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

HEDIS®

2017 Patient-Level Data File Specifications File 1 of 2 Files (2016 Measurement Year)

Version 1.0 Final

12/01/2016

Document Number: HEDIS_PLD-014-2016-PLD-DATA-SPEC-1-v.1.0
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 1 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 1 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. The instructions for File 2 are in a separate document ("2017_HEDIS_Patient_Level_Data_File_Specifications_File_2_of_2")

Contracts that fail to submit an error-free File 1 by the submission deadline will receive 1 star in each of the 2017 Star Ratings measures included in this file. The measures are: Breast Cancer Screening (BCS), Colorectal Cancer Screening (COL), Adult BMI Assessment (ABA), Osteoporosis Management in Women Who Had a Fracture (OMW), Comprehensive Diabetes Care (CDC) – Eye Exam, Comprehensive Diabetes Care (CDC) – Medical Attention of Nephropathy, Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9.0%), Controlling High Blood Pressure (CBP) and Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART).

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

1.5 Document Structure

NOTE: There are no changes to the Measures or the excel file-layout for the 2016 Measurement year.

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 allowed for each column. If you haven't received the email, please feel to contact the Scope Infotech team via the contact details below:

Email: ma_patient_data@scopeinfotechinc.com
Phone: 877-996-1333
Hours of Operation:
April 3 – May 5: M-F 9:00 a.m. to 5:00 p.m. EDT
May 30 – June 15: M-F 8:00 a.m. to 6:30 p.m. EDT

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 each measure. The patient file should contain all beneficiaries enrolled in the contract at the time the summary measures are calculated. The patient file 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. If the measure was calculated using the hybrid method, the patient-level data should be reported on the minimum required sample size, including additional records, if an "over-sample" method was used, or the total denominator population, if the sample was smaller than the minimum required sample size.

2.2 Inclusion of Contract Number

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

2.3 Inclusion of HICN

Include the 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 (HIC numbers) (Rev. 1, 09-11-02)

All HIC numbers 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 - HIC numbers 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 - HIC numbers 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 HIC numbers 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., WD-001234. 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 HIC numbers (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 HIC number 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, it is critical that the HICN be present and in the proper format, without spaces or other random characters. Although the nine digits in the HICN are often the same as a member's Social Security Number, this may not always be the case, so it is important **NOT** to substitute a member's Social Security Number for the HICN. **If the HICN of the member has changed, use the HICN that the member had in measurement year 2016..**

Table 1: HICN examples

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 HIC number
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 - Identifying the Patient's Health Insurance Record Using the Health Insurance Card):

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

2.4 Use Logical vs. Quantitative Values in Numerators and Denominators

The HEDIS 2017 Patient-Level Data File Specifications require logical values for some measures and quantitative values for others. An example of a logical value is found in the Breast Cancer Screening measure. Values of “1” or “0” indicate that the member was either included, or not included, in the numerator or denominator of the measure. An example of a quantitative value can be found in the Follow-Up After Hospitalization for Mental Illness measure, where the submission will show a numerical value that indicates the number of times the member was included in the numerator or denominator of a measure. Pay special attention to the description of each measure in these instructions to derive a valid, acceptable value. Do not use a quantitative value of “2” in columns where only logical values of “1” and “0” are accepted. Please do not use stars, asterisks, or any other values; they are not acceptable.

2.5 Member Months Values and Value of Zero (0) in Member Months Field

The member month contribution (MMC) is the number of months each Medicare member was enrolled in the contract in 2016. The MMC does not vary by measure and does not apply to the Effectiveness of Care or Risk Adjusted Utilization measures. The MMC pertains to only Utilization measures. Each member should have a member month contribution value between "0" and "12". Values greater than "12" are not acceptable.

A value of “0” is valid for the member months’ field in the rare instances when a member may have incurred plan services early in January 2016 and been included in one or more HEDIS measures, but perhaps dis-enrolled prior to the point at which they met the definition for incurring a member month as defined by the plan.

Some members may have “aged” into the Medicare product from the plans commercial product or have dual eligibility with Medicare and Medicaid during the year. In these instances, the contribution to the MMC calculation of a non-Medicare product should not be counted.

2.6 How to Report Rates of “NR,” “NB,” and “NA” in Patient-Level Submissions

Reported rates of “NR” should be recorded in the patient-level file as a “0.” in the numerator and denominator field for all members. For Effectiveness of Care measures with multiple numerators (e.g., Comprehensive Diabetes Care) that are either “NR” or “R,” plans should report “0” in the each "NR" measure's numerator field and record either “0” or “1,” for each numerator assigned an “R.” For such a measure, if at least one of the numerators receives an “R,” members who were included in the eligible population for HEDIS rate calculation should also show a “1” in the associated denominator column.

