Centers for Medicare & Medicaid Services

Healthcare Effectiveness Data and Information Set (HEDIS®)

MY 2021 Patient-Level Detail (PLD) Data File Specifications File 1 of 2

Version 1.1

12/01/2021

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Table of Contents

List of Tables

1. Introduction

1.1 Purpose

This document describes the file-layout for "File 1 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 detail 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 1 specifications.

The following changes were made to the HEDIS Measurement Year (MY) 2021 Patient Level Detail Data File Specifications File 1 of 2. For a more detailed explanation of changes to the HEDIS MY 2021 Patient Level Data File Specifications, participating Plans can refer to the 'HEDIS_MY_2020_to_2021_Patient-Level_Data_File_Specifications_Crosswalk'.

1.2.1 Deleted Measures

The following measure was deleted from the HEDIS MY 2021 PLD Data File, File 1 of 2:

- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

1.2.2 Changes to Existing Measures

One measure was revised in the HEDIS MY 2021 PLD Data File, File 1 of 2:

- 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. The transition period that allowed for the submission of the Health Insurance Claim Number (HICN) ended on 12/31/2019. A new Medicare Beneficiary Identifier (MBI) has replaced the SSN-based HICN. The MBI measure in the HEDIS MY 2021 PLD File, File 1 of 2 was updated to remove reference to the HICN.

1.2.3 New Measures

The following new measures were added to the HEDIS MY 2021 PLD Data File, File 1 of 2:

- Cardiac Rehabilitation (CRE)
- Osteoporosis screening in Older Women (OSW)

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:

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

Email: HEDISPLD_Helpdesk@cms.hhs.gov
Phone: 1-833-760-2116
Hours of Operation:
Annual Dry Run:

- April 4 – April 22, 2022: M-F 9:00 AM to 5:00 PM ET

Annual Data Submission:

- May 25 – June 14, 2022: M-F 8:00 AM to 6:30 PM ET
- June 15, 2022: 8:00 AM to 11:59 PM ET
- May 30, 2022, – Closed for the Memorial Day Holiday

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

- HEDIS_MY_2021_Patient-Level_Data_File_Submission_Instructions
- HEDIS_MY_2021_Patient_Level_Data_File_Specifications_File_1_of_2
- HEDIS_MY_2021_Patient_Level_Data_File_Specifications_File_2_of_2
- HEDIS_MY_2021_Patient_Level_Data_File_1_of_2
- HEDIS_MY_2021_Patient_Level_Data_File_2_of_2
- HEDIS_MY_2020_to_2021_Patient-Level_Data_File_Specifications_Crosswalk
- HEDIS MY 2021 and 2022 Volume 2: Technical Specifications for Health Plans (Please visit https://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
- New Medicare Card

2. Important Technical Elements Regarding HEDIS MY 2021 Patient- Level Data 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-level data should contain all beneficiaries enrolled in the Contract at the time the summary measures are calculated. The patient-level data 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, or if the sample was smaller than the minimum required sample size. Reporting patient-level data should encompass only the members included in the timeframes used in summary measure submitted by your plan. HEDIS specifications regarding timeframes should be strictly followed for each measure and should in no instance include experience from 2022.

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 Medicare Beneficiary Identifier (MBI) Format

The MBI has 11 characters that are a mix of 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. The first position in the MBI will be a numeric value 1 through 9 only. MBIs should not start with a "0".

Table 1: 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 2: 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	Valid MBIs are 11 characters long

NOTE: 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

2.4 Use Logical vs. Quantitative Values in Numerators and Denominators

The HEDIS MY 2021 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 2021. 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. The Enrollment by Product Line (ENP) measure should be used to determine member months.

A value of “0” is valid for the member months’ field in the rare instances when a member may have incurred contract services early in January 2021 and may have been included in one or more HEDIS PLD measures, but perhaps dis-enrolled prior to the point at which they met the definition for incurring a member month as defined by the contract.

Some members may have “aged” into the Medicare product from the contract’s 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, NQ, or BR” “NB,” and “NA” in Patient-Level Submissions

Reported rates of “Not Reported (NR)”, “Not Required (NQ)” and “Biased Rate (BR)” 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, NQ, or BR” or Reportable (R), Plans should report “0” in each "NR, NQ, or BR" 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 PLD rate calculation should also show a “1” in the associated denominator column.

If the measure rate is “No Benefit (NB)” because the contract 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 “Not Applicable (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 3: Member Designation Reporting

Member Designation	Reported Numerator	Reported Denominator
"NR, NQ and BR"	"0"	"0"
Multiple numerators – Some "NR, NQ and BR" and some "R" with single denominator	"0" for "NR, NQ and BR". "0" or "1" for "R"	"1" for at least 1 "R"
Multiple numerators – some “NR” and some “R” for measures with multiple denominators	“0” for “NR” “0” or “1” for “R”	“0” for “NR” “0” or “1” for “R”
"NB" (Contract 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 contract has 29 members in the eligible population for the Breast Cancer Screening (BCS) and 20 members who qualified for inclusion in the numerator, the contract’s Interactive Data Submission System (IDSS) will show “NA” as the reported rate. In its patient-level data file, the contract should show a “1” in BCS denominator for each of the 29 eligible members and a “1” in BCS numerator for each of the 20 members who received the screening.

