Centers for Medicare & Medicaid Services

Healthcare Effectiveness Data and Information Set (HEDIS®)

2020 Patient-Level Detail (PLD) Data File Specifications

File 2 of 2 (2019 Measurement Year)

Version 1.1
12/23/2019

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Contract Number: HHSM-500-2016-00057C

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1. Introduction

1.1 Purpose

This document describes the file-layout for "File 2 of 2" 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), Cost Plans and Demonstration Plans.

1.2 Scope

This specification document is intended to assist the participating Plans in understanding File 2 specifications.

The following changes were made to the 2020 HEDIS Patient Level Data File Specifications File 2 of 2. For a more detailed explanation of changes to the 2020 HEDIS Patient Level Detail Data File Specifications, participating Plans can refer to the 'HEDIS_2019_to_2020_Patient-Level_Data_File_Specifications_Crosswalk'.

1.2.1 Deleted Rows

The following row was deleted from the 2020 Patient-Level Data File, File 2 of 2:

- Base Risk Weight

1.2.2 Changes to Existing Rows

No changes were made to the existing rows.

1.2.3 New Rows

The following new rows were added to the 2020 Patient-Level Data File, File 2 of 2:

- Plan Population
- Outlier Members
- Observation Stay Weight
- Discharge or Transfer to Skilled Nursing Care
- Discharge or Transfer to Skilled Nursing Care: Age/Gender Weight
- Discharge or Transfer to Skilled Nursing Care: Surgery Weight
- Discharge or Transfer to Skilled Nursing Care: Discharge Weight
- Discharge or Transfer to Skilled Nursing Care: Comorbidity Weight. Sum of all Comorbid HCC Weights
- Discharge or Transfer to Skilled Nursing Care: Observation Stay Weight

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

NOTE: This file includes information for the HEDIS measure “Plan All-Cause Readmissions (PCR)” only and is required to be submitted by all participating Plans that submit the HEDIS summary data. Participating Plans with zero enrollment the entire measurement period do not have to submit File 2. 1876 Cost contracts are not allowed to submit summary HEDIS PCR data, so they do not have to submit File 2.

1.3 Technical Support

For technical support regarding this document, contact the HEDIS PLD Help Desk by phone or by email.

HEDIS PLD Help Desk contact details below:

Email: HEDISPLD_Helpdesk@cms.hhs.gov
Phone: 1-877-996-1333
Hours of Operation:
Test Submission Period:

- April 6 – May 1, 2020: M-F 9:00 AM to 5:00 PM ET

Production Submission Period:

- May 26 – June 12, 2020: M-F 8:00 AM to 6:30 PM ET
- June 15, 2020: 8:00 AM to 11:59 PM ET

Participating Plan users may also contact the HEDIS PLD Help Desk by signing into the HEDIS PLD web-portal and submit a Technical Assistance Request (TAR).

1.4 References

- 2020_HEDIS_Patient-Level_Data_File_Submission_Instructions
- 2020_HEDIS_Patient_Level_Data_File_Specifications_File_1_of_2
- 2020_HEDIS_Patient_Level_Data_File_Specifications_File_2_of_2
- 2020_HEDIS_Patient_Level_Data_File_1_of_2
- 2020_HEDIS_Patient_Level_Data_File_2_of_2
- HEDIS_2019_to_2020_Patient-Level_Data_File_Specifications_Crosswalk
- HEDIS 2020 Volume 2: Technical Specifications for Health Plans (visit http://store.ncqa.org/index.php/performance-measurement.html#vol2)
- CMS Data Usage Agreement
- Medicare General Information, Eligibility, and Entitlement: Chapter 2 – Hospital Insurance and Supplementary Medical Insurance
- Understanding the Medicare Beneficiary Identifier (MBI) Format
- Social Security Number Randomization
- Social Security Number Randomization Frequently Asked Questions
- New Medicare Card

2. Important Technical Elements Regarding HEDIS 2020 Patient-Level Submissions

2.1 Patient-Level and Summary-Level Data Must Match

The patient-level file 2 must match the summary-level PCR submission results.. The patient-level file 2 data should be calculated following the same 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 inpatient 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 readmissions (numerator) but did have acute in-patient stays (denominator) should submit a PLD File 2 containing those denominator acute inpatient stays.

