To: Integrated Healthcare Association (IHA) Stakeholders

From: Lindsay Erickson, Director, Program Operations, IHA

Subject: Measurement Years 2019 & 2020 Proposed Changes to the AMP Programs and Measure Sets

2019 IHA Public Comment Period
September 1 – September 30, 2019

IHA staff invite public comment on the following:

1. **General Feedback on IHA Performance Measurement Collaborative Updates**
   IHA staff welcome general comments on programmatic changes including updates to the program timelines and measurement priorities, including Total Cost of Care alignment across all AMP programs, expansion of encounter data measures, development of depression care patient reported outcomes measures, and testing of Department of Health Care Services' accountability measures for Medi-Cal.
2. **Measurement Year 2019 (MY 2019) Measure Set Changes**
   Measures approved for AMP program use for MY 2019 were finalized on December 1, 2018. Proposed changes to the MY 2019 measure set reflect the addition of proposed testing for MY 2019 and any measure retirements or specification updates prompted by measure steward changes to national standards. Given the recent additions of the Medi-Cal Managed Care and Commercial ACO programs, avoiding changes to IHA's measurement is a top priority. However, the IHA Committees identified several priority testing measures for Commercial ACO and Medi-Cal Managed Care to align with participant priorities.
3. **Measurement Year 2020 (MY 2020) Measure Set Changes**
   The changes outlined reflect the measures that are proposed for program use for MY 2020; results will reflect the care provided to members in calendar year 2020 and be collected and reported during calendar year 2021.

Comments are due by 5 p.m. PDT on Monday, September 30, 2019 to the Public Comment website at the following link: https://my.ncqa.org/.

Public Comment Login Instructions:

Access the Public Comment System

Existing NCQA Users: The public comment system is integrated with NCQA's my.ncqa.org. If you have access to the NCQA Policy/Program Clarification Support (PCS) system or other NCQA products and services, you can use the same credentials to login and submit your comments.

*Note: Use the **Forgot Password** button if you are unsure of your password. By using this feature you are changing your password for any NCQA system to which you have access.*

New NCQA Users: If you do not have access to my.ncqa.org click the **Create an Account** button and complete the entire form. Please retain the password for your records.

Submit a Comment

Step 1 Go to the Public Comment page using the following link: https://my.ncqa.org/

Step 2 Complete the **Register** section.

Step 3 Log in and click **My Services**.

- To submit a comment, click **Public Comments** in the drop down**.**
- Click **Add Comment.**
- For *Product,* click **2019 IHA Public Comment** in the drop-down box.
- For *Topic,* select the appropriate category for your question.
- For *Element,* scroll down and click the appropriate measure for your question.
- For *Support Type,* scroll down and click the appropriate support type.
- For *Comments*, enter a comment.
- Type your question (2,500 characters or less).

Step 4 Click **Submit Your Comment**.

Step 5 If you are submitting more than one comment, click **Close** and repeat the process. All of your submitted comments will be displayed on the **Public Comments** page where you have the option of exporting.

Introduction

To complement the expansion of IHA's performance measurement work, the Align. Measure. Perform. (AMP) programs (formerly our suite of physician organization level performance measurement programs) and the California Regional Health Care Cost & Quality Atlas (Atlas), are now collectively known as the Performance Measurement Collaborative. The Performance Measurement Collaborative highlights our deep expertise and commitment to health care that promotes quality improvement, accountability, and affordability.

The Performance Measurement Collaborative was created to collectively establish standardized healthcare performance measures, data collection and aggregation, and reporting processes that could transform how providers, payers, and purchasers deliver, evaluate, and pay for care. The Performance Measurement Collaborative is governed by a multi-stakeholder committee structure, which enables IHA to rigorously generate objective and valid insights to increase accountability, enable performance improvement, and align payment incentives to drive toward high-quality, patient-centered, affordable care. IHA hosts an annual Public Comment period every year to allow IHA stakeholders to provide feedback on the program and on the measure set.

All comments received during the Public Comment period will be reviewed by the IHA Technical Measurement Committee or Technical Payment Committee, and responses, including applicable changes, will be approved by the IHA Governance Committee before being incorporated where appropriate.

General IHA Performance Measurement Collaborative Updates

1. Updates on Program Timelines for Measurement Year 2019 and Beyond

Based on HEDIS©'s efforts to accelerate the finalization of specifications and IHA efforts to improve the predictability of the AMP deliverable timeline, there are several anticipated changes for MY 2019 and MY 2020. The proposed timelines reflect the transition to an earlier finalization of the AMP Program Manual and an updated reporting time for the Onpoint-generated results. A detailed timeline can be found on pages 7-10 of the draft MY 2019 AMP Program Manual.

Earlier this summer, NCQA announced an updated release schedule for HEDIS Volume 2, which will impact future release dates of the AMP Program Manual and Public Comment period. To take full advantage of these updates, IHA anticipates the following timelines for the AMP Program Manual and Public Comment releases.

