

## **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)**

#### **The DOCUMENT HISTORY LOG**

<b>STATUS<sup>1</sup></b>	<b>DOCUMENT REVISION<sup>2</sup></b>	<b>EFFECTIVE DATE</b>	<b>DESCRIPTION<sup>3</sup></b>
Baseline	1.0	September 1, 2024	Initial version in Uniform Managed Care Manual, Chapter 6.2.17 The ATLIS Program Data Reporting Tool.
Revision	2.0	June 1, 2026	Chapter 6.2.17 Data Reporting Tool (DRT) (Excel) was replaced with the ATLIS program description (Word). The DRT will now be distributed to the MCOs via MCO Notice.

<sup>1</sup> Status should be represented as "Baseline" for initial issuances and "Revision" for changes to the Baseline version.

<sup>2</sup> Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "2.2" refers to the first version of the document and the second revision.

<sup>3</sup> Brief description of the changes to the document made in the revision.

### **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" means a Medicaid managed care organization that participates in the STAR, STAR+PLUS, or STAR Kids Medicaid Program. The term does not include Dental Maintenance Organizations (DMOs), provider organizations, private insurers, Medicare-Medicaid Plans (MMPs), or Dual Eligible Specials Needs Plans (D-SNPs).

### **Program Description**

Under the authority of 42 C.F.R. § 438.6(b)(2) HHSC will provide incentive payments to MCOs for achieving certain milestones with the intention that the milestones will build on prior accomplishments. The milestones will center around MCO achievement of actions required to implement the structures, processes, and electronic transmission of client data between MCOs and providers necessary

## **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)**

to improve client outcome measures and to implement, evaluate, improve, and mature alternative payment models (APMs).

The first group of network providers for which MCOs must report data in the ATLIS Program are in-network hospitals.<sup>1</sup> For the purposes of ATLIS, the MCO contracts for inpatient or outpatient services with the following classes of hospitals: (A) Rural Hospitals; (B) Children’s Hospitals; (C) Urban Hospitals; (D) State-owned non-IMDs; and (E) Non-State-Owned IMDs.

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

This program is designed to meet several goals and objectives of the Texas Managed Care Quality Strategy<sup>2</sup> over a multi-year pathway (Table1).

**Table 1 - Managed Care Quality Strategy Goals and Objectives**

<b>TX Health Care Quality Goals</b>	<b>Objectives</b>
Promote optimal health through prevention and by engaging people, families, communities, and the health care system to optimize health outcomes.	<ul style="list-style-type: none"> <li>▪ Increase screening for chronic disease, behavioral health conditions, and substance use disorders.</li> <li>▪ Reduce avoidable hospital admissions and emergency department visits.</li> </ul>

<sup>1</sup> Hospital means a general or special hospital, including a public or private institution licensed under Chapter 241, Health and Safety Code.

<sup>2</sup> <https://www.hhs.texas.gov/sites/default/files/documents/texas-managed-care-quality-strategy-sept-2024.pdf>

**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)**

<b>TX Health Care Quality Goals</b>	<b>Objectives</b>
<p>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.</p>	<ul style="list-style-type: none"> <li>▪ Reduce avoidable hospital readmissions.</li> <li>▪ Promote effective medication management.</li> <li>▪ Improve access to appropriate LTSS.</li> <li>▪ Improve access to specialty care, including through telehealth.</li> <li>▪ Improve the treatment and management of behavioral health conditions and substance use disorders, prioritizing services in community settings.</li> <li>▪ Increase use of integrated physical and behavioral health care.</li> </ul>
<p>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.</p>	<ul style="list-style-type: none"> <li>▪ Update, integrate, and standardize health information systems and data to improve quality health care and reduce redundancies.</li> <li>▪ Increase access to electronic health data.</li> <li>▪ Expand health information exchange (HIE) capacity and participation in the state with particular focus on Medicaid, public health, and behavioral health services.</li> <li>▪ Improve ability to identify and reduce health disparities by geography, sex, race, ethnicity, and disability.</li> </ul>

**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)**

TX Health Care Quality Goals	Objectives
	<ul style="list-style-type: none"> <li>▪ Increase correct and timely contact information in provider directories.</li> <li>▪ Optimize care transitions and access to care through timely data exchange.</li> </ul>

**Background**

Despite recent efforts to advance Health Information Exchange (HIE) participation, barriers to connectivity persist. 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, and some remain unconnected or connect 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.

## 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)

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

#### Program Year and MCO Measures by Year<sup>3</sup>

Each year MCOs must submit a Data Reporting Tool (DRT), in the manner and frequency determined by HHSC, to determine a point score in the Quantified Assessment. 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

In Year 1, MCOs submitted a DRT for the 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 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.

