DSHS QUALITY MONITORING STRATEGIES FOR NORTHSTAR MANAGED BEHAVIORAL HEALTHCARE

As required by the Balanced Budget Act of 1997 (BBA) and the federal Medicaid managed care regulations (42 CFR Chapter 438), the State has developed a written assessment and performance improvement strategy to ensure the delivery of behavioral health services provided through the NorthSTAR managed behavioral healthcare program.

The State will conduct periodic reviews to evaluate the effectiveness of the strategy and update the strategy periodically, as needed.

I. BHO CONTRACT PROVISIONS (42 CFR §438.204(a))

The proposed NorthSTAR Contract, to begin July 1, 2006 (the "Contract"), incorporates the standards specified in 42 CFR Chapter 438, Part D. The State has, and will continue, to regularly monitor and evaluate the NorthSTAR contractor, ValueOptions (referred to in this document as a behavioral health organization,or BHO), for compliance with the contract and with the standards.

For purposes of the federal regulations, ValueOptions is considered to be a prepaid inpatient health plan (PIHP).

The standards and contracts provisions incorporating those standards are as follows:

A. ACCESS STANDARDS

1. 42 CFR §438.206 - Availability of Services

All behavioral health services covered under the Medicaid State plan are available and accessible to NorthSTAR enrollees. These services are included in the mental health and chemical dependency benefits described in Appendices 8A and Appendix 8B to the Contract.

a. Delivery Network
(1) Maintaining and monitoring a network.
(a) Supported by written agreements.

Contract, §3.8: "Contractor shall maintain written subcontracts with all subcontractors, including providers and other subcontractors, and monitor performance under such subcontracts."

Contract, §8.13.1: "Contractor shall enter into subcontracts with its providers and monitor performance of such subcontracts in compliance with §3.8 of the Contract and with 42 CFR §438.230."

(b) Sufficient to provide adequate access to all covered services under the Contract.

Contract, §8.1.1: "Contractor shall maintain a viable provider network in the service area that meets Contractor's State-approved provider network plan and that is sufficient to provide adequate access to the full scope of covered services to Enrollees and that complies with 42 CFR Part 438, Sections 438.206 through 438.214."

Contract, §8.1.2: "Contractor shall include the following providers in its network:

(a) Non-Facility Based Providers
   1. Psychiatrists
   2. Psychologists
   3. Licensed Professional Counselors, Licensed Master's Social Workers-ACP
   4. Licensed Chemical Dependency Counselors
   5. Other Qualified Credentialed Counselors (QCC)

(b) Facility-Based Providers
   1. Freestanding psychiatric facility
   2. General acute facility that delivers behavioral health services
   3. State psychiatric facility
   4. Psychiatric partial hospitalization/ day treatment program
   5. Outpatient chemical dependency treatment program
   6. Inpatient chemical dependency treatment program
   7. Outpatient chemical dependency detoxification program
   8. Inpatient chemical dependency detoxification program
   9. Specialized female chemical dependency treatment program
   10. Intensive outpatient chemical dependency treatment program
   11. Chemical dependency partial hospitalization program
   12. Residential chemical dependency treatment program
   13. Pharmacotherapy program
   14. Dual diagnosis, including detoxification, program.
   15. Mobile Crisis
   16. Youth Programs

(c) Community Hospitals

Contractor shall maintain a community hospital bed capacity of 60 beds per day for inpatient services. Notwithstanding the foregoing, Contractor shall ensure the provision of all medically necessary services to enrollees."

Contract, §8.1.3: "Contractor shall have a system for monitoring patient load on its provider network so that the Contractor can effectively plan for future needs and recruit providers as necessary to assure adequate access to all covered services."

Contract, §7.12.5: "Contractor shall ensure the continued availability of behavioral health providers, including specialty providers, programs and services, based on the assessed needs of the Enrollees."

Contract, §8.1.9: "Contractor shall include in its provider network rural hospitals, physicians, home and community support services service agencies, and other rural health providers who:

(a) Are sole community providers

(b) Agree to accept Contractor's prevailing provider contract rate, and

(c) Meet Contractor's credentials, provided that lack of board certification or accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) may not be the sole ground for exclusion from the provider network."