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 Number (HICN)

Include the Health Insurance Claim Number (HICN) for every contract member enrolled at any point during the measurement year (2019). The HICN number 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 capitalized letter suffix (called a beneficiary identification code or BIC) in the tenth position. If there is an eleventh position, it may be either a capitalized 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 capitalized 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.*

On July 3, 2007, the SSA published its intent to randomize the nine-digit SSN in the Federal Register Notice, Protecting the Integrity of Social Security Numbers [Docket No. SSA 2007-0046]. The SSA changed the way SSN are issued in June 25, 2011. The change is referred to as 'randomization'. Randomization was created to help protect the integrity of the SSN. The SSA eliminated the geographical significance of the first three digits of the SSN, referred to as the area number, by no longer allocating the area numbers for assignment to individuals in specific states. Randomization also introduced previously unassigned area numbers for assignment excluding area numbers 000, 666 and 900-999. SSN randomization will not assign group number 00 or serial number 0000. SSNs containing group number 00 or serial number 0000 will continue to be invalid.

SSN randomization affected the SSN assignment process in the following ways:

- *It eliminated the geographical significance of the first three digits of the SSN, referred to as the area number, by no longer allocating the area numbers for assignment to individuals in specific states.*
- *It eliminated the significance of the highest group number and, as a result, the High Group List is frozen in time and can only be used to see the area and group numbers SSA issued prior to the randomization implementation date.*
- *Previously unassigned area numbers were introduced for assignment excluding area numbers 000, 666 and 900-999.*

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 capitalized 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, it is critical that the HICN be present and in the proper format, without spaces, no lowercase alpha characters, 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, please make sure to submit the HICN the member held for the measurement year 2019.**

Table 1: HICN Examples

Valid HICN	Invalid HICN	Reason for Invalidity
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

WR123456789	Wr123456789	All alpha characters in the HICN should be capitalized

Note: For more information regarding the HICNs please follow the link (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 Medicare Beneficiary Identifier (MBI) Format

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, required CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based HICN. The transition period began around April 1, 2018 and will run through December 31, 2019.

The MBI has 11 characters, like the Health Insurance Claim Number (HICN), which also can have up to 11. MBIs are numbers and upper-case letters. MBI uses numbers 0-9 and all letters from A to Z, except for S, L, O, I, B, and Z. The MBI's 2nd, 5th, 8th, and 9th positions will always be a letter, except for S, L, O, I, B, and Z. Positions 1st, 4th, 7th, 10th, and 11th will always be a number. The 3rd and 6th positions will be a letter or a number. MBIs does not have spaces and dashes.

Note: The first position in the MBI will be a numeric value 1 through 9 only. MBIs should not start with a "0".

Table 2: MBI Format

Position	1	2	3	4	5	6	7	8	9	10	11
Type	C	A	AN	N	A	AN	N	A	A	N	N

C – Numeric 1 through 9
N – Numeric 0 through 9
AN – Either A or N
A – Alphabetic Character (A... Z); Excluding (S, L, O, I, B, Z)

Table 3: MBI Examples

Valid MBI	Invalid MBI	Reason for Invalidity
2M30GF8DP56	0M3G0F8DP56	The first character cannot be 0
9G30ME7KT23	9g30me7kt23	All alpha-characters should be upper-case
1W56QX2NT63	1W5-6QX-2NT-63	Dashes are present in the MBI
1GF6JX2DT72	1GF6JX2DT72	Embedded spaces in the beginning of the MBI
3VD0H35AT10	3VD0H35AT1	MBI are 11 characters long

Note: Participating Plans can only submit either a HICN or MBI. For more information regarding the MBIs please follow the link below: https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI-with-Format.pdf.

