Centers for Medicare & Medicaid Services
CMS eXpedited Life Cycle (XLC)

HEDIS®

2017 Patient-Level Data File Specifications File 2 of 2 Files (2016 Measurement Year)

Version 1.1 FINAL

12/01/2016

Document Number: HEDIS_PLD-015-2016-PLD-DATA-SPEC-2-v.1.1
Contract Number: HHSM-500-2016-00057C

Table of Contents

List of Tables

1. Introduction

1.1 Purpose

This document describes the file layout for "File 2 of 2" files that will support the Centers for Medicare & Medicaid Services (CMS) annual collection of Healthcare Effectiveness Data and Information Set (HEDIS®)[1] patient-level quality of care measures received from Medicare Advantage Organizations (MAOs).

1.2 Scope

This document describes the data file layout for "File 2 of 2" files submitted for HEDIS 2017 patient-level data for the measurement year 2016. The document includes specifications for the Header records and Detail records.

NOTE: This file includes information for the HEDIS measure "Plan All-Cause Readmissions (PCR)" only and is required to be submitted by all MA organizations that submit the HEDIS MA summary data. MA organizations with zero enrollment the entire measurement period do not have to submit. 1876 Cost contracts are not allowed to submit summary HEDIS PCR data so they do not submit File 2. Contracts that fail to submit an error free File 2 by the submission deadline will receive 1 star in the 2017 Star Ratings Plan All Cause Readmissions (PCR) measure.

1.3 Technical Support

For technical support regarding this document, contact the Scope Infotech Team by phone at 1-877-996-1333 or by email at ma_patient_data@scopeinfotechinc.com.

1.4 References

- HEDIS® 2017 Patient-Level Submission Instructions (Please visit http://www.ncqa.org/hedis-quality-measurement)
- HEDIS® 2017 Volume 2: Technical Specifications for Health Plans (Please visit http://www.ncqa.org/hedis-quality-measurement)
- CMS Data Usage Agreement
- Medicare General Information, Eligibility, and Entitlement: Chapter 2 – Hospital Insurance and Supplementary Medical Insurance

1.5 Document Structure

An Excel attachment in the email sent by Scope Infotech team provides a column-by-column description of the Header record and Detail record layouts, and includes valid ranges or values

[1] *HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)*

allowed for each column. If you haven't received the email, please feel to contact the Scope Infotech team via ma_patient_data@scopeinfotechinc.com.

NOTE: Of the HEDIS 2017 files, File 2 differs from File 1 in that File 1 is rolled up to the member-level whereas File 2 has a separate record for each acute in-patient stay. There are no changes to this measure or the excel file-layout for the 2016 Measurement year.

2. Important Technical Elements Regarding HEDIS 2017 Patient-Level Submissions

2.1 Patient-Level and Summary-Level Data Must Match

The patient-level data must match the summary-level data for this measure. The patient–level file measures should be calculated following the same measure specifications as the summary-level data. To ensure an exact match, make a copy or "freeze" the database when the measures are calculated.

2.2 Zero re-admissions

Contracts that had no acute in-patient stays (denominator) during the measurement year which in turn could not possibly have had any hospital re-admissions (numerator) must submit PLD File 2 with a header row and a blank row of data. Contracts that had no hospital re-admissions (numerator) but did have acute in-patient stays (denominator) should submit a PLD File 2 containing those denominator acute in-patient stays.
NOTE: PLD File 2 data must match the summary PCR submission results or contracts will receive 1 star in the Star Ratings PCR measure.

2.3 Inclusion of Contract Number

There should be no embedded spaces or other characters between the "H" or "R" and the four digits of the contract number.

2.4 Inclusion of Health Insurance Claim (HIC) Number

Include the Health Insurance Claim Number (hereafter HICN) for every contract member enrolled at any point during the measurement year (2016). The HICN is the number assigned by CMS to the member upon applying for Medicare services. Chapter 2 of the CMS "Medicare General Information, Eligibility, and Entitlement" document provides the following information:

> *"50.2 – Health Insurance Claims Numbers (HICNs) (Rev. 1, 09-11-02)*
>
> *All HICNs issued by SSA are 9-digit numbers with at least one letter suffix (called a beneficiary identification code or BIC) in the tenth position. If there is an eleventh position, it may be either a letter or number e.g. 123456789A or 987654321D4. The HICN issued by the RRB, may contain either 6 or 9 digit numbers with up to a 3-position letter prefix e.g., A123456 or MA123456789. If a beneficiary's entitlement changes, it is possible for the 9-digit number, the prefix, the suffix or all three to change. It is also possible to go from an SSA issued HICN to a RRB HICN or vice versa.*

The numeric portion of a 9-digit HICN consists of a Social Security Number (SSN). If the BIC is A, T, TA, M, M1, J1, J2, J3, J4 or the RRB prefix is A or H the number is the beneficiary's own SSN. If the BIC or RRB prefix is other than one of the above, the SSN belongs to a number holder and the beneficiary is entitled as an auxiliary or survivor on that SSN.