Contract, §8.6: "Contractor shall ensure Enrollees are not required to travel in excess of 30 miles to secure covered services, with the exception of psychiatric hospitalization, 24-hour residential rehabilitation and inpatient detoxification services, for which Enrollees may not be required to travel in excess of 75 miles."

(c) Provide for a second opinion.

Contract, §8.1.11: "Contractor shall provide for a second opinion from a qualified behavioral health professional within the network, or arrange for the Enrollee to obtain a second opinion outside the network, at no cost to the Enrollee."

(d) Out of network services.

Contract, §8.2.1: "Contractor shall promote and ensure access to covered services within its provider network. If Contractor's provider network is unable to provide medically necessary covered services to an Enrollee, Contractor shall adequately and timely cover these services out of network for the Enrollee for as long as the Contractor is unable to provide the services through the network. Contractor shall coordinate care with out-of-network providers and provide necessary follow-up services."

(e) Provider credentialing.

Contract, §8.5: "Contractor shall credential all providers in accordance with 42 CFR§438.214 and with Appendix 14."

b. Timely Access

(a) State standards for timely access to care and services.

Contract, §7.12.1: "Contractor shall make medically necessary covered services available 24 hours a day, seven days a week within the following time periods:

a) Emergency behavioral health services; immediately;

b) Urgent Care: within 24 hours of request, including transfer between levels of care during a chemical dependency episode;

c) Routine Care: within 14 calendar days of request;

d) For telephone services and queries:

1. telephone callers reach a non-recorded voice within 30 seconds, and
2. telephone abandonment rates do not exceed 5 percent at any given time."

Contract, §7.12.2: "Contractor shall ensure Enrollee access to covered services by providing flexible hours of operation, including evening and weekend hours, and providing services in alternative settings, such as homes and schools."

Contract, §8.13.2 : "Contractor shall require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services."

(b) Hours of operation.

Contract, §7.12.1: "Contractor shall make medically necessary covered services available 24 hours a day, seven days a week within the following time periods ."

a) Emergency behavioral health services; immediately;
b) Urgent Care: within 24 hours of request, including transfer between levels of care during a chemical dependency episode;
c) Routine Care: within 14 calendar days of request;
d) For telephone services and queries:
1. telephone callers reach a non-recorded voice within 30 seconds, and
2. telephone abandonment rates do not exceed 5 percent at any given time."

Contract, §8.13.3: "Contractor shall ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves Medicaid enrollees."

(c) Compliance by providers.

Contract, §8.13.4: "Contractor shall establish mechanism to ensure compliance by providers and monitor providers regularly to determine compliance and take corrective action if there is failure to comply."

c. Cultural Considerations

Contract, §6.14.1 Contractor shall subcontract with and make referrals to providers from different cultural groups so that each Enrollee who needs culturally appropriate services may receive services from a provider who shares his cultural background, values and perspective.

Contract, §6.14.2 Contractor shall ensure equal access and participation in NorthSTAR for limited English proficient individuals through the provision of bilingual services. Contractor shall coordinate services with community advocates and agencies that assist non-English speaking individuals or that provide other culturally appropriate services.

Contract, §6.14.4: "Contractor shall make oral interpretation services for all non-English languages free of charge. Contractor shall notify enrollees and potential enrollees that

oral interpretation services are available for any language and that written information is available in alternative formats and in languages of populations groups that comprise more than 10% of the covered liveshow to access those services and formats.."

Contract, §6.14.5: "Contractor shall provide 24-hour access to interpreter services for Enrollees to access emergency behavioral health services within Contractor's network either through telephone language services or interpreters."

Contract, §6.14.5c: "Contractor shall have an identified staff member to assist Enrollees who are deaf or hard-of-hearing individuals."

2. 42 CFR §438.207 - Assurances of Adequate Capacity and Services

a. Documentation of Appropriate Range of Services for Enrollees.
The range of available services is documented in the NorthSTAR Data Book, which also includes information to monitor network provider capacity. In addition, the BHO submits a monthly report to the State, the Provider Network Change Report. All providers added to or removed from the network are detailed in this report. The State also tracks the number and type of complaints reported to become aware of possible trends with any particular provider.

b. Documentation of Network of Providers.

