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CMS
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FACT SHEET

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Final rule on release of Medicare data to be used for performance measurement

On Dec. 5, 2011, the Centers for Medicare & Medicaid Services (CMS) announced a final rule that will make more information available to the public about the performance of providers and suppliers, while protecting patient privacy. The final rule explains how organizations can become qualified by CMS to receive standardized extracts of Medicare claims data under Parts A, B, and D for the purpose of measuring provider and supplier performance.

The final rule is required by the Affordable Care Act as part of an initiative to promote transparency in the provision of health care services, giving beneficiaries access to information that will help them make more informed decisions about their health care. CMS has made significant modifications in the final rule to respond to concerns expressed in comments about the cost and timeliness of data, flexibility and innovation in measure calculation, and timeframes for provider's and supplier's review and appeal of draft reports.

Provisions of the Final Rule

Eligibility Requirements

To be eligible to participate in the program, qualified entities and their contractors will need to have experience in a variety of tasks related to the calculation and reporting of performance measures, including combining claims data from different payers, designing performance reports, sharing performance reports with the public, working with providers and suppliers regarding requests for error correction, and ensuring the privacy and security of data. Qualified entities will also need to have access to claims data from other sources to combine with the Medicare data in the evaluation of providers and suppliers. They will also need strong systems to ensure the data is secure and protected.

In response to public comments, CMS made the following changes in the final rule:

- Clarified that qualified entities do not need to be a single organization. Applicants may contract with others to achieve the ability to meet the eligibility criteria. Specifically, entities can demonstrate expertise and experience through activities it has conducted directly or through (a) contract(s) with other public or private entities.
- Revised the selection criteria to allow applicants to apply and receive a conditional acceptance as a qualified entity if they do not have other claims data at the time of their application, but meet all the other selection requirements.

Standard and Alternative Measures and Public Reporting

In the NPRM, CMS proposed to allow qualified entities to use only measures calculated in full from claims data. Comments from potential qualified entities, providers, and consumer groups stated that measures that incorporate clinical data offer a more complete and accurate picture of the performance of providers and suppliers. In response to these comments, the final rule allows qualified entities to use standard and alternative measures calculated in full or in part from claims data. This means that qualified entities can calculate measures that include clinical data.

As proposed in the NPRM, standard measures would include any measures endorsed by the National Quality Forum; measures developed pursuant to section 931 of the Public Health Service Act; or claims-based measures that were adopted through rulemaking for use in a current CMS program that includes performance measurement. In the final rule, CMS added measures endorsed by a CMS-approved consensus-based entity to the list of standard measures. CMS will approve organizations as consensus-based entities based on review of documentation of the consensus-based entity's measure approval process.

Individuals or organizations will also be able to submit alternative measures to the Secretary for approval. In the NPRM, CMS proposed that notice and comment rulemaking would be used to obtain public comment on a proposed alternative measure and to help the Secretary determine if the proposed measure is more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use than existing claims-based measures. The final rule retains the original proposal and establishes a second process by which qualified entities may seek approval to use alternative measures. The new provision allows a qualified entity to receive approval to use an alternative measure by submitting documentation to CMS outlining consultation and agreement with stakeholders in the geographic region the qualified entity serves and scientific evidence that the measure is "more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures." Stakeholders must include the input of a valid cross representation of providers of services, suppliers, employers, payers, and consumers in any such request.

The final rule also clarifies that these regulations do not place any added limitations on the qualified entity's ability to copyright the content of the publicly released reports. However, the qualified entity must provide confidential reports to providers of services and suppliers discussed in the reports free of charge and must provide the final reports to the public in a manner consistent with the requirements in the statute.

Data Extraction and Dissemination

In response to public comments about the cost and timeliness of the Medicare claims data, CMS identified efficiencies that will reduce the cost of Medicare claims data under the qualified entity program. CMS estimated that the average cost for a qualified entity for the first year of the program is $40,000, down from the $200,000 estimate in the proposed rule. The estimate is based off the assumption that there will be 25 qualified entities and that the average qualified entity will request data for approximately 2.5 million beneficiaries. In addition, CMS changed the rule to give qualified entities access to more timely Medicare claims data.

In the NPRM, CMS proposed to only release nationwide Medicare claims data if a qualified entity had sufficient other claims data to match with the Medicare data. CMS received multiple

comments requesting that CMS release nationwide Medicare claims data to allow qualified entities to calculate benchmarks for performance measures. In response to public comments, CMS will allow qualified entities to purchase a 5 percent national sample of Medicare claims data for the purpose of calculating national benchmarks.

Data Privacy and Security

Qualified entities will be required to implement strict security and privacy requirements during all phases of the performance measure calculation, confidential reporting to providers and suppliers, appeal, and public reporting processes. Qualified entities will be required to have experience establishing, maintaining, and monitoring a rigorous data privacy and security program, and to submit documentation of rigorous data privacy and security policies.

Before receiving Medicare data, qualified entities will be required to sign a Data Use Agreement (DUA) with CMS that requires them to submit documentation of any inappropriate disclosures or uses of individually identifiable data to CMS, and to inform each individual whose health information has been inappropriately accessed.

Confidential Opportunities to Review, Appeal, and Correct Errors

Prior to publication of any performance reports, qualified entities would be required to confidentially share measures, measurement methodologies, and measure results with providers and suppliers. The providers and suppliers being measured would be able to request the Medicare data used to calculate performance measures in order to analyze the draft reports and request the correction of errors where needed. The proposed rule required qualified entities to share measures, measurement methodology, and measure results with providers and suppliers at least 30 business days prior to making measurement results public. In response to public comments that the 30-day review period was too short, CMS has finalized a review period of at least 60 calendar days.

The final rule on Availability of Medicare Data for Performance Measurement is on display at the Office of the Federal Register at http://www.archives.gov/federal-register/public-inspection/

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