September 2020	Draft AMP Program Manuals for MY 2020 and MY 2021 released at the same time, and annual Public Comment opens for both MY 2020 and MY 2021.	
December 2020	Final MY 2020 AMP Program Manual released.	
June 2021	Final MY 2021 AMP Program Manual released.	*Six months earlier than previous December releases*
October 2021	Draft MY 2022 AMP Program Manual released and annual Public Comment opens.	*Eleven months earlier & prior to measurement year start*
June 2022	Final MY 2022 AMP Program Manual will be released.	*Six months earlier than previous December releases*

2. Aligning Total Cost of Care Measurement Across the AMP Programs

Measuring total cost of care is critical for addressing affordability and improving the value of care delivered by provider organizations (POs) in California. Total cost of care has also been a key differentiator for IHA's value-based performance measurement efforts. Standard measure specifications for total cost of care, using the NQF-endorsed *Total Cost of Care (TCOC)* measure from HealthPartners, were adopted for use in AMP Commercial HMO, Commercial ACO and Medi-Cal Managed Care in MY 2017. The IHA Governance Committee recommended adding *TCOC* to the AMP Medicare Advantage program. Expedited testing maximizes the use of existing data collected for the Medicare Advantage population, emphasizes the importance of total cost of care measurement across all payers and aligns collection of *TCOC* across all AMP programs. *TCOC* is generated by IHA's data partner and requires no additional reporting from health plans or provider organizations. *TCOC* testing results for AMP Medicare Advantage were distributed to participants for review with the preliminary results release on August 26. Testing results will **not** be publicly reported or used in the generation of star ratings or recognition awards at this time. Measure specifications for *TCOC* can be found in the draft MY 2019 Manual.

3. Evolving Medi-Cal Managed Care Measurement

With nearly 11 million Medi-Cal enrollees receiving care through managed care plans and increasing overlap in provider networks serving commercial and Medi-Cal members, aligned and comparative performance measurement is critical. MY 2017 marked the first year for AMP Medi-Cal Managed Care with one health plan reporting results for over 40 POs and Federally Qualified Health Centers. The AMP Medi-Cal Managed Care program features a common measure set that spans clinical quality, patient experience, utilization and total cost of care. Recognizing the unique measurement needs of Medi-Cal providers and patients, alignment with the Department of Health Care Services (DHCS) Managed Care Accountability Set, which holds managed care plans accountable to a minimum performance level (MPL) on 17 measures, is a priority identified by stakeholders. The AMP Medi-Cal Managed Care measure set currently includes 65% of the MPL measures. To support increased alignment with the MPL measures on the Managed Care Accountability Set, the Technical Measurement Committee recommends testing *Prenatal and Postpartum Care (PPC)* and *Well-Child Visits in 3rd, 4th, 5th, and 6th Years of Life (W34)* in MY 2019.

4. Advancing Encounter Data Measure Development

Complete and accurate claims and encounter data plays a critical role in accurate risk adjustment and data completeness. IHA currently collects and reports a standard measure of encounter rates per member per year, including granularity reflecting professional and facility encounters (*Encounter Rate by Service Type - ENRST*). Expanded use of risk-adjustment in performance measurement, health plan reconciliation payments, and State Medi-Cal priorities have driven stakeholder and participant interest in expanding IHA's encounter data measurement to support holistic measurement of encounter data quality. This measurement is intended to help guide organizations' understanding of encounter data quality, identify opportunities for improvement, and support meaningful financial incentives for better data quality. As an initial step in this direction, the IHA committees have identified encounter data timeliness and format as appropriate areas for measure development and testing in MY 2019. Descriptions of the two areas of proposed encounter measures are included in **Appendix A of this document**.

5. Advancing Patient Reported Outcomes Measurement for Depression

Major depressive disorder affects millions of Americans, resulting in significant disability and loss of productivity. Yet, depression is often underdiagnosed and undertreated. Access to behavioral health services is a top-ranked health concern for Californians. In response to purchaser priorities, IHA, the Pacific Business Group on Health, and the California Quality Collaborative co-hosted a multi-stakeholder workgroup to further a collective approach for depression measurement and care redesign. Based on the workgroup's feedback and the AMP Commercial ACO priorities around patient reported outcomes measures (PROMs), the Technical Measurement Committee recommended developing a supplemental data collection system that would support testing of a suite of three depression PROMs measures. The system would enable POs to submit member level data, including depression screening information, using a standard file layout to IHA's data partners, who will then generate the measure results. The measure set recommendations target the testing of these measures in the AMP Commercial ACO program for MY 2020. Recognizing the financial investment in clinical workflows and data infrastructure required by POs to enable routine collection and submission of depression data, the Technical Measurement Committee noted that successful measurement may require purchasers and health plans to focus initial investments to ACOs for reporting these measures (e.g. "pay for reporting"). These recommendations are contingent on the ability to develop and scale the new supplemental data collection approach that IHA is working to pilot. Descriptions for the three depression PROMs measures are included below.

Measurement Year 2019 (MY 2019) Measure Set Changes

The IHA Committees recognize AMP program participant desire to focus on improvement and data collection for existing AMP measures and have made it a priority to maintain stability in the AMP measure sets as much as possible, including minimizing the number of testing measures. To this end, testing of the *Prenatal Immunization Status*—previously slated for MY 2019—has been deferred. The MY 2019 Measure Sets for Commercial HMO, Commercial ACO, Medicare Advantage and Medi-Cal Managed Care are available here. Other changes to the MY 2019 measure sets are summarized below, including the measure name, the AMP program(s) for which the measure is recommended, a brief description and rationale for inclusion.

1. Measure Retirements

A. ***Ambulatory Care: Emergency Department (AMB) - Commercial HMO, Commercial ACO***
NCQA retired *AMB* for the commercial and Medicare product lines for HEDIS 2020, supporting the transition to the available risk-adjusted emergency department utilization measure, *Emergency Department Utilization (EDU)*. *EDU* was adopted for use in the AMP program in MY 2017. In accordance with HEDIS guidelines, *AMB* will be retired for the commercial product lines. Since *EDU* is not specified for the Medicaid product line, *AMB* will be maintained for AMP Medi-Cal Managed Care.

