HEDIS® 2016 Patient-Level Data File Specifications, File 1 of 2 Files (2015 Measurement Year)

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Prepared for:
Lori Teichman
CMS Project Officer
Centers for Medicare & Medicaid Services
CMS/CM/MDBG/DCAPP
7500 Security Blvd, Mailstop C1-25-05
Baltimore, MD 21244-1850

Prepared by:

Edaptive
Intelligently Adapting Technology

400 Red Brook Blvd, Suite 120

Owings Mills, MD 21117

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Final Approvals

Title	Name	Signature (or type name)	Date
CMS Project Officer	Lori Teichman	Lori Teichman	1/12/2016
NCQA Assistant Vice President, Measure Validation	Mary Braman	Mary Braman	1/11/2016
Edaptive Project Manager	Lynne Blair	Lynne Blair	1/12/2016

1 Introduction

1.1 Purpose

This document describes the file layout, for File 1 of 2 files, that supports the Centers for Medicare & Medicaid Services (CMS) annual collection of Healthcare Effectiveness Data and Information Set (HEDIS®) 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, that is required to be submitted for HEDIS 2016 patient-level data for the measurement year 2015. The document includes specifications for the "header" record and "detail" records. The instructions for File 2 are in a separate document.

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 Arhtritis (ART).

1.3 Technical Support

For technical support regarding this document, contact Team Edaptive by phone at 1-877-996-1333 or by email at ma_patient_data@hcdi.com.

1.4 References

- HEDIS® 2016 Patient-Level Submission Instructions
- HEDIS® 2016 Volume 2: Technical Specifications for Health Plans
- CMS Data Usage Agreement

1.5 Document Structure

An Excel attachment to this introductory document provides a column-by-column description of the Header Record and Detail Record layouts, and includes valid ranges or values allowed for each column.

2 Important Technical Elements Regarding HEDIS 2016 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 Health Insurance Claim (HIC) Number

Include the Health Insurance Claim (HIC) number for every contract member enrolled at any point during the measurement year (2015). The HIC number is the number assigned by CMS to the member upon applying for Medicare services. For most members, the HIC number consists of a nine-digit Social Security number followed by one or two alphanumeric characters (e.g., 111223333A, 123456789C1). Only members entitled to Medicare under the Railroad Retirement Board will have a different HIC number format. Typically, the format for these members **starts** with one or two alpha characters (e.g., WA123456). The HIC number 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 HIC number be present and in the proper format, without spaces or other random characters. Although the nine digits in the HIC number 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 HIC number.

2.4 Use of Logical vs. Quantitative Values in Numerators and Denominators

The ***HEDIS 2016 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 2015. 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 2015 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 plan'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," "NB" and "NA" in Patient-Level Submissions

Reported rates of "NR" should be recorded in the patient-level file as a "0." Each member would show a "0" in the numerator and denominator field for all measures receiving an "NR." For *Effectiveness of Care* measures with multiple numerators (e.g., *Comprehensive Diabetes Care*), in which some numerators have been designated as "NR" and some "R," plans should report "0" in the numerator field for each member in each measure designated as "NR," and record a "0" or "1," as appropriate, 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 the purpose of calculating the HEDIS rate 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. 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.

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

When using the hybrid method, record a "1" in the specific measure denominator field for the final set of sampled members and a "1" in the specific measure numerator field for the final set of sampled members who recorded a numerator "hit" when the HEDIS measure was calculated. 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 and another 50 through medical record review. Therefore, all of 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 record 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

Error		Explanation
Contract numbers in file name and header do not match for file name **Invalid contract number in header for file**		*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: Note: file name variables are shown in *lowercaseitalicletters*, all other file name components should be coded **exactly** as shown. **Gentran File Name:***guid*.NONE.HEDIS.Y.*ccccc*.DYYMMDD.THHMMSST.*s*

Error		Explanation
name		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:** g*uid*.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
[*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 2016 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		*One or more rows exceed or is shorter than the total characters required for that row.*

Error		Explanation
correct number of bytes.		The ***HEDIS 2016 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.