If the measure rate is “NB” because the plan does not offer a benefit required for the measure (e.g., pharmacy benefit for Antidepressant Medication Management), each member should receive a “0” for both the denominator and numerator(s) of the measure.

If the measure rate is “NA” because of an insufficient number of members in the eligible population, those members who were in the eligible population of the measure and those who received the event or service in question should be counted in the denominator and numerator, respectively.

Table 2: Member Designation Reporting

Member Designation	Reported Numerator	Reported Denominator
"NR"	"0"	"0"
Multiple numerators – Some "NR" and some "R"	"0" for "NR". "0" or "1" for "R"	"1" for at least 1 "R"
"NB" (plan doesn't offer benefit required)	"0"	"0"
"NA" (insufficient number of members)	Number of members who received event/service	Number of members in eligible population

For example, if a plan has 29 members in the eligible population for the Breast Cancer Screening and 20 members who qualified for inclusion in the numerator, the plan's IDSS submission will show "NA" as the reported rate. In its patient-level data file, the plan should show a "1" in Column 100 for each of the 29 eligible members and a "1" in Column 101 for each of the 20 members who received the screening.

Table 3: Example Plan

Measure	Number of Members per group	Patient-Level Data File – Members' Data Entries	IDSS Submission – Plan's Data Entry
Eligible Population	29 members	"1" in Column 100	"NA"
Qualified for inclusion in numerator	20 members	"1" in Column 101	

2.7 How to Report Data When Using the Hybrid Data Collection Method

When using the hybrid method, go to the specific measure denominator field for the final set of sampled members and record a "1". For the final set of sampled members who recorded a numerator "hit" when the HEDIS measure was calculated, go to the specific measure numerator field, and record a "1".

Table 4: Reporting Hybrid Data

	Patient-Level Data File – Members' Data Entries
Final Set of Sampled Members	"1" in denominator
Final Set of Sampled Members Who Recorded a Numerator "Hit" When the HEDIS Measure was Calculated	"1" in numerator

For example, in a sample of 411 members drawn from the eligible population for Colorectal Cancer Screening, 275 members may have been identified as receiving the procedure through administrative data and another 50 through medical record review. Therefore, all the 325 members identified through either method should show a "1" in the numerator, with the 411 sampled members from the eligible population having a "1" in the denominator column.

2.8 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 878 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 “HIC Number” in the Detail records) must be left-justified and blank filled to the right of the value.

2.9 Common Submission Errors

Table 4: 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 as per 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*.DYYMMDD.THHMMSST.*s* **Actual Submission Name:** Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.DYYMMDD.THHMMSST.P **Test Submission Name:** Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.DYYMMDD.THHMMSST.T **MFT Internet Server:** guid.NONE.HEDIS.Y.*ccccc*.DYYMMDD.THHMMSST.*s* **Actual Submission Name:** Example: AAAAAAA.NONE.HEDIS.Y.H*xxxx*.DYYMMDD.THHMMSST.P NOTE: “AAAAAAA” = System ID **Test Submission Name:** Example: AAAAAAA.NONE.HEDIS.Y.H*xxxx*.DYYMMDD.THHMMSST.T NOTE: “AAAAAAA” = System ID **Connect:Direct File Name**: *s*#EFT.ON.HEDIS.*ccccc*.DYYMMDD.THHMMSST **Actual Submission Name:** Example: P#EFT.ON.HEDIS.H*xxxx*.DYYMMDD.THHMMSST **Test Submission Name:** Example: T#EFT.ON.HEDIS.H*xxxx*.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, the incorrect number of characters, or data for that measure is missing. Each measure in the "HEDIS 2017 Patient Level HEDIS Submission Instructions" document is explained in the Detail Record section. For each measure, there is a criterion listed for the accepted values. This error could occur when the value submitted does not fit the criteria. For example, if the allowed values are "0," or "1," but the value submitted is "7." Numeric values (e.g., member months, denominators, and numerators) must be right-justified and blank filled to the left of the value. For example, "0" not "0." This error could 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 is shorter than the total characters required for that row. The "HEDIS 2017 Patient Level HEDIS Submission Instructions" document details the number of characters for each row. If the number of characters exceeds the accepted limit, the file will not be accepted.

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 5: Record of Changes

Version Number	Date	Author/Owner	Description of Change
1.0	12/01/2016	Mohan Gowda	Update for 2017.

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 Director		
Role:	Scope Infotech Approver		