B. ***Inpatient Utilization-General Hospital/Acute Care (IPU) - Commercial HMO, Commercial ACO***
NCQA retired *IPU* for the commercial and Medicare product lines for HEDIS 2020, supporting the transition to the standard risk-adjusted measure for hospital use, *Acute Hospital Utilization (AHU)*. *AHU* was adopted for use in the AMP program in MY 2017. Since *AHU* is not specified for the Medicaid product line, *IPU* will be maintained for AMP Medi-Cal Managed Care.

C. ***Generic Prescribing Rate (Therapeutic Classes) - Commercial HMO, Medi-Cal Managed Care***
All therapeutic classes of the *Generic Prescribing Rate (GRX)* measure, with the exception of diabetes medications, have "topped out" (defined as any measure whose rate of performance exceeds 90% at the 25th percentile) indicating high performance across the measured population. As such, the IHA Committees recommend retirement of all *GRX* therapeutic classes. IHA will continue to measure and report the *Overall Generic Prescribing Rate*.

2. Testing Measures

Testing measures allow IHA to incorporate relevant new measures to AMP measure sets while ensuring the measure can be reliably collected and produces useful information to AMP program participants. Measures recommended for testing are summarized below, including the measure name, the AMP program(s) for which the measure is recommended for testing, a brief description and rationale for inclusion.

A. Encounter Format - Commercial HMO, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care
This measure will assess whether key encounter data elements meet expectations on use of standard codes, consistency, and completeness. Correct coding and formatting of the content included in an encounter submission affects both its acceptance by a health plan and its usability for a variety of purposes – everything from care gap reporting and performance measurement to risk adjustment and rate setting. Specifications for this measure can be found in **Appendix A of this document**.

B. Encounter Timeliness - Commercial HMO, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care
This measurement area assesses the elapsed time in days between the date a patient receives care (i.e., Date of Service (DOS)) and the date when encounter is accepted by the health plan (i.e., Submission Date). The number of calendar days between those dates is the "lagtime." Shortening the lagtime between the DOS and Submission Date ensures that the information provided on the encounter is available for health plan quality improvement initiatives, performance measurement reporting, and risk-score calculations. Specifications for this measure can be found in **Appendix A of this document**.

C. Hospital Average Length of Stay - Commercial HMO, Commercial ACO, Medi-Cal Managed Care
This measure calculates a risk-adjusted inpatient average length of stay (ALOS) for medical and surgical admissions. The collection and reporting of a risk-adjusted ALOS measure emerged as a priority to support IHA's value-based incentive design: the measure is intended to complement the transition to *Acute Hospital Utilization*, which focuses only on discharges and does not reflect the effective management of hospital stays. Additionally, this measure has been identified as a priority by health plans for AMP Commercial ACO measurement. Towards these ends, the Technical Measurement Committee has recommended the addition of risk-adjusted *ALOS* in MY 2019. Draft specifications for this measure can be found in **Appendix B of this document**.

D. Prenatal and Postpartum Care (PPC) - Medi-Cal Managed Care
This measure assesses the timeliness of prenatal and postpartum care. This measure was approved for testing in the AMP Medi-Cal Managed Care program because of its importance to the Medi-Cal population. Adoption of this measure also supports alignment with the Department of Health Care

Services Managed Care Accountability Set which all Medi-Cal Managed Care plans in California are held accountable to performance standards. Refer to the draft MY 2019 Manual for measure specifications.

E. Well-Child Visit in the 3rd, 4th, 5th, and 6th Years of Life (W34) - Medi-Cal Managed Care

This measure assesses children 3-6 years of age who received one or more well child visits with a primary care practitioner during the measurement year. This measure was approved for testing in the AMP Medi-Cal Managed Care program due to its importance to the Medi-Cal population. Adoption of this measure also supports alignment with the Department of Health Care Services Managed Care Accountability Set, which all Medi-Cal Managed Care plans in California are held accountable to performance standards. Refer to the draft MY 2019 Manual for measure specifications.

3. Measure Specification Updates

A. *Align with Measure Steward Specifications Updates - Commercial HMO, Commercial ACO, Medicare Advantage, Medi-Cal Managed Care*

Alignment with measure steward specifications is a key strategic priority for IHA's performance measurement programs. IHA intends to align with all measure steward specification updates to ensure measure alignment and reduce reporting burden for participating POs and health plans. A summary of changes is listed at the beginning of each measure specification, and a complete Summary of Changes can be found in Appendix 1 of the draft MY 2019 Manual. Measures with notable steward specification updates include:

- *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)*
- *Appropriate Testing for Pharyngitis (CWP)*
- *Cervical Cancer Screening (CCS)*
- *Cervical Cancer Overscreening (CCO)*
- *Osteoporosis Management in Women Who Had a Fracture (OMW)*
- *Prenatal and Postpartum Care (PPC)*
- *Use of Opioids at High Dosage (HDO)*

Measurement Year 2020 (MY 2020) Measure Set Changes

The draft MY 2020 AMP Measure Set is available online for review and comment here. Proposed changes to the MY 2020 measure sets are summarized below, including the measure name, the AMP program(s) for which the measure is recommended, a brief description and rationale for inclusion.

1. Measure Retirements

A. *Adult BMI Assessment (ABA) - Medicare Advantage*

Retirement of this measure in MY 2020 will align with CMS's retirement of this measure in CMS Stars. This measure has high performance (above 90%) and low variation (standard deviation is less than 11% based on MY 2018 benchmarks).

