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HEALTHCARE INTELLIGENCE

Health and Human Services

Rural Access to Primary and Preventive Services (RAPPS) Public Hearing

December 10, 2025

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.

HHSC conducted an online public hearing on December 10, 2025, at 10:00 a.m. CDT to review and receive public comment on proposed quality metrics and requirements for SFY 2027 of RAPPS.

Summary

Overview of Proposed SFY 2027 Quality Changes

There are minimal changes proposed for SFY 2027; more significant updates may occur for SFYs 2028-2030. The program continues to advance existing quality goals, with process and outcome measures unchanged, and there is no pay-for-performance.
Main changes include:

- Using the same measure specifications for SFY 2027 as for SFY 2026, rather than updating annually.
- Removing structure measure R1-105 (Health Information Exchange Participation) to reduce administrative burden.
- Adjusting reporting periods: October reporting now requires an intent to report certification; all measures will be reported in March.

The new quality strategy omits one goal due to the removal of the structure measure, focusing now on promoting optimal health for Texans and effective practices for those with chronic, complex, and serious conditions.

SFY 2027 measures are:

- R1-115: Preventive Care and Screening for Depression
- R1-119: Controlling High Blood Pressure
- R1-163: Non-Medical Drivers of Health Screening and Best Practices

Reporting Period and Timeline Changes

- October reporting shifts from structure measure submission to a provider certification of intent to report.
- March reporting now includes all structure, process, and outcome measures to align RAAPS with CHRP and CHPS reporting.
- The timeline for stakeholder comments closes January 6th, 2026 and final requirements are due to be posted February 27th, 2026.
- Providers will apply for SFY 2027 in February 2026. CMS preprint submission is expected in spring 2026, with CMS approval anticipated summer 2026.

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Hearing Detail

Program Overview The Rural Access to Primary and Preventive Services (RAPPS) program is a directed payment program (DPP) that provides for increased Medicaid payments to rural health clinics (RHCs) for primary and preventive services provided to adults and children enrolled in the STAR, STAR+PLUS, and STAR Kids Medicaid managed care programs.

Quality Goals RAPPS aims to advance the goals of the Texas Managed Care Quality Strategy. Participating RHCs will report quality measures that tie to the following quality strategy goals:

- Promote optimal health through prevention and by engaging people, families, communities, and the health care system to optimize health outcomes.
- 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 Structure Note: The program structure and reporting requirements are subject to change if the Centers for Medicare and Medicaid Services (CMS) requires the change or HHSC determines the change is necessary to continue to meet policy and program goals while complying with federal law and regulations. RAPPS includes one component for state fiscal year (SFY) 2027. RAPPS provides a uniform dollar increase in the form of prospective, monthly payments to all qualifying RHCs. RHCs apply to participate in the program. To be eligible to participate, an RHC must be located in a service area with at least one sponsoring governmental entity and must have provided at least 30 Medicaid managed care encounters in the prior SFY.

Component 1 Component 1 includes structure, process, and outcome measures. Component 1 requires yearly submission of status updates for the structure measure and yearly submission of data for the process and outcome measures. All measures in Component 1 must be reported as a condition of participation by each RHC.

Reporting Requirements As a condition of participation in RAPPS, an RHC must report data for all measures by the deadlines communicated by HHSC. Failure of an RHC to meet this condition of participation will result in removal of the RHC from RAPPS and recoupment of all funds previously paid during the program period.

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Key Reporting Requirements

- Reporting Certification (October 2026): RHCs will submit an Intent to Report certification.
- Performance Reporting (March 2027): RHCs will report progress on structure measures as of August 31, 2026, as well as data for outcome and process measures for January 1, 2026, to December 31, 2026.

Reporting must follow the detailed measure specifications described in Proposed SFY 2027 Measure Specifications (Excel)

For structure measures, RHCs must submit responses to qualitative reporting questions that summarize their progress toward 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 data and respond to qualitative reporting questions as specified by HHSC. RHCs must report data stratified by the specified reporting payer type. Reported qualitative and numeric data will be used to monitor RHC-level progress toward state quality objectives.

