UNIFORM MANAGED CARE MANUAL - 6.2.17 The Medicaid Managed Care Aligning Technology by Linking Interoperable Systems (ATLIS) for Client Health Outcomes Program (ATLIS Program)

DOCUMENT HISTORY LOG

STATUS	DOCUMENT REVISION	EFFECTIVE DATE	DESCRIPTION
Baseline	1.0	September 1, 2024	Initial version Uniform Managed Care Manual, Chapter 6.2.17 The ATLIS Program.
Revision	2.0	September 1, 2025	Chapter 6.2.17 revised to add provisions for Year 2 assessments.

Applicability of Chapter 6.2.17

This chapter applies to Managed Care Organizations (MCOs) participating in the Medicaid Managed Care Aligning Technology by Linking Interoperable Systems (ATLIS) for Client Health Outcomes Program (ATLIS Program). For purposes of this chapter, the term "MCO" includes Medicaid managed care organizations, excluding Dental Maintenance Organizations (DMOs), provider organizations (EPOs), insurers, Medicare-Medicaid Plans (MMPs) and Dual Eligible Specials Needs Plans (D-SNPs), and any other entities licensed or approved by the Texas Department of Insurance.

The requirements in this Chapter apply to three Medicaid Managed Care Programs: STAR, STAR+PLUS and STAR Kids.

Program Description

Under the authority of 42 C.F.R. § 438.6(b)(2) and in accordance with UMCM Chapter 6 Principles, HHSC will enter into incentive arrangements with MCOs for achieving certain milestones on a semi-annual basis with the intention

that the milestones will build on prior accomplishments. The milestones will center around MCO achievement of necessary actions required to implement the structures, processes, and electronic transmission of client data between MCOs and providers necessary to improve client outcome measures and to implement, evaluate, improve, and mature alternative payment models (APMs).

The first group of network provider types that engage in The ATLIS Program, are in-network hospitals. For the purposes of ATLIS, the MCO contracts for inpatient or outpatient services with the following classes of hospitals: (A) Children's Hospitals; (B) Rural Hospitals; (C) State-owned non-Institutions for Mental Diseases (IMD) Hospitals; (D) Urban Hospitals; (E) Non-state-owned IMDs; and (F) State-owned IMDs.

The hospital classes are defined as follows:

1. Children's hospital--A children's hospital as defined by Texas Administrative Code (TAC), Title 1, Part 15 §355.8052 (relating to Inpatient Hospital Reimbursement).
2. Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness. IMD hospitals are reimbursed as freestanding psychiatric facilities under TAC, Title 1, Part 15 §355.8060 (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities).
3. Rural hospital--A hospital that is a rural hospital as defined in TAC, Title 1, Part 15 §355.8052.
4. State-owned non-IMD hospital--A hospital that is owned and operated by a state university or other state agency that is not primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental disease.
5. Urban hospital--An urban hospital as defined under TAC, Title 1, Part 15 §355.8052.

Texas Medicaid Managed Care Strategies and Goals that the Program is Designed to Advance

This incentive payment would meet the following goals and objectives of the Texas Managed Care Quality Strategy[1]:

Managed Care Quality Strategy Goals and Objectives

TX Health Care Quality Goals	Objectives
Promote optimal health through prevention and by engaging people, families, communities, and the health care system to optimize health outcomes.	▪ Increase screening for chronic disease, behavioral health conditions, and substance use disorders. ▪ Reduce avoidable hospital admissions and emergency department visits.
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.	▪ Reduce avoidable hospital readmissions. ▪ Promote effective medication management. ▪ Improve access to appropriate LTSS. ▪ Improve access to specialty care, including through telehealth. ▪ Improve the treatment and management of behavioral health conditions and substance use disorders, prioritizing services in community settings. ▪ Increase use of integrated physical and behavioral health care.

