Attachment C – Question 19 a, b, c, and d.
19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:
a. Will the state require plans to pay a uniform dollar amount or a uniform percentage increase?

The state is utilizing different payment requirements for the respective components of the program. The uniform dollar amount in Component 1 is intended to function as a prospective payment to address fluctuations in funding often occurring in rural settings, a payment methodology that also promotes access to primary care services. The uniform rate increase in Component 2 will be applied specifically to the most frequently utilized primary and preventive care services. The payments will be triggered by successfully meeting program quality requirements that incentivize improvements in primary care.

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)
Component 1 payment is estimated at $22.53 add-on per unit for freestanding rural health clinics and a $20.74 add-on per unit for hospital-based rural health clinics. Component 2 is estimated at a 3.77% increase per claim for all rural health clinics. The enrollment has not begun for year 2, and there are no substantial changes to the program from year 1. New numbers will be provided when enrollment is complete.

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

A minimum of 30 Medicaid managed care encounters in the prior State Fiscal Year (SFY) is required for program eligibility for all payment Components.

A. Component 1 will be a uniform dollar increase. Freestanding and hospital-based rural health clinics will receive a uniform dollar increase for All-Inclusive Clinic Visit, T1015, and office visit codes. In this preliminary calculation, payments are based on the count of claims for services provided from March 1, 2019, to February 29, 2020 (modified period) and will be paid prospectively on a monthly basis (equal to 1/12 of the annual amount), based on the historical utilization of the codes from the modified period, increased by 7% to account for projection to SFY22 enrollment growth among the three Medicaid Managed Care populations (STAR, STAR+PLUS, and STAR Kids). The enrollment has not begun for year 2 (SFY 2023), and there are no substantial changes to the program from year 1. New numbers will be provided when enrollment is complete. All-Inclusive Clinic Visit, T1015, and Office Visit codes were determined using the modified period MCO claims payments for the STAR/STAR+PLUS/STAR Kids programs. This methodology translates to approximately $22.53 add-on per unit for freestanding rural health clinics and approximately $20.74 add-on per unit for hospital-based rural health clinics. A reconciliation to actual utilization will occur at the end of the program period.

B. Component 2 will be a uniform percentage increase. Freestanding and hospital-based rural health clinics will receive a uniform percentage increase for All-Inclusive Clinic Visit, T1015, and office visit MCO payments for the STAR/STAR+PLUS/STAR Kids programs. For Component 2, the uniform percent increase will be approximately 3.77% per each T1015 or office visit claim for all rural health clinics. Payments will be made as part of the MCO's processing of the initial claim, and thus the increase will be based on SFY 2023 claims, but the estimate is based on SFY 2022.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract.

The T1015 and Office Visit codes represented 83% of the modified period MCO claims in the STAR, STAR+PLUS, and STAR Kids programs for both freestanding and hospital-based rural health clinics. Culling the list of eligible codes to All-Inclusive Clinic Visit, T1015, and office visit will make the payments easier to operationalize. In addition, the two classes of RHCs targeted are (1) hospital-based RHCs, which include non-state government-owned and private RHCs, and (2) freestanding RHCs.

For Components 1 and 2, Texas believes that reimbursing RHCs utilizing the Medicare cost reports under the RHC demonstration model is reasonable and appropriate; thus, the program aims to reimburse the participants the difference between the Medicare rates and MCO payments. The calculated Medicare rate from the most recently submitted Medicare cost report will be applied at the procedure code and modifier level to determine the difference in the Medicare rates and the MCO payments. Rural hospitals have closed at an unprecedented rate in the last five years, leaving rural health clinics as an even more critical component to meeting healthcare needs in rural areas. This directed payment program will provide additional funding to assist these key providers and help maintain access to services for Medicaid beneficiaries residing in rural areas of the state.