Component 1 RHC-Reported Measures

Measure ID	Measure Name	Measure Type	CBE ID	Measure Steward	Reporting Payer Type
R1-115	Preventive Care and Screening: Screening for Depression and Follow-up Plan	Process	0418	CMS	• STAR/STAR+PLUS/STAR Kids • Other Medicaid • Uninsured • All-Payer
R1-119	Controlling High Blood Pressure	Outcome	0018	National Committee for Quality Assurance (NCQA)	• STAR/STAR+PLUS/STAR Kids • Other Medicaid • Uninsured • All-Payer
R1-163	Non-Medical Drivers of Health (NMDOH) Screening and Follow-up Plan Best Practices	Structure	N/A	HHSC	N/A

Attribution Methodology RHCs must follow these steps to identify the specific population that should be included in the numerator and denominator for RHC-reported process and outcome measures.

Step 1: Determine the DPP-attributed population.

Step 2: Determine the measure-specific denominator population.

Step 3: Stratify the measure-specific denominator population by required reporting payer type.

Attribution Step	Details
Step 1: Attributed Population Definition	Using a retrospective attribution methodology, the RAPPS-attributed population includes the individuals that a participating RHC, as indicated in the enrollment application, must include in accordance with the "Attributed Population Inclusion Criteria."
Step 1: Attributed Population Inclusion Criteria	The RHC's attributed population includes any individual who has at least one encounter with the RHC during the measurement period.
Step 1: Allowable Exclusions	Encounters with an individual incarcerated in a state or federal facility during the measurement period.
Step 2: Measure-Specific Denominator Population Definition	The measure-specific denominator population (Step 2) includes the individuals or encounters from the RAPPS attributed population (Step 1) that meet all criteria under the "Eligible Physician Specialties and Other Clinicians", "Denominator Inclusions", and "Denominator Exclusions" as applicable for each quality measure, as defined in the Measure Specifications tab. Participating providers may refer to the most recent NUCC Health Care Provider Taxonomy Code Set (https://taxonomy.nucc.org/) for the definitions and taxonomy codes for physician specialties, physician subspecialties, and other clinicians, as defined by the National Uniform Claim Committee (NUCC). The NUCC provider taxonomy definitions and codes for physician subspecialties that are nested within an eligible physician specialty may be included if these subspecialists perform the quality actions described in the measure based on the services provided and the measure specific-denominator coding. Nurse Practitioners and Physician Assistants, as defined by NUCC, practicing under the listed eligible physician specialties or practicing equivalent services may also be included.

Attribution Step	Details
Step 3: Reporting Payer Types	Measures must be stratified by the required reporting payer as outlined below. • Medicaid Managed Care: Exclusive to STAR, STAR+PLUS, and STAR Kids[1] • Other Medicaid: STAR Health and Medicaid Fee-For-Service • Uninsured: Includes No insurance; County-based or other public medical assistance • All-Payer: Includes Medicaid Managed Care, Other Medicaid, Uninsured, and all other payer types such as the Children's Health Insurance Program (CHIP), Medicare, Medicare and Medicaid Dual Eligibles, Commercial Insurance, Qualified Medicare Beneficiaries, and Non-Texas Medicaid individuals and encounters
Step 3: Payer-Type Assignment Methodology	The payer-type assignment methodology depends on the unit of measurement for the denominator. The unit of measurement is defined in the Measure Specifications file. • Individual: If a person can be counted once in the denominator, then the unit of measurement is an individual. The payer type assignment will be determined by either the most recent payer type on record at the end of the measurement period OR as any individual with a Medicaid Managed Care-enrolled service at any point in the measurement period, even if their most recent payer type of record is not Medicaid Managed Care. The same assignment methodology for determining Medicaid Managed Care must be applied consistently across the measurement period. • Encounter: If a person can be counted in the denominator more than once, then the unit of measurement is an encounter. The payer type assignment will be determined by the payer type on record for the qualifying encounter (e.g., visit or admission).