[1] https://www.hhs.texas.gov/sites/default/files/documents/texas-managed-care-quality-strategy-sept-2024.pdf

TX Health Care Quality Goals	Objectives
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.	▪ Update, integrate, and standardize health information systems and data to improve quality health care and reduce redundancies. ▪ Increase access to electronic health data. ▪ Expand health information exchange (HIE) capacity and participation in the state with particular focus on Medicaid, public health, and behavioral health services. ▪ Improve ability to identify and reduce health disparities by geography, sex, race, ethnicity, and disability. ▪ Increase correct and timely contact information in provider directories. ▪ Optimize care transitions and access to care through timely data exchange.

Background

Despite recent efforts to advance Health Information Exchange (HIE) participation, barriers to connectivity persist. Whether lack of information about HIE benefits, absence of infrastructure, hesitancy to share data, or other reasons, the inconsistency in connectivity across the state of Texas has inhibited efficient data sharing that would provide actionable data to improve the quality of care delivered to individuals in Medicaid.

The Centers for Medicare and Medicaid Services (CMS) has signaled that quality measurement will be moving toward all-digital platforms and National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures are following suit. Enhancing connectivity between providers and payers and the types of data that are exchanged will

help the state meet those expectations and reduce provider and MCO administrative burden.

Based on reporting in other programs, various classes of hospitals have differing levels of connectivity to regional or state HIEs. Some hospitals are connected to regional HIEs that share data with the Texas Health Services Authority (THSA), an entity formed under the authority of Texas Health and Safety Code, Chapter 182 in 2007 for the purpose of promoting, implementing and facilitating the secure electronic exchange of health information in Texas. THSA accomplishes this purpose through its state-level health information network, HIETexas. Some hospitals are connected directly with THSA. Some remain unconnected or connect only to a regional or national HIE that may not exchange data with payers or HHSC. Likewise, MCOs have various levels of connectivity to regional or state HIEs.

Aligning Technology by Linking Interoperable Systems (ATLIS) Multi-year Improvement Pathway

Program Year and MCO Measures by Year[2]

The initial phase of The ATLIS Program is anticipated to span five years. Each year HHSC requests MCOs to submit two Quantified Assessments every six months, the first on January 15 and the second on July 15. The quality measures used by HHSC to rate MCOs progress in HIE connectivity and interoperability are anticipated to change every year to monitor the progress made by each MCO participating in the ATLIS Program.

Year 1 (September 1, 2024 - August 31, 2025) and MCO Measures

Quantified Assessment of Baseline HIE Connectivity and Interoperability, including data by provider class regarding: number and percentage of MCO's network providers submitting admit, discharge, transfer (ADT) data to the Medicaid program's Emergency Department Encounter Notification (EDEN) system through a regional HIE connected to the Texas Health Services

[2] Measures are subject to change based upon operational considerations, technical assistance on reporting requirements, and input from stakeholders. Percentage of funding available by MCO model, SDA, and network class for each MCO may vary to ensure incentives are scaled appropriately to level of effort and difficulty of achievement.

Authority (THSA) or through a direct connection to THSA; number and percentage of MCO's network providers submitting patient or encounter level Consolidated Clinical Document Architecture (C-CDA) data to a regional HIE or via a national network; status of MCO's connections or subscriptions to EDEN, regional HIEs, or national HIE networks; a qualitative description of how each MCO is using these connections or subscriptions to improve quality of care, implement digital quality measurement, support value-based care and payment strategies, or other relevant actions; and description of MCO's activities to engage and educate network providers on this 438.6(b) program.

Year 2 (September 1, 2025 - August 31, 2026) and MCO Measures

Point-based assessment measuring incremental progress in HIE connectivity and early implementation activities including: HIE connectivity status and enhancements (including Regional HIEs and HIETexas); documented increases in HIE data volume (ADT and C-CDA data separately); network hospital HIE engagement expansion; implementation of HIE data usage activities (care gap identification, member outreach, discharge notifications, care transitions); establishment of provider care coordination processes; quality measure preparation activities; provider type connectivity expansion including IMDs; and barrier identification with mitigation actions. Assessment accommodates entities at different implementation stages while rewarding meaningful progress toward Year 3 quality outcome goals.