2. Testing Measures

A. *Test the Depression Patient Reported Outcomes Measures (PROMs) suite - Commercial ACO*

The Technical Measurement Committee has recommended that the following three depression focused PROMs measures be tested for AMP Commercial ACO in MY 2020:

1) ***Depression Screening and Follow-Up for Adolescents and Adults (DSF).***
This NCQA measure is adapted from CMS (NQF# 0418) and assesses the percentage of members 12 years of age and older who were screened for clinical depression using a standardized tool and, if screened positive, received follow-up care within 30 days. Current U.S. Preventive Services Task Force guidelines recommend that all adolescents and adults, including pregnant and postpartum women, be screened for depression at least once a year. Note that this measure is currently used in programs such as CMS's Child and Adult Medicaid Core Set and the California Department of Health Care Services Managed Care Accountability Set. This measure is also part of the new HEDIS Electronic Clinical Data Systems (ECDS) reporting system which leverages electronic health record data in addition to claims and case management data. Specifications for this measure can be found in **Appendix C of this document**.

2) ***Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS).***
This NCQA measure is adapted from Minnesota Community Measurement (NQF # 0712) and assesses the percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. While the *Depression Screening and Follow-Up* measure allows the use of multiple validated depression screening tools, the PHQ-9 is the most commonly used tool in primary care to diagnose and monitor depression and all NQF-endorsed remission measures use the PHQ-9 result as the marker for remission. This measure signals the need to monitor patients diagnosed with depression after the initial screening over time. This measure is also a HEDIS ECDS measure. Specifications for this measure can be found in **Appendix C of this document.**

3) ***Depression Remission at Six Months.***
This NQF-endorsed measure (NQF #0711) is stewarded by Minnesota Community Measurement and assesses adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months, defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. Monitoring depression severity and ensuring patients are treated to target is crucial for improving the well-being of patients diagnosed with depression or dysthymia. Specifications for this measure can be found in Minnesota Community Measurement's 2019 Depression Care Direct Data Submission Guide.

APPENDIX A: Encounter Data Measures

Encounter Format

MEASURE UPDATES SEPTEMBER 2019 FOR AMP MY 2019

- Added as a testing measure to all AMP measure sets for MY 2019.

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure.

Description

Correct coding and formatting of the content included in an encounter submission affects both its acceptance by a health plan and its usability for a variety of purposes – everything from care gap reporting and performance measurement to risk adjustment and rate setting.

The following measures under consideration assess whether key encounter data elements meet expectations on use of standard codes, consistency, and completeness.

- Procedures per Visit (2 indicators)
- Procedure Modifiers and Procedure Codes (2 indicators)
- Review of Procedure Code (4 indicators)
- Review of Revenue Codes (4 indicators)
- Review of Diagnosis Codes (4 indicators)
- Review of Billing Provider Identifier (4 indicators)
- Review of Rendering Provider Identifier (3 indicators)
- Review of Referring Provider Identifier (3 indicators)
- Review of Prescribing Provider Identifier (4 indicators)

For additional information on timeliness measures, refer to the California Department of Health Care Services Quality Measures for Encounter Data.

Note: *Health plans and POs are not expected to report this measure. Onpoint will run this measure using health plans claim and encounter submissions for MY 2019.*

APPENDIX A: Encounter Data Measures

Encounter Timeliness

MEASURE UPDATES SEPTEMBER 2019 FOR AMP MY 2019

- Added as a testing measure to all AMP measure sets for MY 2019.

MODIFICATIONS FROM HEDIS

- This is a non-HEDIS measure.

Description

Encounter data timeliness assesses the elapsed time in days between the date a patient receives care (i.e., Date of Service (DOS)) and the date when encounter is accepted by the health plan (i.e., Submission Date). The number of calendar days between those dates is the "lagtime". Shortening the lagtime between the DOS and Submission Date ensures that the information provided on the encounter is available for health plan quality improvement initiatives, performance measurement reporting, and risk-score calculations.

In an effort to align with existing industry measures, the following three encounter data timeliness measures are currently under consideration. Each measure is reported by encounter type: Facility, Professional, and Pharmacy.

- **Categories of Lagtime**: the percent of encounters where the lagtime falls within the category duration. Reported categories include:
  - zero to 30 days *(higher is better)*
  - zero to 60 days *(higher is better)*
  - zero to 90 days *(higher is better)*
  - greater than 365 day *(lower is better)*

- **Average Lagtime by Service Date:** the average lagtime for encounters with dates of service during the measurement period

- **Average Lagtime by Submission Date:** the average lagtime for encounters with submission dates during the measurement period

For additional information on timeliness measures under consideration, refer to the California Department of Health Care Services Quality Measures for Encounter Data.

Note: *Health plans and POs are not expected to report this measure. Onpoint will run this measure using health plans claim and encounter submissions for MY 2019.*

APPENDIX B: Hospital Average Length of Stay

Hospital Average Length of Stay

MEASURE UPDATES SEPTEMBER 2019 FOR AMP MY 2019

- Added as a testing measure to the Commercial HMO/POS, Commercial ACO, and Medi-Cal Managed Care measure sets for MY 2019.

MODIFICATIONS FROM HEDIS

- Based on HEDIS Utilization specifications.
- Added risk adjustment.

Description

This measure calculates a risk-adjusted inpatient average length of stay (ALOS) for maternity and non-maternity admissions. The numerator for this measure is the number of inpatient days and the denominator is the number of inpatient discharges.

The final reported metrics are:

- Risk-adjusted ALOS for maternity inpatient discharges
- Risk-adjusted ALOS for non-maternity inpatient discharges

Risk adjustment for ALOS will be performed using MS-DRG mix.

NOTE: *Onpoint Health Data will generate this measure for MY 2019. Health plans and POs are not expected to report the measure.*

Eligible Population

Note: *Members in hospice are excluded from this measure. Refer to General Guideline 15: Members in Hospice.*

Product lines	Commercial HMO/POS, Commercial ACO, Medicaid.
ALOS	Refer to *Specific Instructions for Utilization Tables* for the formula. Calculate average length of stay for total inpatient, maternity, surgery and medicine.