Contractor shall maintain an automated standardized provider network change report summarizing changes in the Contractor's provider network. The report shall be submitted electronically to the State and to the Enrollment Broker on the 15th day following the end of each quarter. The report shall identify all provider network changes for that quarter, including:

a) Number of participating significant traditional providers;
b) The change in providers' HUB status; and

The number of providers who have ceased participation in the provider network and the reason(s) the provider ceased such participation.

c) The report shall also include the impact of any provider network changes on Enrollees' geographic access and cultural and linguistic services. The report shall be in the format described in Appendix 24A, for individual providers, or Appendix 24B, for facility providers.

3. 42 CFR §438.208 - Coordination and Continuity of Care
a. Primary care and coordination of health care services

Contract, §7.12.7: "Contractor shall implement policies and procedures to ensure effective information sharing and monitoring of diagnosis, treatment, follow-up and medication usage between providers and other health care plans."

7.13.1 Contractor shall coordinate care with physical health care plans participating in STAR according to the Memorandum of Agreement for Coordination of Medicaid

Services entered into between STAR MCOs and NorthSTAR BHOs (APPENDIX 3) and in accordance with 42 CFR §438.208(b).

Contract, §5.4: "Contractor may only receive and disclose individually identifiable health information ("health information") to carry out Contractor's duties relating to treatment, payment or health care operations, as defined in 45 CFR §164.501, and as required under this contract. When using or disclosing health care information or when requesting health information from another entity, Contractor shall make reasonable efforts to limit the health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request."

b. Additional services for enrollees with special health care needs
(1) Identification.

Contract, §8.8.1: "Contractor shall contract with an SPN to arrange for or provide intensive treatment and care management for adults with SMI or children with SED. "

Contract, §8.8.4: "Individuals who are eligible for services through the SPN are:

a) Individuals who require multiple services or multiple agency involvement will be assigned to the SPN. For purposes of this subsection, "multiple services" means services in addition to medication services. Individuals discharged from state psychiatric hospitals will also be referred to the SPN when the need for specialty services is indicated; and
b) Through the intake and assessment process, Contractor will identify Enrollees eligible for covered services through the SPN and will authorize the Enrollee to receive these services through the SPN. Contractor shall make reasonable efforts to ensure that the Enrollee follows through on the referral and is engaged in treatment. Contractor is also responsible for authorizations, UM, UR and quality oversight of services provided by the SPN."

(2) Assessment.

Contract, §8.8.3: "In collaboration with Contractor, the SPN will:

a) Assess using DSHS approved assessment instrument, develop a treatment plan and ensure service coordination for each Enrollee for whom the SPN is responsible;
b) Assess persons referred by the courts for involuntary mental health commitments and provide service coordination to ensure appropriate coordination of treatment;
c) Provide specialized mental health services for adults with SMI;
d) Provide specialty mental health services to children with SED;
e) Provide outreach to persons with mental illness in local jails and juvenile facilities; and
f) Provide information and data as required to Contractor to track services, treatment outcomes and costs."

4. 42 CFR §438.210 - Coverage and Authorization of Services

a. Coverage.

Contract, §7.1.1: "Appendix 8A describes the scope of mental health benefits. Appendix 8B describes the scope of chemical dependency benefits. Contractor shall provide medically necessary services to enrollees in the amount, duration and scope that can reasonably be expected to achieve the purpose for which the services are provided. Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required services because of a diagnosis, type of illness, or condition of the enrollee."

Contract, §7.1.3: "Mental health benefits for enrolled youth is not limited. Utilization shall be based on meeting medical necessity criteria."

Contract, §7.2: "The following behavioral health services are excluded from the NorthSTAR benefits for Medicaid individuals, but are covered for Medicaid individuals enrolled in the STAR program:

a) Screening for behavioral health disorders during well adult checks;
b) THSteps exams and other ambulatory health exams;
c) Emergency medical transportation for behavioral health emergencies;
d) Behavioral health services provided by primary care physicians, other STAR physicians or other applicable Medicaid physicians within the scope of their licenses;
e) Behavioral health services provided by federally qualified health centers and rural health clinics;
f) Ambulatory laboratory services for Medicaid eligible individuals, and
g) Certain emergency room and inpatient hospital services, as described in Appendix 3.

