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Emily Sentilles
Director, Healthcare Transformation Waiver
Texas Health and Human Services Commission
Mail Code H400
PO Box 13247
Austin, TX 78711

Submitted by email to txhealthcaretransformation@hhsc.state.tx.us

Dear Ms. Sentilles:

Texas Hospital Association appreciates the opportunity to comment on proposed rules §353.1315 Rural Access to Primary and Preventive Services Program (RAPPS) and §353.1317 Quality Metrics for Rural Access to Primary and Preventive Services Program. These rules describe conditions under which rural health clinics, including hospital-based rural health clinics (RHCs), may receive uniform rate increases and uniform dollar increases for delivering preventive and primary care to Medicaid enrollees.

Our rural members sincerely appreciate HHSC's recognition that rural access to care remains a challenge across Texas, and applaud the agency for integrating new payment opportunities for hospital-based rural health clinics into the recent 1115 waiver extension. We believe RAPPS will be a valuable tool to expand the reach of rural hospitals and sustain gains realized under DSRIP.

With this in mind, we would strongly encourage HHSC to consider ways to expand the total program value. Currently estimated at \$18.7 million, RAPPS is the smallest proposed directed payment program. Enhancing the program value makes payment opportunities more plentiful for RHCs. Many will need resource infusions to implement the program's structure measures, such as technology upgrades and integrating care coordination staff into care teams. A larger total program size may accelerate the desired upgrades in this regard, since this component will be equal to 75% of total program value.

In addition, we appreciate HHSC prioritizing simplicity in proposed quality measures that must be reported as a condition of RAPPS participation. We understand the time constraints under which HHSC is being asked to bring these programs online. However, certain hospital-based rural health clinics may not yet have IT capabilities in place to capture and report quality data on the proposed timeline. To allow enough time for RHCs to align reporting capabilities with new requirements, an even simpler initial list of quality measures may be appropriate to start.

We recommend HHSC consider a transition period for preparing to report on these measures, which would allow hospital-based rural health clinics to continue prioritizing pandemic response in the near-term.

On Component 2 process measures, which are 25% of program value, we also ask HHSC to consider the potential negative impacts of measuring rural performance against median national benchmarks on measures for which the state historically underperforms national rates. These methods may create an artificially high barrier to achieving the measure goal. It may also fail to reward meaningful gains in clinical quality for certain RHCs who may fall in a lower percentile at baseline but eventually demonstrate improvement over self.

We look forward to continuing work with HHSC to ensure successful transition from DSRIP to RAPPS, which we know will be a key component of maintaining Texas' rural health care infrastructure moving forward. In order to maximize RAPPS uptake among targeted RHC participants, it is important the quality measures minimize barriers to participation, and that the size of the investment conforms with resources needed to achieve the program's overall goals. With additional questions, please contact astelter@tha.org.

Kind regards,

A handwritten signature in black ink that reads "A Stelter". The signature is written in a cursive, flowing style.

Anna Stelter
Senior Director, Policy Analysis
Texas Hospital Association