The Medicaid Managed Care Aligning Technology by Linking Interoperable Systems for Client Health Outcomes Program	
Description	
Under the authority of 42 C.F.R. § 438.6(b)(2) and in accordance with the Texas UMCM Chapter 6, the Medicaid Managed Care Aligning Technology by Linking Interoperable Systems for Client Health Outcomes Program (a.k.a. The ATLIS) will enter into incentive arrangements with Medicaid Managed Care Organizations (MCOs) for achieving certain milestones on a semi-annual basis with the intention that the milestones will build on prior accomplishments over a 5-year period. The milestones will center around MCO achievement of necessary actions required to implement the structures, processes, and use of client data transmitted electronically between MCOs and providers in their networks to improve client outcome measures and to implement, evaluate, improve, and mature alternative payment models (APMs) for Medicaid beneficiaries.	
Texas September 2021 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.	
	3. Providing the right care in the right place at the right time to ensure people can easily navigate the health system to receive timely services in the least intensive or restrictive setting appropriate.
	Ø Objective a. Reduced rate of avoidable hospital admissions and readmissions.
	Ø Objective b. Reduced rate of avoidable emergency department visits.
	Ø Objective e. Optimized care transitions and care coordination.
	5. Promoting 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 regardless of where they live in Texas.
	Ø Objective d. Increased prevention, identification, treatment, and management of behavioral and mental health.
	6. Attracting and retaining high-performing Medicaid providers, including medical, behavioral health, dental, and long-term services and supports providers to participate in team based, collaborative, and coordinated care.

	Ø Objective c. Providers actively monitor patient outcomes and perspectives to address their needs and improve healthcare delivery.
	Ø Objective e. Timely and efficient exchange of health information and increased interoperability.

Problem Statement

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 NCQA 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 ultimately, reduce provider and MCO administrative burden.

Based on reporting in the CHIRP program, the various classes of hospitals have differing levels of connectivity. Some hospitals are connected to regional HIEs that share data with the Texas Health Services Authority (THSA), a state-level health information exchange established by the Texas Legislature. 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, the MCOs have different levels of connectivity to regional or state HIE. As such, the first year of the program would require an assessment of current connectivity and interoperability status to identify and quantify opportunities for improving health information exchange. As the program progresses, HHSC proposes to add additional process and outcome measures that will assess the impact of improved data exchange on the health outcomes of Medicaid beneficiaries.

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

Program Year (Rating Period)	ftn1

Year 1 (September 1, 2024-August 31, 2025)	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 Event 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 (CCDA) 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 the 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)	Increase over baselines established in year 1 on all measures by class – targets set based on class; metrics of the timeliness of data transmission by in-network providers and receipt by MCOs related to ADT and CCDA data, including MCO identifying criteria for further action.
Year 3 (September 1, 2026-August 31, 2027)	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 notification for Medicaid patients identified with mental health-related admission criteria and flagged for follow up by network provider class.
Year 4 (September 1, 2028-August 31, 2029)	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 notification from the 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.
Year 5 (September 1, 2029-August 31, 2030)	Reduce the percentage of total enrollees on MCO panels with five or more emergency department 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.

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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 their APMs. Ultimately, in future iterations, the program could incorporate additional provider types, such as ambulatory providers and mental health providers, into connectivity metrics that MCOs would be accountable for to drive improvement in follow-up care and providers' ability to participate with transparency in APMs.

Year 1 MCO Achievement Milestones

By January 15, 2025, the MCO must submit to HHSC in a 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 emergency department visits occurring in a hospital connected to EDEN; number and percentage of MCO's network providers submitting patient or encounter level CCDA 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 the MCO and a qualitative description of how the 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. Achievement for the MCO will be 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 will be measured as having achieved the milestone if percentage of data completion is 90% or higher. If an MCO does not achieve the minimum achievement percentage, the MCO will not receive an incentive payment.

The MCO must collect a certification by in network providers that the HIE connectivity status and subscription information is accurate and complete for the MCO report to HHSC to be considered complete. To earn the incentive payment, the MCO also must collect a certification from a statistically significant number of in-network providers that were responsible for submitting a significant percentage of hospital claims in the prior fiscal year that the hospital-specific data reported to HHSC by the MCO is accurate and complete. The minimum thresholds to demonstrate that the number of in-network providers certifying the reported data is valid for use as a future baseline are listed in the table following Milestone 2.

MCO Achievement Milestone 2

By July 15, 2025, the MCO must report to HHSC in a manner prescribed by HHSC an updated Quantified Assessment of Baseline HIE Connectivity and Interoperability detailing the barriers that the MCO is experiencing in establishing interoperable connectivity of ADT and/or CCDA data by in-network providers, who were in the network on September 1, 2024, and a plan by the MCO to improve the ratio of network providers, who were in the network on September 1, 2024, connected to HIE in the future. Achievement for the MCO will be 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 will be measured as having achieved the milestone if percentage of data completion is greater than in the preceding measurement period or is 100%. If an MCO does not achieve an improvement over-self or maintain a percentage of 100% completion, the MCO will not receive an incentive payment.

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

Class of Hospital	Minimum Percentage of Prior Year Unique Claims	Minimum Sample Size
Rural	95%	**98% Confidence with a 2% Interval**
Children's	95%	**90% Confidence with a 2% Interval**
Urban	95%	**90% Confidence with a 10% Interval**
State-Owned Non-IMD	95%	**95% Confidence with a 5% Interval**