Medication benefits are also excluded from the NorthSTAR benefits for Medicaid enrollees, but are covered in the Medicaid Vendor Drug Program."

Contract, Appendix 1 (Definitions): "Medically Necessary Service – A behavioral health service that:

A. is reasonably necessary for the diagnosis or treatment of a mental health or chemical dependency disorder to improve or maintain an individual's level of functioning resulting from such a disorder;
B. is in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
C. is furnished in the most appropriate and least restrictive setting in which services can be safely provided;
D. is the most appropriate level or supply of service which can safely be provided; and
E. Could not be omitted without adversely affecting the individual's mental and/or physical health or the quality of care rendered."

b. Authorization.

Contract, §7.19.2: "Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested shall be reviewed by board certified or board eligible psychiatrists of the same or similar specialty as the services being denied. If the service denials are for children's services, the denial review shall be made by a board eligible or certified child psychiatrist. If chemical dependency services are denied, the denial shall be made by a physician or psychiatrist who is a certified addictionologist or has American Society for Addictive Medicine (ASAM) certification or a psychiatrist who can demonstrate the equivalence to such certification through training and experience. Contractor shall consult with the requesting provider when appropriate."

Contract, §7.19.3: "Contractor must maintain a comprehensive UM manual, which complies with DSHS-approved UM criteria. Contractor must ensure that all UM reviewers apply the UM criteria consistently and in compliance with applicable TDI statutes. Any changes must be approved by DSHS."

Contract, §7.19.4: "Contractor may not require prior notification or authorization for emergency behavioral health services before such services are delivered."

d. Notice of adverse action.

Contract, §6.12.3: "Contractor shall comply with the Enrollee complaint system procedures approved by the State. The Enrollee complaint system procedures shall include the following:

> . . .
> (c) Written notice to the enrollee and notice to the requesting provider within the timeframes specified in 42 CFR §438.404(c), meeting the linguistic requirements of Section 6.14.3 of this Contract, of any action or adverse action and containing the following information: an explanation of the action the contractor has taken or intends to take; the reasons for the action, the enrollee's or provider's right to file an appeal of the action; the enrollee's right to request an appeal and, for life-threatening conditions: prior to exhausting the Contractor's complaint procedures, the right of the Medicaid enrollee to request a State fair hearing and the right of the non-Medicaid enrollee to request a review by an Independent Review Organization; the procedures for exercising the enrollee's rights, and circumstances under which expedited resolution of appeals is available and how to request it; the enrollee's right to have benefits continued pending resolution of the appeal, and the circumstances under which the enrollee may be required to pay the costs of these services."

e. Timeframe for decision.

Contract, §6.12.3: "Contractor shall comply with the Enrollee complaint system procedures approved by the State. The Enrollee complaint system procedures shall include the following:

> . . .
> (m) Standard resolution of appeals of actions and adverse actions and notification of such resolution shall be completed not later than the 30th calendar day after receipt of written request for appeal. Expedited appeals concerning emergencies, denials of continued stays for hospitalization and denials of care for life-threatening conditions, in accordance with Texas Insurance Code, Articles 20A.12 and 21.58A and expedited resolution of appeals, in accordance with 42 CFR §§ 438.408 and 438.410."

Contract, §7.19.5: "For all routine care requests, Contractor shall complete the authorization process and communicate a decision to the provider within twenty-four hours of the provider's request. For urgent service requests, Contractor shall communicate its decision to the provider within five hours of the provider's request."

f. Compensation for utilization management activities.

Contract, §7.19.9: "Contractor shall ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Enrollee."

§12.12 Ownership of Data

The State shall be and remain the sole and exclusive owner of any and all data (the "State's Data") pertaining to the operation of NorthSTAR. The State's Data includes all data entered into Contractor's MIS System, including without limitation, all Covered Lives and Enrollee information, eligibility data, claims reports, utilization reports, and any information from the State's present data processing and information system which shall be transferred and converted to operate on Contractor's MIS System. Neither Contractor nor any of its employees, agents, consultants, or assigns shall have any rights in any of the State's Data in any form including, but not limited to, raw data, stripped data, cumulated data, usage information, and statistical information derived from or in connection with the State's Data. The parties agree that Contractor shall promptly download for and provide to the State, at no cost to the State, all such State's Data in an electronically accessible form upon the termination of this Contract. Nothing in this section precludes Contractor from maintaining a copy of the data elements listed in this section. This provision shall survive the term or termination of this Contract.