Year 3 (September 1, 2026 - August 31, 2027) and MCO Measures

Demonstrated utilization of HIE connections with early outcome measurement including: regular use of HIE data for care coordination with documented examples; quality measure gaps closed using HIE data; provider workflow efficiency gains; member outcome improvements; increase over previous year achievement levels on all measures by in network class; establish baselines for the number and percentage of birth or delivery event notices received by MCO within 48 hours by network provider class and flagged for follow-up; number and percentage of ADT notifications for Medicaid patients identified with mental health-related admission criteria and flagged for follow up by network provider class.

Year 4 (September 1, 2027 - August 31, 2028) and MCO Measures

Increase over previous year achievement levels on all measures by in network class; establish a baseline for number and percentage of networked ambulatory clinics receiving ADT notifications from each MCO; increase rate of timeliness of post-partum contraceptive care; increase rate of follow-up after hospitalization for mental illness (FUH) in 7 days; increase rate of follow-up after Emergency Department (ED) Visit for Mental Illness (FUM) in 7 days.

Measurable quality impact including readmission rate improvements; care transition effectiveness measurement; increase over previous year achievement levels on all measures by in network class; establish a baseline for number and percentage of networked ambulatory clinics receiving ADT notifications from each MCO; increase rate of timeliness of post-partum contraceptive care; increase rate of FUH in 7 days; increase rate of follow-up after EDFUM in 7 days.

Year 5 (September 1, 2028 - August 31, 2029) and MCO Measures

Population health outcomes and sustainability including chronic disease management outcome improvements; value-based payment development using HIE data; reduce the percentage of total enrollees on MCO panels with multiple ED visits in a year; reduce the rate per MCO enrollees for avoidable ED and hospital admissions due to asthma; increase transmission of lab and prescription data.

Post-program Desired Outcome

Greater connectivity across the state will positively impact the health outcomes of Medicaid beneficiaries. Better exchange of actionable data also will help payers and providers advance APMs.

Year 1

Year 1 MCO Achievement Milestones

Each year’s milestones will be constructed around a set of quality measures for HIE connectivity and interoperability. Connectivity leads to integration data sharing between systems, collaboration and alignment between health

system layers, interoperability in health information is crucial for improving patient care, enhancing the efficiency of healthcare delivery, and enabling better health outcomes. By facilitating seamless data exchange among various healthcare stakeholders, interoperability supports a more coordinated and effective healthcare system.

Year 1 MCO Achievement Milestone 1

On or before January 15, 2025, each MCO had to submit to HHSC in the manner prescribed by HHSC, a Quantified Assessment of Baseline HIE Connectivity and Interoperability, including data by provider class regarding: number and percentage of MCO's network providers who were in the network on September 1, 2024, submitting ADT data to the Medicaid program's EDEN system through a regional HIE connected to THSA or through a direct connection to THSA; estimated percentage of MCO's ED visits occurring in a hospital connected to EDEN; number and percentage of MCO's network providers submitting patient or encounter level C-CDA data to a regional HIE or via a national network; status of MCO's connections or subscriptions to EDEN, regional HIEs, or national HIE networks; number of ADT notices received by each MCO and a qualitative description of how each MCO was using these connections or subscriptions to improve quality of care, implement digital quality measurement, support value-based care and payment strategies, or other relevant actions; and description of MCO's activities to engage and educate network providers on 438.6(b) program. Achievement for each MCO was measured by quantifying the number of data fields and responses required in the report and calculating a percentage of data completion of the report. An MCO was measured as having achieved the milestone if the percentage of data completion was 90% or higher. If an MCO did not achieve the minimum achievement percentage, each MCO would have not receive an incentive payment.

Each MCO had to collect a certification by in network providers that the HIE connectivity status and subscription information was accurate and complete for each MCO report to HHSC to be considered complete. To earn the incentive payment, each MCO had to also collect a certification from a statistically substantial number of in network providers that were responsible for submitting a significant percentage of hospital claims in the prior fiscal year, and that the hospital-specific data reported to HHSC by each MCO was accurate and complete. The minimum thresholds to demonstrate that the

number of in network providers certifying the reported data was valid for use as a future baseline, are listed in the table following Milestone 2.