Currently, the first three digits of the HICN range from 001-772. However, this may change as SSA issues more numbers. All numbers except 00 are possible for the fourth and fifth digits and all numbers except 0000 are possible for the last four digits.

The patient's HICN is on his/her HI card, SSA award letter, SSA Benefit Verification letter, an SSA issued Temporary Notice of Eligibility, Explanation of Medicare Benefits (EOMB), Notice of Utilization (NOU), or Medicare Summary Notice (MSN). Where the patient cannot furnish a HICN, it may be an indication that he/she has not filed an application with SSA to establish entitlement to health insurance benefits, or that SSA action on a pending application has not been completed.

50.3 - HICNs Assigned by CMS (Rev. 1, 09-11-02)

(See section 50.2 for an explanation of the valid 9-digit numbers issued by SSA.)

A, B, B1, B2, B3, B4, B5, B6, B7, B8, B9, BA, BD, BG, BH, BJ, BK, BL, BN, BP, BQ, BR, BT, BW, BY, C1, C2, C3, C4, C5, C6, C7, C8, C9, CA, CB, CC, CD, CE, CF, CG, CH, CI, CJ, CK, CL, CM, CN, CO, CP, CQ, CR, CS, CT, CU, CV, CW, CX, CY, CZ, D, D1, D2, D3, D4, D5, D6, D7, D8, D9, DA, DC, DD, DG, DH, DJ, DK, DL, DM, DN, DP, DQ, DR, DS, DT, DV, DW, DX, DY, DZ, E, E1, E2, E3, E4, E5, E6, E7, E8, E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM, F1, F2, F3, F4, F5, F6, F7, F8, J1, J2, J3, J4, K1, K2, K3, K4, K5, K6, K7, K8, K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM, T, TA, TB, TC, TD, TE, TF, TG, TH, TJ, TK, TL, TM, TN, TP, TQ, TR, TS, TT, TU, TV, TW, TX, TY, TZ, and, T2, W, W1, W2, W3, W4, W5, W6, W7, W8, W9, WB, WC, WF, WG, WJ, WR, WT

50.4 - HICNs Assigned by the RRB (Rev. 1, 09-11-02)

The RRB began using the social security number in their numbering system during calendar year 1964. The HICNs assigned prior to that time were 6-digit numbers assigned in numerical sequence and had no special characteristics. However, both the 6-digit numbers and the 9-digit social security numbers when used as claim numbers by the RRB always have letter prefixes. In rare cases, a qualified railroad retirement beneficiary may have a claim number with less than 6-digits. In this case, sufficient zeros are added between the prefix and other digits to make a 6-digit number, e.g., WD001234. The current range of valid RRB claim numbers is 000001-994999.

50.4.1 - Six-Digit Numbers (Rev. 1, 09-11-02)

The basic RRB claim numbers assigned to each type of prefix are shown in this section. Under the RRB system, it is permissible for two beneficiaries to have identical claim numbers. For example, when a widower remarries, the second wife is assigned the same claim number that was assigned to the first wife. Under the Medicare program, however, every individual has a distinctive claim number. Therefore, for Medicare purposes, pseudo numbers are assigned to railroad retirement beneficiaries who would otherwise have a claim number that was assigned to someone else.

The numbers in the series 995000 through 999999 were assigned to these beneficiaries. But, whenever possible, the Board will use the railroad retirement beneficiary's own 9-digit social security number with the appropriate prefix. They will only use the 6-digit number if the railroad retirement beneficiary does not have their own social security number and cannot obtain one because of Social Security Administration limitations on issuing numbers. An example of an individual who cannot get a number is a beneficiary who lives outside the United States and is not a citizen of the U.S.

50.4.2 - Valid RRB HICNs (Rev. 1, 09-11-02)

A000000, A000000000, CA000000, CA000000000, H000000, H000000000, JA000000, JA000000000, MA000000, MA000000000, MH000000, MH000000000, PA000000, PA000000000, PD000000, PD000000000, PH000000, PH000000000, WA000000, WA000000000, WCA000000, WCA000000000, WCD000000, WCD000000000, WCH000000, WCH000000000, WD000000, WD000000000, WH000000, WH000000000."