Use the following steps to identify and categorize inpatient discharges.

Step 1 Identify all acute inpatient discharges on or between January 1 and December 31 of the measurement year. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

Step 2 Exclude discharges with a principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set) on the discharge claim.

Exclude newborn care rendered from birth to discharge home from delivery (only include care rendered during subsequent rehospitalizations after the delivery

discharge). Identify newborn care by a principal diagnosis of live-born infant (Deliveries Infant Record Value Set). Organizations must develop methods to differentiate between the mother's claim and the newborn's claim, if needed.

Step 3 Report ALOS for total inpatient, using all discharges identified after completing steps 1 and 2.

Step 4 Report ALOS for maternity. A delivery is not required for inclusion in the *Maternity* category; any maternity-related stay is included. Include birthing center deliveries and count them as one day of stay.

Starting with all discharges identified in step 3, identify maternity using either of the following:

- A maternity-related principal diagnosis (Maternity Diagnosis Value Set).
- A maternity-related stay (Maternity Value Set).

Step 5 Report ALOS for surgery and medicine (combined). Calculate based on all discharges remaining after removing maternity (identified in step 4) from total inpatient (identified in step 3).

Note

- *Supplemental data may not be used for this measure.*

Risk Adjustment Calculation

Step 1	*Calculate expected ALOS for each MS-DRG by product line.* Collect ALOS values for all discharges into MS-DRG-specific "bins". The expected ALOS for each DRG is the arithmetic mean of all ALOS values attributed to that DRG-bin.
Step 2	*Calculate population ALOS.* The population ALOS is defined as the arithmetic mean of ALOS scores across all discharges, within each DRG bin.
Step 3	*Calculate risk-adjusted ALOS.* Divide the Observed ALOS by the Expected ALOS; multiply the observed to expected ratio by the population ALOS. Risk-adjusted ALOS = [Σ Observed ALOS/Σ Expected ALOS] * population ALOS. The same process is followed for both the maternity ALOS calculations, For the maternity ALOS adjustment, DRGs are limited to maternity DRGs during the DRG case-mix adjustment.

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

*Depression Screening and Follow-Up for Adolescents and Adults (DSF)**

***Adapted with financial support from CMS from a provider-level measure developed by Quality Insights of Pennsylvania (QIP) (NQF #0418, CMS2).**

SUMMARY OF CHANGES TO HEDIS 2020

- Restructured the format of ECDS measures header layout (e.g., reformatted stratifications, added Participation Period to the *Definitions* section, removed underlining from value set names).
- Added Reporting to the *Guidance* section.
- Updated the positive finding score for the Center for Epidemiologic Studies Depression Scale-Revised (CESD-R) depression screening instrument from ≥10 to ≥17.
- Added Edinburgh Postnatal Depression Scale (EPDS) to list of depression screening instruments for adolescents.
- Added Duke Anxiety Depression Scale (DADS) to list of depression screening instruments for adults and added an associated direct reference code.
- Modified value sets to make them compatible with digital measure formatting.
- Revised the timing for the exclusion for bipolar disorder from "during the Measurement Period or the year prior to the Measurement Period" to "during the year prior to the Measurement Period."
- Added direct reference codes for Medicaid, Medicare, Private Health Insurance (Commercial) and Birth Date.
- Added Attributes to the *Data Criteria (element level)* section.
- Revised the former "Data Source" column to "Data Source Logic" in the Data Elements for Reporting tables.
- Removed the collection of the "Initial Population" and "Denominator" data elements by SSoR in the Data Elements for Reporting tables.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

Description

The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.

- *Depression Screening.* The percentage of members who were screened for clinical depression using a standardized instrument.
- *Follow-Up on Positive Screen*. The percentage of members who received follow-up care within 30 days of a positive depression screen finding.

Measurement Period

January 1–December 31.

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

Clinical Recommendation Statement

The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents 12–18 years and the general adult population, including pregnant and postpartum women. The USPSTF also recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.

References

U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6.

U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.

Characteristics

Scoring Proportion.

Type Process.

Item count Person.

Stratification

1. Commercial: 12–17.*
2. Commercial: 18–44.*
3. Commercial: 45–64.*
4. Commercial: 65+*.
5. Medicaid: 12–17.
6. Medicaid: 18–44.
7. Medicaid: 45–64.
8. Medicaid: 65+.
9. Medicare: 18–44.
10. Medicare: 45–64.
11. Medicare: 65+.

**Note that "Commercial" plans can be identified via the "Private Health Insurance" Direct Reference Code.*

Risk adjustment None.

Improvement notation A higher rate indicates better performance.

Guidance

Allocation:

The member was enrolled with a medical benefit throughout the Participation Period.

Requirements:

- This measure requires the use of an age-appropriate screening instrument. The member's age is used to select the appropriate depression screening instrument.
- Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the member answered the questions and a total score is calculated.

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

Reporting:
The total for each product line is the sum of the age stratifications.