B. STRUCTURE AND OPERATION STANDARDS

1. 42 CFR §438.14 - Provider Selection

a. Credentialing and recredentialing.

Contract, §8.6: "Contractor shall credential all providers in accordance with 42 CFR §438.214 and with Appendix 14."

b. Nondiscrimination.

Contract, §8.1.5: "Contractor's provider selection policies and procedures shall not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment."

c. Excluded providers.

Contract,§8.1.8: "Contractor may not contract with providers who have been excluded from participating in the Medicaid or Medicare programs."

Contract, §8.1.10: "Contractor may not contract with any contractor who is not in good standing with the State."

2. 42 CFR §438.218 - Enrollee Information

The State complies with the information requirements under §438.10, which constitute part of the State's quality strategy at §438.204.

3. 42 CFR §438.224 - Safeguarding Information

Contract, §5.4: "Contractor may only receive and disclose individually identifiable health information ("health information") to carry out Contractor's duties relating to treatment, payment or health care operations, as defined in 45 CFR §164.501, and as required under this contract. When using or disclosing health care information or when requesting health information from another entity, Contractor shall make reasonable efforts to limit the health information to the minimum necessary to accomplish the intended purpose of the use, disclosure or request."

Contract, §5.4.2: "Contractor shall inform Enrollees, subcontractors, and providers of the provisions of 42 CFR Part 431, Subpart F, regarding Safeguarding Information on Applicants and Recipients, and Contractor shall ensure that confidential information is protected from disclosure except for authorized purposes."

4. 42 CFR §438.226 - Enrollment and Disenrollment

6.5.1 Contractor shall ensure that Enrollee requests for disenrollment are not processed through Contractor's complaint procedures but are submitted to the State for processing within five business days after the Contractor receives the disenrollment request.

Contract, §6.6.1: "Contractor may request disenrollment of an Enrollee against his or her will under limited conditions. These conditions include, but are not limited to:

a) Severe disruptive behavior not caused by a behavioral health condition at a network provider's office;

b) Fraudulent loaning of the Enrollee's Medicaid identification card to another person, or
c) the Enrollee no longer meets the eligibility criteria set forth in §6.1."

Contract, §6.6.2: "Contractor may not request a disenrollment based on any of the following:

a) An adverse change in the Enrollee's health or behavioral health status;
b) The Enrollee's utilization of services;
c) Enrollee's race, color, national origin, sex, age, disability, political beliefs or religion;
d) Enrollee's diminished mental capacity, or
e) Enrollee's uncooperative or disruptive behavior due to his or her behavioral health condition."

Contract, §6.6.3: "Prior to exercising a right to disenroll an Enrollee under this section, Contractor shall:

a) Document that necessary steps have been taken to educate the Enrollee regarding the conditions for disenrollment listed in §6.6.1 above, and
b) If an Enrollee exhibits disruptive behavior, Contractor shall work with the Enrollee and his family, as appropriate, to develop a plan to address the disruptive behavior prior to requesting disenrollment of the Enrollee."

Contract, §6.6.4: "The State shall approve all involuntary disenrollments. No involuntary disenrollment will be effective until the State has approved the request for disenrollment."

Contract, §6.6.6: "Contractor shall provide the State with a written request to disenroll an Enrollee against his or her will."

5. 42 CFR §438.228 -Grievance Systems

6. 42 CFR §438.230 - Subcontractual Relationships and Delegation

C. MEASUREMENT AND IMPROVEMENT STANDARDS

1. Practice Guidelines

Contract, §7.19.6: "Contractor shall adopt practice guidelines that meet the following requirements:

a) are based on valid and reliable clinical evidence or a consensus of health care professionals in the behavioral healthcare field;
b) consider the needs of the enrollees;
c) are adopted in consultation with contracting health care professionals;
d) are reviewed and updated periodically as appropriate."