The HICN must be a continuous string, with no hyphens or embedded spaces. The HICN allows CMS to match HEDIS data to other patient-level data for dual/low income subsidy work and other research projects. Because this is the key field for linking members to other CMS databases, the HICN must be present in the proper format, without spaces or other random characters. Although the nine digits in the HICNare often the same as a member's Social Security Number (SSN), this may not always be the case, so do not substitute a member's SSN for the HICN. **If the HICNof the member has changed, please make sure to submit the HICN the member held for the measurement year 2016.**

Table 1: HICNexamples

Valid HIC Number	Invalid HIC Number	Reason for Invalid
123456789A	123-456-789-A	Dashes present in the HICN
987654321D4	987654321D4	Embedded spaces in the beginning of the HICN
A123456	A-123456	Dashes present in the HICN
MA123456	MA123456AM	BIC present at the beginning and at the end of the HICN
123456789A	000456789A	The starting digits cannot be '000' in a HICN
123456789A	W21234560000	The last digits cannot be '0000' in a HICN
WR123456789	WW123456789	'WW' is not a valid BIC in a HICN
123456789B	000000000B	Substituting all 0s is not a valid HICN

Note: For more information regarding the HICNs please follow the link below (Refer to Section 50.4.2 - Identifying the Patient's Health Insurance Record Using the Health Insurance Card):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c02.pdf

2.5 File Validation Rules

Each record in the data set will be validated against the following validation rules:

- Each row will be validated to ensure that it is exactly 173 characters long.
- Numeric values (e.g., member months, denominators, and numerators) must be right-justified and blank filled to the left of the value.
- Text fields (e.g., “Organization Name” in the Header records and the “HICN in the Detail records) must be left-justified and **blank filled to the right of the value.**

2.6 Common Submission Errors

Table 2: Common Submission Errors

Error	Explanation
"Contract numbers in file name and header do not match for file name" "Invalid contract number in header for file name."	The contract number of the file name does not match the header line inside the file. Please name the file according to the following CMS policies and procedures below. Please note that the file name variables are shown in lowercase, italic letters (e.g., "*guid*"), however all other file name components should be coded **exactly** as shown. **Gentran File Name**: *guid*.NONE.HEDIS.Y.*ccccc*.PCR.DYYMMDD.THHMMSST.*s* **Actual Submission Name** Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.PCR.DYYMMDD.THHMMSST.P **Test Submission Name**: Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.PCR.DYYMMDD.THHMMSST.T **MFT Internet Server:** *guid*.NONE.HEDIS.Y.*ccccc*.PCR.DYYMMDD.THHMMSST.*s* **Actual Submission Name:** Example: AAAAAAA.NONE.HEDIS.Y.H*xxxx*.PCR.DYYMMDD.THHMMSST.P NOTE: “AAAAAAA” = System ID **Test Submission Name:** Example: AAAAAAA.NONE.HEDIS.Y.H*xxxx*.PCR.DYYMMDD.THHMMSST.T NOTE: “AAAAAAA” = System ID **Connect:Direct File Name:** *s#*EFT.ON.HEDIS.*ccccc*.PCR.DYYMMDD.THHMMSST **Actual Submission Name:** Example: P#EFT.ON.HEDIS.H*xxxx*.PCR.DYYMMDD.THHMMSST **Test Submission Name:** Example: T#EFT.ON.HEDIS.H*xxxx*.PCR.DYYMMDD.THHMMSST

Error	Explanation
"[NAME OF MEASURE] **Column** [XXX-XXX] [NAME OF MEASURE] **Row** [XXX] **has** [1] **column(s) with errors Column** [X] [NAME OF MEASURE]"	There are incorrect characters, an incorrect number of characters, or the data for that measure is missing. Each measure in the "HEDIS 2017 Patient Level Data File Specifications File 2 of 2 Files" document is explained in the "Detail Record" section and lists the accepted values for that measure. This error could occur when the value submitted does not fit the criteria. For example, if the allowed values are "0," and "1," but the value submitted is "7," that would be counted as an error. Numeric values (e.g., ages, weights) must be right-justified and blank filled to the left of the value. For example, the values should look like "0" and not "0." This error could also occur if there are no characters in the submitted field when at least one character is required.
"Row data does not contain correct number of bytes"	One or more rows exceed or are shorter than the total characters required for that row. The "HEDIS 2017 Patient Level Data File Specifications File 2 of 2 Files" document details the number of characters for each row. If the number of characters exceeds the accepted limit, the file will not be accepted.
"Admission Date should be less than Discharge Date"	Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

3. HEDIS® 2017 Patient-Level File Specifications, 2016 Measurement Year

3.1 Header Record

Refer to Excel attachment in the email sent by the Scope Infotech team.

3.2 Detail Record

Refer to Excel attachment in the email sent by the Scope Infotech team.

Appendix A: Record of Changes

Table 3: Record of Changes

Version Number	Date	Author/Owner	Description of Change
1.0	12/01/2016	Mohan Gowda	Update for 2017.
1.1	12/09/2016	Mohan Gowda	Updated for comments from CMS.

Appendix B: Approvals

The undersigned acknowledge that they have reviewed this document and agree with the information presented within this document. Changes to this document will be coordinated with, and approved by, the undersigned, or their designated representatives.

Signature:		Date:	
Print Name:	Lori Teichman		
Title:	CMS Project Officer		
Role:	CMS Approver		
Signature:		Date:	
Print Name:	Mary Braman		
Title:	NCQA Assistant Vice President		
Role:	Measure Validation		
Signature:		Date:	
Print Name:	Brian Anderson		
Title:	Project Manager		
Role:	Scope Infotech Approver		