Centers for Medicare & Medicaid Services

HEDIS®

2019 Patient-Level Data File Specifications File 1 of 2 (2018 Measurement Year)

Version 1.2

12/28/2018

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Contract Number: HHSM-500-2016-00057C

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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 quality of care measures received from Medicare Advantage Organizations (MAOs).

Contracts that fail to submit error-free HEDIS 2019 PLD files by 11:59 p.m. Eastern Time, on Monday, June 17, 2019, will receive one star in each of the 2020 Star Ratings measures included in the file. The measures per file are:

HEDIS PLD File 1 (MA & 1876 Cost contracts):

- 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%)
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)
- Medication Reconciliation Post-Discharge (MRP)
- Statin Therapy for Patients with Cardiovascular Disease (SPC)

1.2 Scope

This specification document is intended to assist MA Contracts understand File 1 of 2 specifications. The instructions for File 2 are in a separate document ("2019_HEDIS_Patient_Level_Data_File_Specifications_File_2_of_2").

The following changes were made to the 2019 HEDIS Patient Level Data File Specifications File 1 of 2. For a more detailed explanation of changes to the 2019 HEDIS Patient Level Data File Specifications, MA Contracts can visit the 'Documents' tab on the MAPLD Website to view the Crosswalk Documents.

1.2.1 Deleted Measures

No measures were deleted from the 2019 Patient-Level Data File, File 1 of 2.

1.2.2 Changes to existing Measures

The following measures experienced changes in the 2019 Patient-Level File Data, File 1 of 2:

- Follow-Up After Hospitalization for Mental Illness (FUH)

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

    - Added New Age Stratification
- Identification of Alcohol and Other Drug Services (IAD)
    - Updated from 'Outpatient/MAT Services' to 'Outpatient/Medication Treatment'
- Acute Hospital Utilization (AHU)
    - Removed row for 'Eligible Population'
    - Removed 'Inpatient' from 'Observed Inpatient Discharges'
- Hospitalization for Potentially Preventable Complications (HPC)
    - Removed row for 'Eligible Population'
    - Added Total ACSC Non-Outlier
    - Added Total ACSC Outlier
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
    - Added New Age Stratification
- Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)
    - Updated Measure Field Description from 'People With High-Risk' to 'People With Multiple High-Risk'
- Breast Cancer Screening (BCS)
    - Added new SES Stratifications
- Colorectal Cancer Screening (COL)
    - Added new SES Stratifications
- Comprehensive Diabetes Care (CDC) Eye Exam
    - Added new SES Stratifications

1.2.3 New Measures

No new measures were added to the 2019 HEDIS Patient-Level File Data, File 1 of 2.

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. Users may also contact the Scope Infotech Team by signing into the MAPLD web-portal and submit a Technical Assistance Request (TAR).

1.4 References

- HEDIS 2019 Patient-Level Submission Instructions, HEDIS 2019 Patient-Level File Specifications File 1 of 2, and 2018 to 2019 Patient-Level Data File Specifications Crosswalk (Please visit the 'Documents' tab at https://mapld.scopeinfotechinc.com)
- HEDIS 2019 Volume 2: Technical Specifications for Health Plans (Please 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

1.5 Document Structure

The Excel attachment which provides a column-by-column description of the Header record and Detail record layouts is located on the 'Documents' tab at the MAPLD website at https://mapld.scopeinfotechinc.com. The Excel attachments includes valid ranges or values allowed for each column. If you have questions regarding the excel attachment, you may contact the Scope Infotech team via the contact details below:

Email: ma_patient_data@scopeinfotechinc.com
Phone: 877-996-1333
Hours of Operation:
Test Submission Period:

- To be determined by CMS

Production Submission Period:

- May 28, 2019 – June 14, 2019: M-F 8:00 AM to 6:30 PM ET
- June 17, 2019: 8:00 AM to 11:59 PM ET

2. Important Technical Elements Regarding HEDIS 2019 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-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, 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 Health Insurance Claim Number (HICN)

Include the Health Insurance Claim Number (HICN) for every contract member enrolled at any point during the measurement year (2018). 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 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 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 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 last HICN the member held for the measurement year 2018.**

Table 1: HICN Examples

Valid HICN	Invalid HICN	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
WR123456789	wr123456789	All alpha characters in the HICN should be capitalized

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 Medicare Beneficiary Identifier (MBI) Format

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, requires 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 will begin no earlier than April 1, 2018 and run through December 31, 2019.