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<sup>3</sup> 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.

## **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)**

### **Year 2 (June 1, 2026 – August 31, 2026) and MCO Measures**

In Year 2, a point-based Quantified Assessment is being introduced to assess MCO HIE connectivity and early implementation activities including: HIE connectivity status and enhancements (including regional HIEs and HIETexas); documented 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 Institutions for Mental Diseases (IMD); and identification of barriers with documented proof of mitigation actions. The Quantified Assessment accommodates entities at different implementation stages while recognizing a pathway toward Year 3 quality outcome goals.

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

In Year 3, MCOs will demonstrate utilization of HIE connections with early outcome measurement, which may include: 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. In Year 3, MCO payment amounts may be tied to performance on the Quantified Assessment.

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

In Year 4, MCOs must increase their achievement levels over previous years on all measures by in-network providers, which may include: establishing a baseline

## **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)**

for number and percentage of networked ambulatory clinics receiving ADT notifications from each MCO; increasing rate of timeliness of post-partum contraceptive care; increasing rate of Follow-Up After Hospitalization for Mental Illness (FUH) in 7 days; increasing rate of Follow-Up After Emergency Department (ED) Visit for Mental Illness (FUM) in 7 days.

Measurable quality impacts may be considered, 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. In Year 4, MCO payment amounts will be tied to performance on the Quantified Assessment.

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

In Year 5, MCOs must demonstrate improvement of 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. In Year 5, MCO payment amounts will be tied to performance on the Quantified Assessment.

### **Post-program Desired Outcome**

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

## **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)**

#### **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 and 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 submitted to HHSC in the manner prescribed by HHSC, a DRT for the 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, and 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.

## **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)**

If an MCO did not achieve the minimum achievement percentage, the MCO did not receive an incentive payment.

Each MCO was required 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 Table 2.

#### **Year 1 MCO Achievement Milestone 2**

On or before July 15, 2025, each MCO was required to report to HHSC in the manner prescribed by HHSC an updated DRT for the Quantified Assessment of Baseline HIE Connectivity and Interoperability detailing the barriers that each MCO was 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 maintain a percentage of 100% completion, the MCO did not receive an incentive payment.

Each MCO was required 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

## **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)**

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 2.

**Table 2 – Minimum Thresholds of Providers to Certify Data in Year 1**

<b>Hospital Class</b>	<b>Minimum Percentage of Prior Year Unique Claims</b>	<b>Minimum Sample Size Percentage and Confidence Interval</b>
Rural	95%	98% with Confidence Interval of 2%
Children’s	95%	90% with Confidence Interval of 10%
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 introduce a point-based Quantified Assessment to emphasize the processes for HIE data use and the measurement of activities to increase connectivity and interoperability. The point system will **not** determine the payment eligibility, as the basis for payment will remain a pass/fail determination related to meeting Year 2 program requirements. Year 2 requirements for MCOs to receive an ATLIS incentive payment from HHSC will include completion of 100% of data fields in the DRT and submission of required documentation.

The purpose of introducing the point system is to help MCOs participating in the ATLIS Program to identify their status in Year 2 and to give MCOs the ability to establish a base-point level going forward to track progress into future program years.

## **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)**

#### **Year 2 Assessment Framework 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 connected to HIETexas or a direct connection to THSA, (2) HIE connectivity via a regional HIE sharing data with MCO(s), or (3) direct provider-to-MCO data exchange systems. All pathways are considered for scoring purposes when pathways achieve the same data exchange and interoperability objectives.

#### **Year 2 MCO Achievement Milestones**

Year 2 focuses on Connectivity Growth, Early Implementation, Quality Preparation and Workflow Integration, along with the inclusion of IMDs as a new in-network provider type. The Quantified Assessment Framework will evaluate HIE connectivity among MCOs and in-network hospitals, building on Year 1 results while accommodating varying levels of HIE adoption.

On or before July 15, 2026, each MCO must submit to HHSC in a manner prescribed by HHSC, a comprehensive point-based Quantified Assessment using the DRT showing HIE connectivity and implementation activities of the preceding 12-month period (July 1, 2025 – June 30, 2026). The DRT employs a point-based scoring system providing 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 MCO DRT will be used to assess: HIE connectivity status and enhancement activities; 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

## **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)**

facilities, primary care practices, and specialty physician practices; and identification of barriers with documentation of mitigation actions taken.

In addition to quantitative point-based scoring, the Year 2 assessment requires MCOs to submit documentation that clearly demonstrates MCO activities intended to address barriers to HIE connectivity. Barriers are obstacles or challenges that prevent hospitals from connecting to HIEs or that degrade the quality or utility of HIE data. Barriers may include hospital refusal or resistance to connectivity, data quality issues, resource constraints (funding or staffing), technical limitations, or infrastructure gaps.

