Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations
Monitoring Report Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's serious mental illness and serious emotional disturbance (SMI/SED) demonstration or the SMI/SED component of the broader demonstration

The state should complete this title page at the beginning of a demonstration and submit as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	District of Columbia
Demonstration name	Behavioral Health Transformation
Approval period for section 1115 demonstration	01/01/2020 – 12/31/2024
SMI/SED demonstration start date[a]	01/01/2020
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	Click here to enter text.
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	The goal of this demonstration is for the District to maintain and enhance access to mental health services and continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries with serious mental illness (SMI) and serious emotional disturbance (SED). This demonstration authorizes the District to receive federal financial participation (FFP) for delivering high-quality, clinically appropriate treatment to beneficiaries diagnosed with SMI and receiving treatment while they are short-term residents in settings that qualify as Institutions for Mental Diseases (IMD). This demonstration also complements the District's efforts to implement models of care that are focused on increasing supports for individuals outside of institutions, in home and community-based settings (HCBS) to improve their access to SMI/SED services at varied levels of intensity.
SMI/SED demonstration year and quarter	SMI/SED DY2Q4
Reporting period	10/01/2021 – 12/31/2021

[a] SMI/SED demonstration start date: For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SMI/SED demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions of mental disease.

2. Executive summary

There were some significant changes in the SMI quarterly measures, as explained below. There were also significant increases in the HIT metrics due to the activities of the HIE Connectivity grant, as outlined in the implementation plan. Finally, there were significant increases in the number of grievances and critical incidents. The District attributes these changes to natural variation.

Per the Annual Availability Assessment, beneficiaries with mental health service needs has held fairly steady since the initial assessment and the District has seen mostly increases in the availability of mental health services.

The District expended $27,048,588.35 in local funding for outpatient community-based mental health services in FY21, compared to $30,343,484.26 in FY19, a variance of $3,294,895.91. Several factors contributed to the decline in local expenditures and are detailed in the relevant section below.

The District held the annual post-award public forum on October 18, 2021. Over 100 attendees participated in the meeting. Several questions were asked during the forum and one set of written questions was submitted.

3. Narrative information on implementation, by milestone and reporting topic

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings (Milestone 1)			
1.1. Metric trends			
1.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 1.	X		
1.2. Implementation update			
1.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 1.2.1a. The licensure or accreditation processes for participating hospitals and residential settings	X		
1.2.1b. The oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	X		
1.2.1c. The utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	X		
1.2.1d. The program integrity requirements and compliance assurance process	X		
1.2.1e. The state requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	X		
1.2.1f. Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings	X		
1.2.2. The state expects to make other program changes that may affect metrics related to Milestone 1.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
2. Improving Care Coordination and Transitions to Community-Based Care (Milestone 2)			
2.1. Metric trends			
2.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 2.	X		
2.2. Implementation update			
2.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 2.2.1a. Actions to ensure that psychiatric hospitals and residential treatment settings carry out intensive pre-discharge planning, and include community-based providers in care transitions	X		
2.2.1b. Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers	X		
2.2.1c. State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers within 72 hours post discharge	X		
2.2.1d. Strategies to prevent or decrease the lengths of stay in EDs among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers)	X		
2.2.1e. Other State requirements/policies to improve care coordination and connections to community-based care	X		
2.2.2. The state expects to make other program changes that may affect metrics related to Milestone 2.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
3. Access to Continuum of Care, Including Crisis Stabilization (Milestone 3)			
3.1. Metric trends			
3.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 3.		#14: Intensive Outpatient and Partial Hospitalization #16: ED #17: Telehealth	DHCF calculated the following changes that were less or more than 2% between Q2 (4/1/21-6/30/21) and Q3 (7/1/21-9/30/21): • There was a 6% increase in the number of Medicaid beneficiaries receiving intensive outpatient and partial hospitalization services. This is consistent with the increase in SMI utilization that we have observed since the initial drop from the COVID-19 public health emergency. • There was a 16% decrease in the number of Medicaid beneficiaries receiving ED services. We attribute the decrease to the COVID surge caused by the Delta variant over the summer/fall of 2021, which may have led to a decrease in beneficiaries seeking emergency care. • There was an 18% decrease in the number of Medicaid beneficiaries receiving telehealth services. The District experienced a similar decline in telehealth services overall (not limited to mental health services) and it may be attributed to more beneficiaries seeking care in-person.
3.2. Implementation update			
3.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 3.2.1a. State requirement that providers use an evidenced-based, publicly-available patient assessment tool to determine appropriate level of care and length of stay	X		
3.2.1b. Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	X		
3.2.2. The state expects to make other program changes that may affect metrics related to Milestone 3.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
4. Earlier Identification and Engagement in Treatment, Including Through Increased Integration (Milestone 4)			
4.1. Metric trends			
4.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to Milestone 4.		#21: Count of beneficiaries with SMI/SED (monthly)	There was a 3% increase in the number of Medicaid beneficiaries with SMI/SED between Q2 (4/1/21-6/30/21) and Q3 (7/1/21-9/30/21). We attribute this increase to a return to more normal utilization since the initial impacts of the COVID-19 public health emergency.
4.2. Implementation update			
4.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 4.2.1a. Strategies for identifying and engaging beneficiaries in treatment sooner (e.g., with supported education and employment)	X		
4.2.1b. Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	X		
4.2.1c. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED	X		
4.2.1d. Other state strategies to increase earlier identification/engagement, integration, and specialized programs for young people	X		
4.2.2. The state expects to make other program changes that may affect metrics related to Milestone 4.	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5. SMI/SED health information technology (health IT)			
5.1. Metric trends			
5.1.1. The state reports the following metric trends, including all changes (+ or -) greater than 2 percent related to its health IT metrics.		Q1: Active DC HIE behavioral health provider users	Q1: The number of active DC HIE behavioral health provider users increased by 5.8% due to the activities of the HIE Connectivity grant. As outlined in the implementation plan, the HIE Connectivity grant provides technical assistance to connect nearly all Medicaid providers to HIE by 2022 and behavioral health providers were assigned priority for technical assistance.
		S1: DC Medicaid-enrolled behavioral health care facilities/ providers receiving data from the HIE	S1: The number of DC Medicaid-enrolled behavioral health care facilities/providers receiving data from the HIE increased by 9.1% due to the activities of the HIE Connectivity grant, as described above.
		Q2: Behavioral health providers managed in provider directory	Q2: The 14.6% increase in the number of behavioral health providers managed in provider directory corresponds with the overall increase in the number of active DC HIE behavioral health provider users, as described above.
		Q3: DC HIE behavioral health users who performed a patient care snapshot in the last 30 days	Q3: The 10.3% increase in the number of behavioral health users who performed a patient care snapshot corresponds with the overall increase in the number of active DC HIE behavioral health provider users, as described above.
5.2. Implementation update			
5.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes: 5.2.1a. The three statements of assurance made in the state's health IT plan	X		