Definitions

Depression screening instruments

A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

Instruments for Adolescents (12–17 years)	Positive Finding
Patient Health Questionnaire (PHQ-9)®	Total Score ≥5
Patient Health Questionnaire Modified for Teens (PHQ-9M)®	Total Score ≥5
PRIME MD-PHQ2®	Total Score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®*	Total Score ≥4
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥17
Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥9
PROMIS Depression	Total Score (T Score) ≥52.5
Instruments for Adults (18+ years)	**Positive Finding**
Patient Health Questionnaire (PHQ-9)®	Total Score ≥5
PRIME MD-PHQ2®	Total Score ≥3
Beck Depression Inventory-Fast Screen (BDI-FS)®*	Total Score ≥4
Beck Depression Inventory (BDI-II)	Total Score ≥14
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥17
Duke Anxiety-Depression Scale (DADS)®*	Total Score ≥30
Geriatric Depression Scale Short Form (GDS)	Total Score ≥5
Geriatric Depression Scale Long Form (GDS)	Total Score ≥10
Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥9
My Mood Monitor (M-3)®	Total Score ≥5
PROMIS Depression	Total Score (T Score) ≥52.5
Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥11

*Proprietary; may be cost or licensing requirement associated with use.

Participation

The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for HEDIS reporting is based on eligibility during the Participation Period.

Participation Period

The Measurement Period.

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

Initial Population

Members 12 years of age and older at the start of the Measurement Period who also meet criteria for Participation.

Exclusions

Exclusions

Exclude members with any of the following:

- Bipolar disorder during the year prior to the Measurement Period.
- Depression during the year prior to the Measurement Period.
- In hospice or using hospice services during the Measurement Period.

Depression Screening (Population Criteria 1)

Denominator 1

The Initial Population, minus Exclusions.

Numerator 1

Members with documentation of depression screening performed using an age-appropriate standardized instrument between January 1 and December 1 of the Measurement Period.

Follow-Up on Positive Screen (Population Criteria 2)

Denominator 2

All members from Numerator 1 with a positive depression screen finding between January 1 and December 1 of the Measurement Period.

Numerator 2

Members who received follow-up care on or up to 30 days after the date of the first positive screen.

Any of the following on or 30 days after the first positive screen:

- An outpatient or telephone follow-up visit with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
- A dispensed antidepressant medication.

or

- Receipt of an assessment on the same day and subsequent to the positive screen.
  - Documentation of additional depression screening indicating either no depression or no symptoms that require follow-up. For example, if the initial positive screen resulted from a PHQ-2 score, documentation of a negative finding from a subsequent PHQ-9 qualifies as evidence of follow-up.

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

Data Criteria (Element Level)

Value Sets:

- Diagnosis: Bipolar Disorder (2.16.840.1.113883.3.464.1004.1044)
- Diagnosis: Depression (2.16.840.1.113883.3.464.1004.1390)
- Diagnosis: Other Bipolar Disorder (2.16.840.1.113883.3.464.1004.1399)
- Encounter, Performed: Behavioral Health Encounter (2.16.840.1.113883.3.464.1004.1383)
- Encounter, Performed: Depression Case Management Encounter (2.16.840.1.113883.3.464.1004.1389)
- Encounter, Performed: Follow Up Visit (2.16.840.1.113883.3.464.1004.1385)
- Encounter, Performed: Hospice Encounter (2.16.840.1.113883.3.464.1004.1761)
- Intervention, Order: Hospice Intervention (2.16.840.1.113883.3.464.1004.1762)
- Intervention, Performed: Hospice Intervention (2.16.840.1.113883.3.464.1004.1762)
- Medication, Dispensed: Antidepressant Medication (2.16.840.1.113883.3.464.1004.1503)

Direct Reference Codes:

- Assessment, Performed: Beck Depression Inventory Fast Screen total score [BDI] (LOINC Code 89208-3)
- Assessment, Performed: Beck Depression Inventory II total score [BDI] (LOINC Code 89209-1)
- Assessment, Performed: Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R] (LOINC Code 89205-9)
- Assessment, Performed: Clinically Useful Depression Outcome Scale [CUDOS] (LOINC Code 90221-3)
- Assessment, Performed: Final score [DADS] (LOINC Code 90853-3)
- Assessment, Performed: Edinburgh Postnatal Depression Scale [EPDS] (LOINC Code 71354-5)
- Assessment, Performed: Geriatric depression scale (GDS) short version total (LOINC Code 48545-8)
- Assessment, Performed: Geriatric depression scale (GDS) total (LOINC Code 48544-1)
- Assessment, Performed: Patient Health Questionnaire 2 item (PHQ-2) total score [Reported] (LOINC Code 55758-7)
- Assessment, Performed: Patient Health Questionnaire 9 item (PHQ-9) total score [Reported] (LOINC Code 44261-6)
- Assessment, Performed: Patient Health Questionnaire 9: Modified for Teens total score [Reported.PHQ.Teen] (LOINC Code 89204-2)
- Assessment, Performed: PROMIS 29 Depression score T score (LOINC Code 71965-8)
- Assessment, Performed: Total score [M3] (LOINC Code 71777-7)
- Participation: MEDICAID (SOP Code 2)
- Participation: MEDICARE (SOP Code 1)
- Participation: PRIVATE HEALTH INSURANCE (SOP Code 5)
- Patient Characteristic Birthdate: Birth date (LOINC Code 21112-8)
- Symptom: Symptoms of depression (finding) (SNOMEDCT Code 394924000)

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

Attributes:

- Depression or Other Behavioral Health Condition (2.16.840.1.113883.3.464.1004.1501)

Data Elements for IDSS Reporting

Organizations that submit data to NCQA must provide the following data elements in a specified file.