Documentation requirements include:

- If MCO identified 5 or fewer barriers: Document all mitigation actions taken to address the identified barriers.
- If MCO identified more than 5 barriers: Document a minimum of 5 representative examples spanning different barrier types.

For each barrier/example, provide:

- Barrier Description (e.g., hospital non-participation, data quality issues)
- Action Taken (specific MCO actions to address the barrier)
- Outcome Status (Resolved, Ongoing, Escalated, Unable to Resolve)
- Supporting Documentation (one piece of evidence: meeting notes, email, contract, hospital confirmation, etc.).

The DRT consists of two sections, one completed by MCOs only and another completed by MCOs and their in-network hospitals. MCOs are responsible for ensuring completion of the entire DRT before submission to HHSC. Although the in-network hospital section contains questions related to barriers, submission of barrier mitigation documentation is only applicable to MCOs. An MCO will be evaluated as having achieved the milestone if the MCO: (1) completes 100% of data fields in the MCO Data and In-Network Hospital Survey tabs; (2) meets minimum percentage threshold of In-Network Hospital data completion established; and (3) submits the required barrier mitigation documentation. If an

## **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)**

MCO does not meet these requirements, the MCO will not receive an incentive payment.

Each MCO will be evaluated using a point-based system allocated to each category, with a total possible score of 1,055 (Table 3).

**Table 3 – MCO Achievement Level for each HIE Category**

<b>Category</b>	<b>Number of Points</b>
Connectivity	150
HIE Data	195
Hospital Engagement	120
Implementation	110
Provider Notification	75
Quality Measures	105
Care Coordination	85
Connectivity Expansion	155
Barrier Mitigation	60
<b>Total Number of Points</b>	<b>1055</b>

Using the number of points accumulated, MCOs will be classified into performance levels according to their performance tiers (Table 4).

**Table 4 – MCO Performance Level**

<b>Performance Levels</b>	<b>Percentage Tiers</b>	<b>Number of Points</b>
Exceptional	90-100%	950-1055
Advanced	75-89%	791-949
Developing	60-74%	633-790
Basic	45-59%	475-632
Emerging	<45%	<475

In-network hospitals' connectivity status will be evaluated using a point-based system associated with each category, with a maximum achievement level of 1070 (Table 5).

## **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)**

**Table 5 – In Network Hospital Achievement Level**

<b>Category</b>	<b>Number of Points</b>
HIE Participation Growth	140
Volume and Type of Data Sharing with MCOs	160
MCO Partnership Development	120
Discharge Planning Processes	100
Care Transition Activities	90
Quality Initiative Participation	85
Workflow Development	95
Facility Readiness and Implementation Status	120
Multi-Provider Care Coordination	100
Current Barriers and Challenges	60
<b>Total Possible Number of Points</b>	<b>1070</b>

Based on the number of points accumulated, in-network hospital performance will be classified into several performance levels according to their performance tiers (Table 6).

**Table 6 – In Network Hospital Performance Level**

<b>Performance Levels</b>	<b>Percentage Tiers</b>	<b>Number of Points</b>
Exceptional	90-100%	963-1070
Advanced	75-89%	803-962
Developing	60-74%	642-802
Basic	45-59%	482-641
Emerging	<45%	<482

For the MCO Quantified Assessment reported to HHSC to be considered complete, 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. The assessment framework accommodates providers at various stages of HIE adoption, including newly included IMD class. The thresholds for provider certification by hospital class

## **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)**

must represent both a certain percentage of prior year unique claims and a minimum sample size of the MCO's in-network hospitals. These thresholds are listed in Table 7.

**Table 7 – Minimum Requirements of Provider Certification in Year 2**

<b>Class of Hospital</b>	<b>Minimum Percentage of Prior Year Unique Claims</b>	<b>Minimum Sample Size and Confidence Interval</b>
Rural	95%	98% with Confidence Interval of 2%.
Children's	95%	90% with Confidence Interval of 10%.
Urban	95%	90% with Confidence Interval of 10%.
State-owned non-IMD	95%	95% with Confidence Interval of 5%.
Non-State-Owned IMD	95%	90% with Confidence Interval of 10%.