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
5.2.1b. Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider and/or physician/mental health provider to community-based supports	X		
5.2.1c. Electronic care plans and medical records	X		
5.2.1d. Individual consent being electronically captured and made accessible to patients and all members of the care team	X		
5.2.1e. Intake, assessment and screening tools being part of a structured data capture process so that this information is interoperable with the rest of the health IT ecosystem	X		
5.2.1f. Telehealth technologies supporting collaborative care by facilitating broader availability of integrated mental health care and primary care	X		
5.2.1g. Alerting/analytics	X		
5.2.1h. Identity management	X		
5.2.2. The state expects to make other program changes that may affect metrics related to health IT.	X		
6. Other SMI/SED-related metrics			
6.1. Metric trends			
6.1.1. The state reports the following metric trends, including all changes (+ or -) greater than two 2 percent related to other SMI/SED-related metrics.		#36: Grievances Related to Services for SMI/SED #38: Critical Incidents Related to Services for SMI/SED	#36: The District believes that the 550% increase in grievances is due to natural variation. #38: The District believes the 32% increase in critical incidents is due to natural variation.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State response
6.2. Implementation update			
6.2.1. The state expects to make the following program changes that may affect other SMI/SED-related metrics.	X		

4. Narrative information on other reporting topics

Prompt	State has no trends/update to report (place an X)	State response
7. Annual Assessment of the Availability of Mental Health Services (Annual Availability Assessment)		
7.1. Description of changes to baseline conditions and practices		
7.1.1. Describe and explain any changes in the mental health service needs (for example, prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.		The share of beneficiaries with mental health service needs, as measured based on the presence of an SMI/SED diagnosis, has held fairly steady between the initial assessment of the availability of mental health services (2019) and the current assessment of the availability of mental health services (2021). The percentage of Medicaid beneficiaries with an SMI/SED decreased from 15% to 14%. The percentage of Medicaid beneficiaries with an SMI/SED by age remains the same: 20% of adults in 2019 and 2021 and 3% of children in 2019 and 2021. There were small changes in the number of adults and children with an SMI/SED between 2019 and 2021. The number of adults increased from 35,337 to 37,841 and the number of children decreased from 2,744 to 2,409.
7.1.2. Describe and explain any changes to the organization of the state's Medicaid behavioral health service delivery system compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.		Since the initial assessment, the District has begun reimbursing for behavioral health services provided to individuals with SMI/SED or SUD by psychologists and other licensed behavioral health providers practicing independently (in either a separate practice or hospital setting). The District also issued rulemaking and implemented new crisis stabilization reimbursement methodologies to increasing the availability of non-hospital, non-residential crisis stabilization services.