Table DSF-A-1/2/3: Metadata Elements for Depression Screening and Follow-Up for Adolescents and Adults

Metadata ID	Metadata Specification
MeasurementYear	Measurement year
CollectionMethod	Data collection methodology (electronic clinical data)

Table DSF-B-1/2: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults (Medicaid and Commercial)

Indicator	Age	Data Element	Data Source Logic
Depression Screening	12-17	Initial population	Summed over data sources
Follow-Up on Positive Screen	18-44	Exclusions	Report by data source
	45-64	Denominator	Summed over data sources
	65+	Numerator	Report by data source

Table DSF-B-3: Data Elements for Depression Screening and Follow-Up for Adolescents and Adults (Medicare)

Indicator	Age	Data Element	Data Source Logic
Depression Screening	18-44	Initial population	Summed over data sources
Follow-Up on Positive Screen	45-64	Exclusions	Report by data source
	65+	Denominator	Summed over data sources
		Numerator	Report by data source

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

Rules for Allowable Adjustments of HEDIS

This section *may not* be used for reporting health plan HEDIS. HEDIS measures may not be adjusted for any NCQA program.

NCQA's Rules for Allowable Adjustments of HEDIS describe how NCQA's HEDIS measure specifications can be adjusted for non-health plan reporting. Refer to the *Guidelines for the Rules of Allowable Adjustments of HEDIS* for additional information.

Rules for Allowable Adjustments for Depression Screening and Follow-Up for Adolescents and Adults

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age 12 during the measurement year). The denominator age may be changed if the range is within the specified age range (12 years and older). The denominator age may not be expanded.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Value sets and logic may not be changed for Denominator 2.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Apply exclusions according to specified value sets.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
• Depression Screening • Follow-Up on Positive Screen	No	Value sets, Direct Reference Codes and logic may not be changed.

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

*Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)**

***Adapted with financial support from the Agency for Healthcare Research and Quality (AHRQ) and CMS under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS025296, from depression measures developed by Minnesota Community Measurement.**

SUMMARY OF CHANGES TO HEDIS 2020

- Restructured the format of ECDS measures header layout (e.g., reformatted stratifications, added Participation Period to the *Definitions* section, removed underlining from value set names).
- Revised Item Count from Encounters to Person.
- Added Reporting to the *Guidance* section.
- Added a definition for *Interactive Outpatient Encounter*.
- Modified value sets to make them compatible with digital measure formatting.
- Added individual Initial Populations for each of the three rates.
- Added individual Exclusions for each of the three rates.
- Moved each of the three Denominator criteria to the corresponding Initial Population.
- Added direct reference codes for Medicaid, Medicare, Private Health Insurance (Commercial) and Birth Date.
- Revised the former “Data Source” column to “Data Source Logic” in the Data Elements for Reporting tables.
- Removed the collection of the “Denominator” data element by SSoR in the Data Elements for Reporting tables.
- Added the *Rules for Allowable Adjustments of HEDIS* section.

Description

The percentage of members 12 years of age and older with a diagnosis of major depression or dysthymia, who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter.

Measurement Period

January 1–December 31.

The Measurement Period is divided into three assessment periods with specific dates of service:

- *Assessment Period 1:* January 1–April 30.
- *Assessment Period 2:* May 1–August 31.
- *Assessment Period 3:* September 1–December 31.

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

Clinical Recommendation Statement

Standardized instruments are useful in identifying meaningful change in clinical outcomes over time. Guidelines for adults recommend that providers establish and maintain regular follow-up with patients diagnosed with depression and use a standardized tool to track symptoms. For adolescents, guidelines recommend systematic and regular tracking of treatment goals and outcomes, including assessing depressive symptoms.

The PHQ-9 tool assesses the nine DSM, Fourth Edition, Text Revision (DSM-IV-TR) criteria symptoms and effects on functioning, and it has been shown to be highly accurate in discriminating between patients with persistent major depression, partial remission and full remission.

References

Trangle, M., J. Gursky, R. Haight, J. Hardwig, T. Hinnenkamp, D. Kessler, N. Mack, M. Myszkowski. Institute for Clinical Systems Improvement. *Adult Depression in Primary Care.* Updated March 2016.

Cheung, A.H., R.A. Zuckerbrot, P.S. Jensen, D. Laraque, R.E.K. Stein, GLAD-PC STEERING GROUP. 2018. "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing management." *Pediatrics* 141(3):e20174082.

Characteristics

Scoring	Proportion.
Type	Process.
Item count	Person.
Stratification	1. Commercial: 12–17*. 2. Commercial: 18–44*. 3. Commercial: 45–64*. 4. Commercial: 65+*. 5. Medicaid: 12–17. 6. Medicaid: 18–44. 7. Medicaid: 45–64. 8. Medicaid: 65+. 9. Medicare: 18–44. 10. Medicare: 45–64. 11. Medicare: 65+. **Note that "Commercial" plans can be identified via the "Private Health Insurance" Direct Reference Code.*
Risk adjustment	None.
Improvement notation	A higher rate indicates better performance.
Guidance	**Allocation:** The member was enrolled with a medical benefit throughout the Participation Period. **Requirements:** • Members may have an eligible encounter in any or all three assessment periods and may be included in the measure up to three times during the Measurement Period. • The measure allows the use of two PHQ-9 assessments. Selection of the appropriate assessment should be based on the member's age.

  - *PHQ-9:* 12 years of age and older.
  - *PHQ-9 Modified for Teens:* 12–17 years of age.
- When identifying encounters where a diagnosis of major depression or dysthymia was addressed, look for visits for depression/dysthymia. When using only claims data, the diagnosis code and the visit must be from the same visit.
- The PHQ-9 assessment does not need to occur during a face-to-face encounter; it may be completed over the telephone or through a web-based portal.

Reporting:

The total for each product line is the sum of the age stratifications.

Definitions

Participation	The identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Allocation for reporting is based on eligibility during the Participation Period.
Participation period	The Measurement Period.
Interactive Outpatient Encounter	A bidirectional communication that is face-to-face, phone based or via secure electronic messaging. This does not include communications for scheduling appointments.