Table 4: Example Contract

Measure	Number of Members per Group	Patient-Level Data File – Members' Data Entries	IDSS Submission – Contract's Data Entry
Eligible Population	29 members	"1" in BCS denominator	"NA"
Qualified for inclusion in numerator	20 members	"1" in BCS numerator	“NA”

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

When using the Hybrid Method, record “1” in the measure denominator field for the final set of sampled members and record “1” in the measure numerator field for the final set of sampled members who were also in the numerator when the HEDIS PLD measure was calculated.

Table 5: Reporting Hybrid Data

Members	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 PLD Measure was Calculated	"1" in numerator

For example, in a sample of 411, members drawn from eligible population for *Colorectal Cancer Screening,* 275 members may have been identified as receiving the procedure through administrative data, 25 through medical record review and 25 through supplemental data. Therefore, all 325 members identified through all methods show “1” in the numerator and the 411 sampled members from the eligible population show “1” in the denominator column. The PLD Data file does not consider how the member was determined to be numerator compliant.

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 831 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) 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 Data Files using their Medicare Advantage (MA) Submission IDs and not Plan Benefit Package (PBP) Submission IDs
- Only HEDIS PLD files received from Participating Plans will be processed
- The system will reject mismatched contract numbers 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 to include MBI for every contract member enrolled at any point during the 2021 measurement year

2.9 Common Submission Errors

Table 6: 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 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*.FUTURE.*s* **Annual Data Submission File Name:** Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.FUTURE.P **Annual Dry Run File Name:** Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.FUTURE.T **MFT Internet Server File Name:** guid.NONE.HEDIS.Y.*ccccc*.FUTURE.*s* **Annual Data Submission File Name:** Example: AAAAAAA.NONE.HEDIS.Y.H*xxxx*.FUTURE.P NOTE: “AAAAAAA” = System ID **Annual Dry Run File Name:** Example: AAAAAAA.NONE.HEDIS.Y.H*xxxx*.FUTURE.T NOTE: “AAAAAAA” = System ID **Connect:Direct File Name**: *s*#EFT.ON.HEDIS.*ccccc*.DYYMMDD.THHMMSST **Annual Data Submission File Name:**

Error	Explanation
	Example: P#EFT.ON.HEDIS.H*xxxx*.DYYMMDD.THHMMSST **Annual Dry Run File Name:** Example: T#EFT.ON.HEDIS.H*xxxx*.DYYMMDD.THHMMSST
"[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 MY 2021 Patient Level Data File 1 of 2" 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, "0X" not "0X" with “X” representing the blank spaces. 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 MY 2021 Patient Level Data File 1 of 2" document details the number of characters for each row. If the number of characters exceeds the accepted limit, the file will not be accepted.
“The submission ID that you have submitted is incorrect. Please verify the submission ID and resubmit the file. If you have both MA and PBP Submission IDs, please submit the file using the MA submission ID. Refer to the File Specifications for more information.”	The Submission ID is entered in column 67-71. The Submission ID has been validated against the submission list and it does not match. *Due to the addition of 5-digit submission IDs, follow the guidelines below: Submission IDs must be left justified and 4-digit submissions IDs should blank fill column 71. Examples: In column 67-71, a 5-digit ID would be entered as (12345). A 4-digit ID would be entered starting at column 67 as (1234) with “1” bring in column 67, leaving column 71 blank.
"Admission Date should be less than Discharge Date"	Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.
“The contract number in the file name does not match our records. Please verify the contract number and resubmit the file.”	The contract number has been validated against the submission list and it does not match or exists.
“The File 1 that you submitted is not required for submission and will not be processed. Contact the HEDIS PLD Help Desk at HEDISPLD_Helpdesk@cms.hhs.gov if you have any questions regarding this error message.”	According to the submission list, the submitted contract is not required to be submitted and it will not be processed.

Error	Explanation
"A production file has been submitted during the Annual Dry Run period. The file will not be processed. Refer to the Submission Instructions for more information."	A production file was submitted during the Annual Dry Run period. The file will not be processed. Please refer to section *2.10 File Naming Conventions* in the *HEDIS MY 2021 PLD Submissions Instructions* document for more detailed information.
"A test file has been submitted during the Annual Data Submission period. The file will not be processed. Refer to the Submission Instructions for more information."	A test file was submitted during the Annual Data Submission period. The file will not be processed. Please refer to section *2.10 File Naming Conventions* in the *HEDIS MY 2021 PLD Submissions Instructions* document for more detailed information.

3. HEDIS MY 2021 Patient-Level Data File 1 of 2

3.1 Header Record

Refer to the HEDIS_MY_2021_HEDIS_Patient_Level_Data_File_1_of_2

3.2 Detail Record

Refer to the HEDIS_MY_2021_HEDIS_Patient_Level_Data_File_1_of_2

Appendix A: Record of Changes

Table 7: Record of Changes

Version Number	Date	Author/Owner	Description of Change
0.1	10/04/2021	Tashana Nunes, Scope Infotech, Inc.	Document Creation
0.2	10/21/2021	Tashana Nunes, Scope Infotech, Inc.	Addressed peer review comments
0.3	10/26/2021	Tashana Nunes, Scope Infotech, Inc.	Addressed PSO review comments
1.0	10/26/2021	Tashana Nunes, Scope Infotech, Inc.	Approved for baseline
1.1	11/15/2021	Tashana Nunes, Scope Infotech, Inc.	Addressed CMS Comments