2.6 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 242 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.

- Contract number in the file name and the corresponding Submission ID will be validated against the submission list.
- Participating Plans are expected to submit HEDIS PLD Files using their MA Submission IDs and not PBP Submission IDs
- Only contract numbers that are in the submission list for File 2 will be processed
- The system will reject mismatch contracts number in the file name and the header of the file. If the contract number in the filename does not match the contract number in the Header record, the file will not be processed and subsequently rejected
- Participating Plans are only to include either HICN or MBI for every contract member enrolled at any point during the 2019 measurement year

2.7 Common Submission Errors

Table 4: Common Submission Errors

Error	Explanation
"The contract number in the file name does not match the contract number in the header of the file" "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.s **Production Submission File Name** Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.PCR.P **Test Submission File Name**: Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.PCR.T **MFT Internet Server File Name:** *guid*.NONE.HEDIS.Y.*ccccc*.PCR.*s* **Production Submission File Name:** Example: AAAAAAA.NONE.HEDIS.Y.H*xxxx*.PCR.P NOTE: "AAAAAAA" = System ID **Test Submission File Name:** Example: AAAAAAA.NONE.HEDIS.Y.H*xxxx*.PCR.T NOTE: "AAAAAAA" = System ID **Connect:Direct File Name:** *s*#EFT.ON.HEDIS.*ccccc*.PCR.DYYMMDD.THHMMSST **Production Submission File Name:** Example: P#EFT.ON.HEDIS.H*xxxx*.PCR.DYYMMDD.THHMMSST **Test Submission File 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 2020 Patient Level Data File 2 of 2" document is explained in the "Detail Record" section 3.2 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 2020 Patient Level Data File 2 of 2" document details the number of characters for each row in specification document. 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.
"A production file has been submitted during the test submission period. The file will not be processed. Refer to the Submission Instructions for more information."	A production file was submitted during the testing period. The file will not be processed. Please refer to section 2.10 File Naming Conventions in the *2020 Submissions Instructions* document for more detailed information.
"A test file has been submitted during the production submission period. The file will not be processed. Refer to the Submission Instructions for more information."	A test file was submitted during the production period. The file will not be processed. Please refer to section 2.10 File Naming Conventions in the *2020 Submissions Instructions* document for more detailed information.
"The file that you have submitted does not match the naming specification for File 2. If you intended to submit a PCR File, please verify that both the File Name and the Header contains PCR. Refer to Data Specification File 2 of 2 for more information "	File 2 of 2 should have PCR in the file name and in the header of the file. The system will reject files that have PCR in the file name but not in the header of the file. The system will reject files that have PCR in the header of the file but not in the file name.

3. HEDIS 2020 Patient-Level File Specifications, 2019 Measurement Year

3.1 Header Record

Refer to the 2020_HEDIS_Patient_Level_Data_File_2_of_2

3.2 Detail Record

Refer to the 2020_HEDIS_Patient_Level_Data_File_2_of_2

Appendix A: Record of Changes

Table 5: Record of Changes

Version #	Date	Author/Owner	Description of Change
0.1	11/27/2019	Scope Infotech, Inc	Document Creation
0.2	12/04/2019	Scope Infotech, Inc	Addressed Peer Review Comments
0.3	12/05/2019	Scope Infotech, Inc	Addressed PSO Comments
1.0	12/05/2019	Scope Infotech, Inc	Baselined.
1.1	12/23/2019	Scope Infotech, Inc	Addressed Comments from NCQA

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 Contracting Officer Representative (COR)	
Role:	CMS Approver	
Signature:	_____	Date
Print Name:	Mary Braman	
Title:	NCQA Assistant Vice President	
Role:	NCQA Approver	
Signature:	_____	Date
Print Name:	Prathiba Manoharan	
Title:	Project Director	
Role:	Scope Infotech Approver	