Exclusions

Exclusions	Members with any of the following at any time during the Measurement Period: • Bipolar disorder. • Personality disorder. • Psychotic disorder. • Pervasive developmental disorder. • In hospice or using hospice services.

Utilization of PHQ-9 Period 1 (Population Criteria 1)

Initial Population 1	Members 12 years and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one interactive outpatient encounter during Assessment Period 1, with a diagnosis of major depression or dysthymia.
Exclusions 1	Members in Initial Population 1 who meet the Exclusions criteria.
Denominator 1	The Initial Population 1, minus Exclusions.
Numerator 1	A PHQ-9 score in the member's record during Assessment Period 1.

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

Utilization of PHQ-9 Period 2 (Population Criteria 2)

Initial Population 2	Members 12 years and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one interactive outpatient encounter during Assessment Period 2, with a diagnosis of major depression or dysthymia.
Exclusions 2	Members in Initial Population 2 who meet the Exclusions criteria.
Denominator 2	The Initial Population 2, minus Exclusions.
Numerator 2	A PHQ-9 score in the member's record during Assessment Period 2.

Utilization of PHQ-9 Period 3 (Population Criteria 3)

Initial Population 3	Members 12 years and older at the start of the Measurement Period who also meet the criteria for Participation, with at least one Interactive Outpatient Encounter during Assessment Period 3, with a diagnosis of major depression or dysthymia.
Exclusions 3	Members in Initial Population 3 who meet the Exclusions criteria.
Denominator 3	The Initial Population 3, minus Exclusions.
Numerator 3	A PHQ-9 score in the member's record during Assessment Period 3.

Data Criteria (Element Level)

Value Sets:

- Diagnosis: Bipolar Disorder (2.16.840.1.113883.3.464.1004.1044)
- Diagnosis: Major Depression or Dysthymia (2.16.840.1.113883.3.464.1004.1351)
- Diagnosis: Other Bipolar Disorder (2.16.840.1.113883.3.464.1004.1399)
- Diagnosis: Personality Disorder (2.16.840.1.113883.3.464.1004.1355)
- Diagnosis: Pervasive Developmental Disorder (2.16.840.1.113883.3.464.1004.1356)
- Diagnosis: Psychotic Disorders (2.16.840.1.113883.3.464.1004.1352)
- Encounter, Performed: Interactive Outpatient Encounter (2.16.840.1.113883.3.464.1004.1347)
- Encounter, Performed: Hospice Encounter (2.16.840.1.113883.3.464.1004.1761)
- Intervention, Order: Hospice Intervention (2.16.840.1.113883.3.464.1004.1762)
- Intervention, Performed: Hospice Intervention (2.16.840.1.113883.3.464.1004.1762)

Direct Reference Codes:

- Assessment, Performed: Patient Health Questionnaire 9 item (PHQ-9) total score [Reported] (LOINC Code 44261-6)
- Assessment, Performed: Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen] (LOINC Code 89204-2)
- Participation: MEDICAID (SOP Code 2)
- Participation: MEDICARE (SOP Code 1)

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

- Participation: PRIVATE HEALTH INSURANCE (SOP Code 5)
- Patient Characteristic Birthdate: Birth date (LOINC Code 21112-8)

Data Elements for IDSS Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table DMS-A-1/2/3: Metadata Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

Metadata ID	Metadata Specification
MeasurementYear	Measurement year
CollectionMethod	Data collection methodology (electronic clinical data)

Table DMS-B-1/2: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (Medicaid and commercial)

Indicator	Age	Data Element	Data Source Logic
Utilization of PHQ-9-Period 1	12-17	Initial population	Report by data source
Utilization of PHQ-9-Period 2	18-44	Exclusions	Report by data source
Utilization of PHQ-9-Period 3	45-64	Denominator	Summed over data sources
	65+	Numerator	Report by data source

Table DMS-B-3: Data Elements for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (Medicare)

Indicator	Age	Data Element	Data Source Logic
Utilization of PHQ-9-Period 1	18-44	Initial population	Report by data source
Utilization of PHQ-9-Period 2	45-64	Exclusions	Report by data source
Utilization of PHQ-9-Period 3	65+	Denominator	Summed over data sources
		Numerator	Report by data source

APPENDIX C: Depression Patient Reported Outcomes Measures (PROMs)

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Rules for Allowable Adjustments for Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults

NONCLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Product Lines	Yes	Organizations are not required to use product line criteria; product lines may be combined and all (or no) product line criteria may be used.
Ages	Yes, with limits	The age determination dates may be changed (e.g., select, "age as of June 30"). Changing the denominator age range is allowed if the limits are within the specified age range (12 and older). Expanding the denominator age range to 11 and older is allowed.
Continuous enrollment, Allowable gap, Anchor Date	Yes	Organizations are not required to use enrollment criteria; adjustments are allowed.
Benefits	Yes	Organizations are not required to use a benefit; adjustments are allowed.
Other	Yes	Organizations may use additional eligible population criteria to focus on a population of interest such as gender, sociodemographic characteristic or geographic region.
CLINICAL COMPONENTS		
Eligible Population	**Adjustments Allowed (Yes/No)**	**Notes**
Event/Diagnosis	No	Only events or diagnoses that contain (or map to) codes in the value sets may be used to identify visits with a diagnosis. The value sets and logic may not be changed.
Denominator Exclusions	**Adjustments Allowed (Yes/No)**	**Notes**
Exclusions	No	Apply exclusions according to specified value sets.
Numerator Criteria	**Adjustments Allowed (Yes/No)**	**Notes**
PHQ-9 Score	No	Value sets, Direct Reference Codes and logic may not be changed.