MBI has 11 characters, unlike the Health Insurance Claim Number (HICN), which can have up to 12. 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. The first position in the MBI will be a numeric value 1 thru 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 thru 9
N – Numeric 0 thru 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 Invalid
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

2.5 Use Logical vs. Quantitative Values in Numerators and Denominators

The HEDIS 2019 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.

2.6 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 2018. 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 2018 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 contract.

Some members may have “aged” into the Medicare product from the contracts 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.

2.7 How to Report Rates of “NR, NQ, or BR” “NB,” and “NA” in Patient-Level Submissions

Reported rates of “NR, NQ and 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 “R,” contracts 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 rate calculation should also show a “1” in the associated denominator column.

If the measure rate is “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 “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 4: Member Designation Reporting

"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 and 20 members who qualified for inclusion in the numerator, the contract’s IDSS submission 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 5: Example Contract

Eligible Population	29 members	"1" in BCS denominator	"NA"
Qualified for inclusion in numerator	20 members	"1" in BCS numerator	“NA”

2.8 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 a numerator hit when the HEDIS measure was calculated.

Table 6: 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 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 file does not consider how the member was determined to be numerator compliant.

2.9 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 883 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 NCQA extract.
- MA Contract Members are expected to submit HEDIS PLD Files using their MA Submission IDs and not PBP Submission IDs.
- Only contracts allowed to submit File 1 as per the NCQA extract will be processed.
- If the contract number in the filename does not match the contract number in the Header record, this file will not be processed and subsequently rejected.
- MA Contract are only to include either HICN or MBI for every contract member enrolled at any point during the 2018 measurement year.

2.10 Common Submission Errors

Table 7: 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* **Actual Submission Name:** Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.FUTURE.P **Test Submission Name:** Example: UHCDDMV.NONE.HEDIS.Y.H*xxxx*.FUTURE.T **MFT Internet Server:** guid.NONE.HEDIS.Y.*ccccc*.FUTURE.*s* **Actual Submission Name:** Example: AAAAAAA.NONE.HEDIS.Y.H*xxxx*.FUTURE.P NOTE: "AAAAAAA" = System ID **Test Submission 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 **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 2019 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, "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 2019 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.
"The submission ID that you have submitted has been validated and it does not match with the NCQA provided list. 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 detailed information"	The Submission ID is entered in column 67-71. The Submission ID is a unique identifier assigned by NCQA to the CMS contract for summary-level data submission. *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.
"The following contract number in the file name does not match the NCQA provided list."	The contract number has been validated against NCQA provided list and it does not match or exists.
“The File that you submitted is not required for submission according to NCQA provided list and will not be processed. Contact the HEDIS Helpdesk at Ma_patient_data@scopeinfotechinc.com if you have any questions regarding this error message”	According to the NCQA provided list, the submitted contract is not required to be submitted and it will not be processed.
"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 *2019 Submissions Instructions* document for more detailed information.

Error	Explanation
"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 *2019 Submissions Instructions* document for more detailed information.

3. HEDIS 2019 Patient-Level File Specifications, 2018 Measurement Year

3.1 Header Record

Refer to 2019 Data Specification File 1 of 2 excel attachment located at the 'Documents' tab of the MAPLD Website: https://mapld.scopeinfotechinc.com

3.2 Detail Record

Refer to 2019 Data Specification File 1 of 2 excel attachment located at the 'Documents' tab of the MAPLD Website: https://mapld.scopeinfotechinc.com

Appendix A: Record of Changes

Table 8: Record of Changes

Version Number	Date	Author/Owner	Description of Change
0.1	11/27/2018	Scope Infotech, Inc.	Initial Draft for peer/QA review.
1.0	12/03/2018	Scope Infotech, Inc.	Document Baselined.
1.1	12/14/2018	Scope Infotech, Inc.	Addressed NCQA's Comment.
1.2	12/28/2018	Scope Infotech, Inc.	Updates made to remove test submission schedule for 2019 submission.

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:	/Signed/	Date:	12/28/2018
Print Name:	Lori Teichman		
Title:	CMS Contracting Officer Representative (COR)		
Role:	CMS Approver		

Signature:	/Signed/	Date:	12/28/2018
Print Name:	Mary Braman		
Title:	NCQA Assistant Vice President		
Role:	NCQA Approver		

Signature:	/Signed/	Date:	12/28/2018
Print Name:	Prathiba Manoharan		
Title:	Project Director		
Role:	Scope Infotech Approver		