7.19.7 Contractor shall disseminate the practice guidelines to all affected providers and upon request, to enrollees and potential enrollees.

2. Quality Assessment and Performance Improvement Program

Contract, §3.10.2: "Contractor shall conduct performance improvement projects designed to achieve, through ongoing measurements and intervention, significant improved, sustained over time, in clinical and nonclinical care areas. Contractor shall have mechanisms to detect both underutilization and overutilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs."

3.10.4 Contractor shall report the status and results of each project to the State as requested. Each performance improvement project shall be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

3.10.5 Contractor's QAPI program shall apply to covered services received by all Enrollees regardless of their eligibility type.

3.10.6 Contractor shall submit a description of its QAPI for approval to the State by August 31, 2006.

3.10.7 Contractor shall comply with the medical records standards contained in Appendix 2 or the treatment records standards contained in the current National Committee for Quality Assurance (NCQA) Standards for Managed Behavioral Health Care Organizations, or Joint Commission on Accreditation of Healthcare Operations (JCAHO), or the Utilization Review Accreditation Committee (URAC)

3. Health Information Systems

II. STATE PROCEDURES (42 CFR §438.204(b))

Information on race, ethnicity, and primary language is obtained in the enrollment process. Maximus, the enrollment broker, is contracted with the STAR health plan. This contract is overseen by the State Medicaid Agency, the Texas Health and Human Services Commission

The State conducts the following quality monitoring activities:

A. CONSUMER ADVOCACY AND INVOLVEMENT

Through local Regional Advisory Committee (RAC) meetings and the Local Behavioral Health Authority, consumers will have meaningful input into the policy directions,

resolution of complaints, and quality and scope of care provided. The BHO will also include consumers on their internal quality improvement committees.

B. CONTRACT COMPLIANCE MONITORING

Using methods including onsite reviews and monitoring of deliverables, the State will monitor the Contractors conformance with contract requirements. In addition, performance incentives and penalties within the contract will assist the State in encouraging compliance.

C. COMPREHENSIVE ANALYSIS OF DATA

Using advance data collection and analysis techniques, the State will monitor major aspects of the BHO's activities including types of care, frequency of services, claims payment information, financial information, and clinical quality indications including outcome measurement.

D. FOCUSED STUDIES

The State, the EQRO, and the BHO will collaborate on two State approved focused studies. These studies will meet the requirements of the QAPI standards.

E. CONSUMER AND LOCAL REVIEW OF REPORTS DATA AND COMPLAINTS

The LBHA and RAC will review the results of monitoring activities and participate in interpretation and development of corrective action plans, and new policies relating to the program.

III. NATIONAL PERFORMANCE MEASURES (42 CFR §438.204(c))

The State uses the few HEDIS measures that are relevant to behavioral health.

IV. ANNUAL, EXTERNAL INDEPENDENT REVIEWS (42 CFR §438.204(d))

In compliance with CMS requirements, the State contracts with a External Quality Review Organization (EQRO) to review, on an annual basis, the quality of services delivered by the BHO. The EQRO is a private accreditation organization approved by CMS. The EQRO is not a part of the State government, and is not a managed care organization or an association of managed care organizations. The current EQRO is Institute for Child Health Policy (ICHP).

<u>On Site Review by External Quality Review Organization (EQRO)</u>

The EQRO will perform yearly onsite surveys of the BHO in order to determine compliance with the contract provisions.

Customer satisfaction survey
Texas Health and Human Services Commission (HHSC) or the EQRO will perform a customer satisfaction survey in collaboration with the BHO and the DSHS.
Provider satisfaction survey
Texas Health and Human Services Commission (HHSC) or the EQRO will perform a provider satisfaction survey in collaboration with the BHO and DSHS.

V. INFORMATION SYSTEM (42 CFR §438.204(f))

Our data system provides us with detailed information on enrollment, encounter, drug, and assessment data. Thus, the State has the capacity to monitor any or all of these data categories for quality and performance information. Since we own the data, we have flexibility to use our analyses to monitor any indicators and make adjustments, if necessary, for quality improvement.