### **Payment Eligibility**

MCO eligibility for the Year 2 incentive payment is determined by whether the MCO meets all four of the following requirements:

- **DRT Completion:** MCO completes 100% of data fields in both MCO and In Network Hospital assessment tabs. All quantitative fields must contain numeric data. All categorical fields must have a selection made.
- **Provider Certification:** MCO obtains applicable required percentages of written certifications from all In-Network Hospitals confirming accuracy of reported HIE connectivity status, data exchange information, and barrier assessments.
- **Barrier Mitigation Documentation:** MCO provides supporting documentation for barrier mitigation activities.

## 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)

- MCO Attestation: MCO executive completes and signs attestation certifying accuracy and completeness of all required items.

If an MCO meets all four requirements, the MCO is eligible for an incentive payment. If any of the four requirements are not met, the MCO does not receive an incentive payment.

## Guide for Reporting the Quantified Assessment using the ATLIS Data Reporting Tool

### MCO Deliverable: ATLIS Program

Year 2 introduces a point-based assessment framework for HIE Connectivity. According to the assessment framework, each participating MCO must complete a comprehensive point-based Quantified Assessment of HIE connectivity and early implementation activities in the previous 12-month period, using the DRT. The Quantified Assessment employs a scoring system based on the points accumulated, to capture and recognize varying levels of achievement across HIE implementation activities.

### Quantified Assessment Overview

**Assessment Focus:** Four key areas:

- Connectivity Growth: HIE enhancements through a valid pathway, data volume increases, and hospital network expansion.
- Early Implementation: HIE data usage activities regardless of connection method, provider notifications, quality measure preparation.
- Workflow Integration and Care Coordination: Care coordination processes, provider type expansion across all HIE pathways.

## 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)

- Barrier Management: Barriers and challenges identification and documented mitigation actions taken for advancing all connection types.

**Scoring System:** Point-based assessment with 1055 total points.

- Performance Tiers: Exceptional (950-1055 points), Advanced (791-949 points), Developing (633-790 points), Basic (475-632 points), Emerging (<475 points).

#### 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 IMDs.

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

**Data Preparation:** MCOs may gather documentation of:

- HIE data volume changes over the past 12-month period (ADT and C-CDA data separately) from all connection sources.
- New HIE connections and enhancements made in the 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 documented mitigation actions taken for all connection types.

#### MCO Assessment Sections:

- Section 1: Connectivity Growth (Progress-Based Scoring).
- Section 2: Early Implementation & Data Utilization.

## **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)**

- 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.

**Sample Size Calculation:** MCOs must complete provider certification requirements using the Sample Size Calculation component. Minimum certification thresholds by hospital class are presented in Table 8.

**Table 8 – Minimum Requirements of Provider Certification in Year 2**

<b>Class of Hospital</b>	<b>Minimum Percentage of Prior Year Unique Claims</b>	<b>Minimum Sample Size and Confidence Interval</b>
Rural	95%	98% with Confidence Interval of 2%
Children's	95%	90% with Confidence Interval of 10%
Urban	95%	90% with Confidence Interval of 10%
State-owned non-IMD	95%	95% with Confidence Interval of 5%
Non-State-Owned IMD	95%	90% with Confidence Interval of 10%

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

#### **DRT Completion Requirements:**

- HHSC will provide access to the DRT and related resources.

## **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)**

- 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.

#### **Facility Changes and Special Circumstances**

**Facility Ownership Changes:** Ownership changes should not affect MCO-facility relationships 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.

#### **Data Reporting Tool Submission Requirements**

##### **Submission Timeline:**

**Year 2 Milestone:** DRT demonstrating previous 12- month activity (July 1, 2025 – June 30, 2026) must be completed and submitted to HHSC on or before July 15, 2026. In addition, MCOs must submit supporting documentation for barrier mitigation actions. The DRT and barrier mitigation documentation should be submitted to MCOHub in the MCO/PHI/DELIV folder and attached via email to Provider Finance Department at [PFD\\_Hospitals@hhs.texas.gov](mailto:PFD_Hospitals@hhs.texas.gov) and Quality Data Analytics and Reporting at [ValueBasedInitiatives@hhs.texas.gov](mailto:ValueBasedInitiatives@hhs.texas.gov). Please mark the email as "Confidential!".



## **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)**

### **Questions and Technical Support:**

Data Reporting Tool and Quantified Assessment Content: Please send email to HHSC Value Based Initiatives at [ValueBasedInitiatives@hhs.texas.gov](mailto:ValueBasedInitiatives@hhs.texas.gov) and Provider Finance Department at [PFD\\_Hospitals@hhs.texas.gov](mailto:PFD_Hospitals@hhs.texas.gov)

### **Confidentiality and Data Security**

**Proprietary Information Protection: If submitting information considered proprietary or confidential, clearly mark such information within the DRT. 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 DRT responses and supporting documentation in accordance with contract requirements and applicable retention schedules.**