Year 1 MCO Achievement Milestone 2

On or before July 15, 2025, each MCO had to report to HHSC in the manner prescribed by HHSC an updated Quantified Assessment of Baseline HIE Connectivity and Interoperability detailing the barriers that each MCO is experiencing in establishing interoperable connectivity of ADT and/or C-CDA data by in network providers who were in the network on September 1, 2024, and a plan by each MCO to improve the ratio of network providers, who were in the network on September 1, 2024, connected to HIE. Achievement for each MCO was measured by quantifying the number of data fields and responses required in the report and calculating a percentage of data completion of the report. An MCO was measured as having achieved the milestone if the percentage of data completion was greater than in the preceding measurement period or was 100%. If an MCO did not achieve an improvement over-self or maintained a percentage of 100% completion, the MCO did not receive an incentive payment.

Each MCO had to collect a certification from a statistically significant number of in network providers, who were in the network on September 1, 2024, and were responsible for submitting a significant percentage of hospital claims in the prior fiscal year, that the HIE connection status and data exchange information was accurate and complete, and that the in network provider concurred with the barriers identified by each MCO for each MCO report to HHSC to be considered complete. The minimum thresholds to demonstrate that the number of in network providers certifying the reported data was valid for use as a future baseline are listed in Table 1.

Table 1 – Minimum Thresholds of Providers to Certify Data in Year 1

Hospital Class	Minimum Percentage of Prior Year Unique Claims	Minimum Sample Size Percentage and Confidence Interval
Rural	95%	98% with Confidence Interval of 2%
Children's	95%	90% with Confidence Interval of 10%

Hospital Class	Minimum Percentage of Prior Year Unique Claims	Minimum Sample Size Percentage and Confidence Interval
Urban	95%	90% with Confidence Interval of 10%
State-owned non-IMD	95%	95% with Confidence Interval of 5%

Year 2

Year 2 of The ATLIS Program will bring changes by placing emphasis on the established processes for HIE data use and the measurement of main activities to increase connectivity and interoperability, by introducing an assessment framework based on a point system.

Year 2 Assessment Pathways

The ATLIS Program recognizes multiple valid pathways for HIE connectivity and data exchange. MCOs and their network providers may achieve program objectives through any combination of: (1) HIE connectivity via Regional HIEs or THSA, (2) direct regional HIE participation, or (3) direct provider-to-MCO data exchange systems. All pathways are considered for scoring purposes when they achieve the same data exchange and interoperability objectives.

Year 2 MCO Achievement Milestones

Year 2 key focus areas are Connectivity Growth, Early Implementation, Quality Preparation and Workflow Integration, along with the incorporation of IMDs as new network provider types. The assessment framework will comprehensively measure the HIE connectivity status of MCOs and in-network hospitals by incrementally building on Year 1 responses, seeking valuable progress, while accommodating entities at various stages of HIE adoption.

Year 2 MCO Achievement Milestone 1

On or before January 15, 2026, each MCO must submit to HHSC in a manner prescribed by HHSC, a comprehensive point-based assessment measuring progress in HIE connectivity and early implementation activities of the

preceding 12-month period. The assessment employs a point-based scoring system to capture incremental progress and provide granular measurement of diverse HIE implementation activities, moving beyond Year 1's binary assessment approach to monitor MCOs' varying levels of achievement and progress.

This enhanced MCO assessment will include measurement of: HIE connectivity status and enhancement activities; increases in HIE data volume with separate measurement of ADT and C-CDA data by source (Regional HIEs and HIETexas); network hospital HIE engagement and expansion; implementation of HIE data usage activities including care gap identification, member outreach after ED visits, discharge notifications, medication adherence monitoring, care transition communication processes, and high-risk member identification; establishment of provider notification systems; quality measure preparation activities; care coordination process development; provider type connectivity expansion, including acute care hospitals, behavioral health facilities, specialty hospitals, ambulatory surgery centers, long-term care facilities, primary care practices, and specialty physician practices; and identification of barriers with documentation of mitigation actions taken. The assessment consists of two sections, one completed by MCOs only and another completed by MCOs and their in-network hospitals; the MCOs are responsible for ensuring completion of the entire assessment before submission to HHSC.