Additional Reporting Information

Data Sources and Data Elements Depending on the measure steward and the publicly available measure specifications source, the measure specifications may have been written based on electronic health record (E.H.R.) and claims data sources available to health care providers or health plans. For any measures where the measure specifications were originally written based on data sources available to health plans, HHSC has adapted the measure specifications for DPP-participating providers.

For DPP reporting purposes, DPP-participating providers are responsible for complying with measure specifications and should use the most complete data available to ensure that the data reported are representative of the entire population served. In cases

where a variance from a designated measure specification is required due to variances in data sources,

DPP-participating providers may opt to use local or proprietary data elements (codes or values) mapped to the standard data elements (codes or values) included in the measure specifications. DPP-participating providers that use local or proprietary data elements must maintain documentation of the relevant clinical concepts, definitions, or other information as applicable that crosswalks to the standard data elements. DPP-participating providers should keep a record of such variances to make note of and ensure consistency when reporting each measurement year.

Data Measurement Periods The data measurement period required for a given reporting period is identified under the "Data Measurement Period" column in the Measure Specifications file. Additionally, measure-specific denominator specifications may place additional limitations on the measurement period used for denominator inclusion. This may include using only a portion of the measurement period for denominator inclusion or identifying encounters or a diagnosis that occurred before the measurement period for denominator inclusion (a lookback period).

All measures are specified for a 12-month data measurement period, unless otherwise specified under the "Data Measurement Period" column in the Measure Specifications file.

Sampling Methodology Requirements DPP-participating providers should use the most complete data available to ensure that the rates reported are representative of the entire population served. All cases that meet the eligible population requirements for the measure must be included.

For measures where all required data elements are not available electronically (E.H.R., claims data, or registry) or are of poor quality, providers may conduct a sample to determine the rate for a given measurement year. DPP-participating providers should follow the sampling methodology included in the measure specifications, or if no sampling methodology is specified, providers should follow the HHSC sampling methodology identified below:

HHSC Sampling Methodology DPP-participating providers should use available administrative data to determine the denominator population. Sampling must be

systematic and random to ensure that all eligible individuals have an equal chance of inclusion. The resulting sample must be representative of the entire eligible population for the measure. At the time of reporting, DPP-participating providers will indicate if a sampling methodology is used. DPP-participating providers must maintain records of sampling methodology and random selection.

HHSC Minimum Sample Size for All-Payer

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on a random sample of not less than 76 cases.
- For a measurement period where the denominator size is greater than 380, providers must report on a random sample of cases that is not less than 20 percent of all cases; however, providers may cap the total sample size at 411 cases.

It is recommended to select an oversample of 10 to 15 percent of the sample size for substitution in the event that cases in the original sample are excluded from the measure.

Summary of Program Changes

- Removing structure measure R1-105: Health Information Exchange (HIE) Participation.
- Removing the Quality Strategy Goal listed below because of the removal of the only RAPPS measure tied to this goal, structure measure R1-105: Health Information Exchange (HIE) Participation: (Use high quality health information for people, families, communities, and the health care system to make data driven decisions to improve quality health care for all Texans).
- Changing the measurement period from CY 2025 (for SFY 2026) to CY 2026 (for SFY 2027).
- Eliminating the separate October reporting period for structure measures. RHCs will report the remaining structure measure in March 2027 concurrently with process and outcome measures. Adding a reporting certification for October 2026 where RHCs will submit an Intent to Report certification.

Public Comment and Questions (There was no public comment and only one question)

One question from Kristen Cooper (UT Health East Texas) concerned the reason for moving the reporting period from April to March; HHSC explained this aligns with other programs and baseline reporting needs for CMS and MCO contracts.

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