Prompt	State has no trends/update to report (place an X)	State response
7.1.3. Describe and explain any changes in the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state compared to those described in the Initial Assessment of the Availability of Mental Health Services. At minimum, explain any changes across the state in the availability of the following services: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. Recommended word count is 500 words or less.		Changes in availability between the two assessments include: - The number of Medicaid-enrolled psychologists and other licensed BH providers practicing independently increased from 0 to 46. - The number of Medicaid-enrolled crisis stabilization units increased from 1 to 3. - The number of crisis call centers (1), mobile crisis units (2), crisis observation/assessment centers (1), and coordinated community crisis response teams (1) stayed the same. - The number of Medicaid-enrolled FQHCs that offer behavioral health services increased from 42 to 54 (29% increase). - The number of Medicaid-enrolled psychiatrists or other practitioners authorized to prescribe psychiatric medications decreased from 423 to 400 (5% decrease). - The number of licensed psychiatric hospital beds increased from 605 to 625, while the number of psychiatric hospitals (2) and the number Medicaid-enrolled psychiatric units in acute care hospitals (7) remained unchanged.
7.1.4. Describe and explain any changes in gaps the state identified in the availability of mental health services or service capacity while completing the Annual Availability Assessment compared to those described in the Initial Assessment of the Availability of Mental Health Services. Recommended word count is 500 words or less.		Gaps identified by the District are reflected in part by changes to reimbursement policies noted above. With regard to independent licensed BH practitioners and crisis stabilization in particular, both saw an increase in the number of Medicaid-enrolled providers offering these services.
7.1.5. Describe and explain whether any changes in the availability of mental health services have impacted the state's maintenance of effort (MOE) on funding outpatient community-based mental health services. Recommended word count is 500 words or less.		Changes in the availability of mental health services have not impacted the District's maintenance of effort. Other changes that affected the maintenance of effort are described in Section 8 below.
7.2. Implementation update		
7.2.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 7.2.1a. The state's strategy to conduct annual assessments of the availability of mental health services across the state and updates on steps taken to increase availability		In recognition of the need for a more holistic view of the demand for and supply of behavioral health services in the District, additional analytic resources are being devoted to this effort over the next year (e.g., through the District's contract with its independent evaluator, AIR). The results of this effort will inform future annual availability assessments.

Prompt	State has no trends/update to report (place an X)	State response
7.2.1b. Strategies to improve state tracking of availability of inpatient and crisis stabilization beds		
8. Maintenance of effort (MOE) on funding outpatient community-based mental health services		
8.1. MOE dollar amount		
8.1.1. Provide as a dollar amount the level of state appropriations and local funding for outpatient community-based mental health services for the most recently completed state fiscal year.		The District expended $27,048,588.35 in local funding for outpatient community-based mental health services in FY21, compared to $30,343,484.26 in FY19, a variance of $3,294,895.91.
8.2. Narrative information		
8.2.1. Describe and explain any reductions in the MOE dollar amount below the amount provided in the state's application materials. The state should confirm that it did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.		The District saw a 10.9 percent reduction in local expenditures for outpatient community-based mental health services in FY21 compared to the amount provided in our application materials. The decline in local expenditures is due to several factors. On October 1, 2020 (the beginning of FY21), the District implemented two policy changes that dramatically reduced the local expenditures reflected in the dollar amount provided above. First, DC Medicaid transitioned approximately 18,000 beneficiaries from fee-for-service to managed care organizations (MCOs). Most mental health services are carved out of the MCO contracts but federally qualified health center (FQHC) mental health spending and free-standing mental health clinic (FSMHC) spending are not. FQHC mental health spending and FSMHC spending that was previously reported on a fee-for-service basis is now included in the MCO capitation payments and not reflected in the dollar amount provided above. Second, DC Medicaid transitioned from fee-for-service FQHC wrap payments to requiring the MCOs to pay FQHCs at the fee-for-service APM rate, thus negating the necessity of wrap payments. The previous fee-for-service expenditures on wrap payments are now included in the MCO capitation payment and therefore not reflected in the dollar amount provided above. In addition to these factors, during FY21 increased federal matching funds were available to the District during the public health emergency under the federal CARES Act and contributed to a proportionate decline in local expenditures. Finally, there was also decreased mental health service utilization during the COVID-19 public health emergency. The District did not move resources to increase access to treatment in inpatient or residential settings at the expense of community-based services.