Achievement for each MCO will be measured using a point-based system with a total score of 1,075 [150 connectivity; 140 + 55 HIE Data; 120 Hospital Engagement; 110 Implementation; 95 Provider Notification; 105 Quality Measures; 85 Care Coordination; 155 Connectivity Expansion; 60 Barrier Mitigation) points. MCOs will be classified into performance tiers: Exceptional 90-100% (968-1075 points), Advanced 75-89% (806-967 points), Developing 60-74% (645-805 points), Basic 45-59% (484-644 points), and Emerging <45%) <484 points).

An MCO will be measured as having achieved the milestone if percentage of data completion is 100%. If an MCO does not achieve a percentage of 100% completion, the MCO will not receive an incentive payment.

Each MCO must collect a certification from in-network providers, including IMDs, that the HIE connectivity status, data exchange information, and barrier assessments are accurate and complete for each MCO report to HHSC to be considered complete. The assessment framework accommodates

providers at various stages of HIE adoption, including newly included IMD class. The thresholds for provider certification by hospital class are listed in Table 2.

Table 2 – Minimum Requirements of Provider Certification in Year 2

Class of Hospital	Minimum Percentage of Prior Year Unique Claims	Minimum Sample Size and Confidence Interval
Rural	90%	95% with Confidence Interval of 5%.
Children's	90%	90% with Confidence Interval of 10%.
Urban	90%	90% with Confidence Interval of 10%.
State-owned non-IMD	90%	95% with Confidence Interval of 5%.
IMD	85%	90% with Confidence Interval of 10%.

Note: Reduced certification requirements for Year 2 reflect the transition from baseline establishment to progress measurement, with accommodations for newly participating hospital class (IMDs).

Year 2 MCO Achievement Milestone 2

On or before July 15, 2026, each MCO must submit to HHSC in a manner prescribed by HHSC, an updated point-based assessment demonstrating progress over the January 2026 assessment. The framework measures meaningful advancement in HIE connectivity and implementation activities with expectations for incremental improvement appropriate for the 6-month timeframe.

Achievement for each MCO will be measured by both absolute performance tier achievement and demonstrated progress from the January assessment. Minimum progress thresholds are: High Performers (800 + points in January): + 75 - 100 points by July; Mid-Level (500 - 799 points): + 100 - 150 points by July; Emerging (<500 points): + 150 + points by July. An MCO will be measured as having achieved the milestone if the MCO improves

its performance tier and meets the minimum progress threshold (10% score improvement) for its baseline category.

The assessment continues to focus on process establishment and early implementation rather than outcome demonstration, recognizing that Year 2 represents the foundation-building phase for quality outcome measurement in Years 3-5. Each MCO must collect updated certifications from in-network providers that the reported progress and continued barrier assessment information is accurate and complete. The thresholds for provider certification by hospital class are listed in Table 2 above.

Guide for Reporting the Quantified Assessments using the ATLIS Data Reporting Tool

MCO Deliverable: ATLIS Program

Year 2 is introducing a Point-Based Assessment Framework for HIE Connectivity Progress and Implementation. According to the assessment framework, each participating MCO must complete a comprehensive point-based assessment measuring progress in HIE connectivity and early implementation activities since Year 1. The assessment employs a sophisticated scoring system to capture incremental progress and reward varying levels of achievement across diverse HIE implementation activities.

Assessment Overview

Assessment Focus: Progress measurement in four key areas:

- Connectivity Growth: HIE enhancements through a valid pathway, data volume increases, network expansion.
- Early Implementation: HIE data usage activities regardless of connection method, provider notifications, quality preparation.
- Workflow Integration: Care coordination processes, provider type expansion across all HIE pathways.
- Barrier Management: Challenge identification and mitigation actions for all connection types.

Scoring System: Point-based assessment with 1075 total points.

- Performance Tiers: Exceptional (968-1075 points), Advanced (806-967 points), Developing (645-805 points), Basic (484-644 points), Emerging (<484 points).
- Progress Expectations: 6-month improvement requirements based on baseline performance.

Pre-Assessment Requirements

Every year, each participating MCO is required to submit to HHSC, in a manner and date prescribed by HHSC, an updated list of all in-network hospitals in each SDA in which each MCO operates, including any contracted Institutions for Mental Diseases (IMDs).

