how and when IGTs should be made in support of RAPPS.

(4) Network RHC--An 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.

(5) 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.

(6) Rural health clinic (RHC)--Has the meaning assigned by 42 U.S.C. §1396d(l)(1).

(7) Suggested IGT responsibility--Notice of potential amounts that a sponsoring governmental entity may wish to consider transferring in support of RAPPS.

(8) 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. An RHC is eligible to participate in RAPPS if it meets the requirements described in this subsection.

(1) Location. The RHC must be located in an 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 an 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 on 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 an 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 its 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.

(7) Encounter data used to calculate RAPPS payments must be designated as paid status with a reported paid amount greater than zero. Encounters reported as paid status but with a reported paid amount of zero or negative dollars will be excluded from the data used to calculate RAPPS payments.

(8) If a provider with the same Tax Identification Number as the payor is being paid more than 200 percent of the Medicaid reimbursement on average for the same services in a one-year period, then a related party adjustment will be applied to the encounter data for those encounters. This adjustment will apply a calculated average payment rate from the rest of the provider pool to the related party's paid units of service.

(f) Conditions of Participation. 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 release of suggested IGT responsibilities.

(A) Enrollment is conducted annually and participants may not join the program after the enrollment period closes. Any updates to enrollment information must be submitted prior to the publication of the IGT notification under subsection (g)(3) of this section.

(B) Network status for providers for the entire program period will be determined at the time of enrollment based on the submission of documentation through the enrollment process that shows an MCO has identified the provider as having a network agreement.

(2) An entity that bills on behalf of the RHC must certify, on a form prescribed by HHSC, that no part of any RAPPS payment will be used to pay a contingent fee and that the entity's agreement with the RHC does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the RHC's receipt of RAPPS funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) If an RHC has changed ownership in the past five years in a way that

impacts eligibility for RAPPS, the RHC must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the RHC and which reference the administration of, or payments from, RAPPS.

(4) Report all quality data denoted as required as a condition of participation in subsection (h) of this section.

(5) Failure to meet any conditions of participation described in this subsection will result in removal of the provider from the program and recoupment of all funds previously paid during the program period.

(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 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) 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.

(3) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred, no fewer than 14 business days before IGT transfers are due. The IGT notification 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 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 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 for program periods beginning on or before September 1, 2023. For program periods beginning on or after September 1, 2024, Component One will be 100 percent of the total program value.

(B) Allocation of funds across qualifying RHCs will be based on 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 120 days after the last day of the program period.

(i) Redistribution resulting from the reconciliation will be based on actual utilization of enrolled NPIs.

(ii) If a provider eligible for RAPPS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(E) Providers must report quality data as described in §353.1317 of this subchapter as a condition of participation in the program.

(2) Component Two.

(A) The total value of Component Two will be equal to 25 percent of the total program value for program periods beginning on or before September 1, 2023. For program periods beginning on or after September 1, 2024, the total value of Component Two will be equal to zero percent of the 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 an RHC demonstrates achievement of performance requirements as described in §353.1317

of this subchapter during the reporting period.

(D) Providers must report quality data as described in §353.1317 of this subchapter as a condition of participation in the program.

(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 and payment period. The model for scorecard payments and the reconciliation calculations will be based on the enrolled NPIs at the time of the application under subsection (f)(1) of this section. For example, for an 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) For program periods beginning on or before September 1, 2023, payments from Component Two 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, an 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) An MCO will distribute payments to an enrolled RHC based on criteria established under this subsection.

(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.

(l) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) and §353.1301(k) of this subchapter.