Prompt	State has no trends/update to report (place an X)	State response
9. SMI/SED financing plan		
9.1. Implementation update		
9.1.1. Compared to the demonstration design and operational details, the state expects to make the following changes to: 9.1.1a. Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, and observation/assessment centers, with a coordinated community crisis response that involves law enforcement and other first responders	X	
9.1.1b. Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model	X	
10. Budget neutrality		
10.1. Current status and analysis		
10.1.1. Describe the current status of budget neutrality and an analysis of the budget neutrality to date. If the SMI/SED component is part of a broader demonstration, the state should provide an analysis of the SMI/SED-related budget neutrality and an analysis of budget neutrality as a whole.		The District is working with CMS program staff to request changes to the PMPM threshold upon which our 1115 Behavioral Health Transformation waiver budget neutrality is based. Two of the MEG have been affected by fundamental and unforeseen changes in the underlying assumptions made to create the PMPM thresholds including: 1) direction from CMS not to include the $1 MAT copay waiver in our expenditure reports, and 2) the transition of approximately 18,000 aged, blind, and disabled persons from the DC Medicaid's FFS program into managed care on October 1, 2020.

Prompt	State has no trends/update to report (place an X)	State response
10.2. Implementation update		
10.2.1. The state expects to make the following program changes that may affect budget neutrality.		The District plans to implement changes to the methodologies used to calculate rates for some waiver services in FY24 (Q4 of WY4). Many of these services will also be carved into our managed care contracts. These changes will likely result in rate increases and/or significant shifts from the underlying assumptions used to calculate the current PMPM thresholds. The agency is in the midst of fine-tuning these anticipated programmatic changes and is unable to calculate impact at this time.
11. SMI/SED-related demonstration operations and policy		
11.1. Considerations		
11.1.1. The state should highlight significant SMI/SED (or if broader demonstration, then SMI/SED-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SMI/SED demonstration's approved goals or objectives, if not already reported elsewhere in this document. See Monitoring Report Instructions for more detail.		The COVID-19 public health emergency has the potential to broadly affect DC Medicaid. The public health emergency could impact beneficiary enrollment, access to services, and timely provision of services.
11.2. Implementation update		
11.2.1. The state experienced challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers) and/or noted any performance issues with contracted entities.	X	
11.2.2. The state is working on other initiatives related to SMI/SED.	X	
11.2.3. The initiatives described above are related to the SMI/SED demonstration as described (The state should note similarities and differences from the SMI/SED demonstration).	X	

Prompt	State has no trends/update to report (place an X)	State response
11.2.4. Compared to the demonstration design and operational details, the state expects to make the following changes to: 11.2.4a. How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)	X	
11.2.4b. Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)	X	
11.2.4c. Partners involved in service delivery	X	
11.2.4d. The state Medicaid agency's Memorandum of Understanding (MOU) or other agreement with its mental health services agency	X	
12. SMI/SED demonstration evaluation update		
12.1. Narrative information		
12.1.1. Provide updates on SMI/SED evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. There are specific requirements per the Code of Federal Regulations (CFR) for annual reports. See Monitoring Report Instructions for more details.		In accordance with the District's approved evaluation design: • AIR continued to develop code for quantitative data analysis and DHCF provided guidance as needed. • AIR continued its work on the mid-point assessment report and shared a draft report during the quarter. • AIR conducted follow-up discussions to inform the mid-point assessment.
12.1.2. Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.	X	
12.1.3. List anticipated evaluation-related deliverables related to this demonstration and their due dates.	X	

Prompt	State has no trends/update to report (place an X)	State response
13. Other demonstration reporting		
13.1. General reporting requirements		
13.1.1. The state reports changes in its implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol.	X	
13.1.2. The state anticipates the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes.	X	
13.1.3. The state identified real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation.	X	
13.1.4. Compared to the demonstration design and operational details, the state expects to make the following changes to: 13.1.4a. The schedule for completing and submitting monitoring reports	X	
13.1.4b. The content or completeness of submitted monitoring reports and/or future monitoring reports	X	
13.2. Post-award public forum		
13.2.1. If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual monitoring report.		The District held the annual post-award forum on October 18, 2021. Over 100 attendees participated in the meeting. Several questions were asked during the forum. The questions pertained to logistics of MCO and FFS payment for IMD stays, waiver service utilization data, and expenditure data compared to budget neutrality projections. The District also received one set of written comments pertaining to waiver service utilization data and service creation for acquired brain injury. The District is drafting a response to the written comments.

Prompt	State has no trends/update to report (place an X)	State response
14. Notable state achievements and/or innovations		
14.1. Narrative information		
14.1.1. Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SMI/SED (or if broader demonstration, then SMI/SED related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.	X	

*The state should remove all example text from the table prior to submission.

Note: Licensee and state must prominently display the following notice on any display of Measure rates:

The MPT, FUH-CH, FUH-AD, FUA-AD, FUM-AD, AAP, and APM measures (#13, 14, 15, 16, 17, 18, 7, 8, 9, 10, 26, 29) are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called a "HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Adjusted, Uncertified, Unaudited HEDIS rates."