MCOs will use a template provided and prepopulated by HHSC to gather the required information from in-network hospitals. MCOs must coordinate with in-network hospitals to complete the corresponding template.

In case of facility ownership change, which should not affect the relationship between the MCO and the respective facility, HHSC advises that MCO continues to collect data. In case of facility closure, MCO should notify HHSC. HHSC will adjust the hospital data collection calculations so the closure will not affect the MCO hospital response rate.

Data Preparation: MCOs should gather documentation of:

- HIE data volume changes over past 12-month period (ADT and C-CDA data separately) from all connection sources.
- New HIE connections and enhancements made in past 12 months through any pathway.
- Implementation activities initiated for HIE data utilization regardless of connection method.
- Provider engagement and support activities undertaken across all HIE options.
- Barriers encountered and mitigation actions taken for all connection types.

MCO Assessment Sections:

- Section 1: Connectivity Growth (Progress-Based Scoring).
- Section 2: Early Implementation & Data Utilization.
- Section 3: Workflow Integration & Care Coordination.
- Section 4: Barrier Assessment and Mitigation Actions.

Hospital Assessment Sections:

- Section 1: Connectivity Expansion.
- Section 2: Clinical Workflow Integration.
- Section 3: Quality Initiative Participation.
- Section 4: Cross-Provider Integration and Barrier Assessment.

Sample Size Calculation: MCOs must complete provider certification requirements using the Sample Size Calculation component (managed separately by designated HHSC contractor). Minimum certification thresholds by hospital class are presented in Table 3.

Table 3 – Minimum Requirements of Provider Certification in Year 2

Class of Hospital	Minimum Percentage of Prior Year Unique Claims	Minimum Sample Size and Confidence Interval
Rural	90%	95% with Confidence Interval of 5%
Children's	90%	90% with Confidence Interval of 10%
Urban	90%	90% with Confidence Interval of 10%
State-owned non-IMD	90%	95% with Confidence Interval of 5%
IMD	85%	90% with Confidence Interval of 10%

MCO Attestation: Attestation certifying accuracy and completeness of submitted assessment data and provider certifications.

Completion Requirements:

- All assessment sections must be completed for submission to be considered valid.
- Point calculations will be automated within the assessment platform.
- Progress indicators will show completion status throughout the assessment.
- Real-time scoring will display points earned and performance tier placement.

Assessment Tool Access: HHSC will provide assessment tool access and detailed navigation instructions to MCOs when the assessment tool is published by HHSC. The assessment and related resources will include:

- Guided Navigation: Section-by-section completion with progress tracking.
- Automated Scoring: Real-time point calculation and tier placement.
- Data Validation: Built-in checks to ensure response consistency and completeness.
- Help Resources: Contextual guidance and support contact information.

Facility Changes and Special Circumstances

Facility Ownership Changes: Ownership changes should not affect MCO-facility relationship for assessment purposes. Continue data collection and reporting for affected facilities.

Facility Closures: Notify HHSC immediately of any in-network facility closures. HHSC will adjust hospital data collection calculations to ensure closures do not negatively impact MCO response rates.

IMD Contracts: For contracted IMDs, document their current HIE readiness status and planned implementation activities. The assessment framework provides appropriate scoring for entities beginning HIE participation.

Merger/Acquisition Activity: Report any significant network changes that may affect HIE connectivity landscape or assessment completion capability.

Assessment Submission Requirements

Submission Timeline:

- Milestone 1: Assessment must be completed and submitted on or before January 15, 2026.
- Milestone 2: Updated assessment demonstrating 6-month progress must be completed and submitted on or before July 15, 2026.

Questions and Technical Support:

Assessment Content: HPCS_UMCC_Provisions@hhsc.state.tx.us

Confidentiality and Data Security

Proprietary Information Protection: If submitting information considered proprietary or confidential, clearly mark such information within the assessment platform. MCOs remain responsible for responding to open records requests and submitting arguments to the Texas Attorney General's Open Record Division as needed. MCOs should maintain records of assessment responses and supporting documentation in accordance with contract requirements and applicable retention schedules.