§ 401.711 Updates to plans submitted as part of the application process.

(a) If a qualified entity wishes to make changes to the following parts of its previously-approved application:

(1) Its list of proposed measures—the qualified entity must send all the information referenced in § 401.707(a) for the new measures to CMS at least 30 days before its intended confidential release to providers and suppliers.

(2) Its proposed prototype report—the qualified entity must send the new prototype report to CMS at least 30 days before its intended confidential release to providers and suppliers.

(3) Its plans for sharing the reports with the public—the qualified entity must send the new plans to CMS at least 30 days before its intended confidential release to providers and suppliers.

(b) CMS will notify the qualified entity when the entity’s proposed changes are approved or denied for use, generally within 30 days of the qualified entity submitting the changes to CMS. If a CMS decision on approval or disapproval for a change is not forthcoming within 30 days and CMS does not request an additional 30 days for review, the change or modification shall be deemed to be approved.

(c) If the amount of claims data from other sources available to a qualified entity decreases, the qualified entity must immediately inform CMS and submit documentation that the remaining claims data from other sources is sufficient to address the methodological concerns regarding sample size and reliability. Under no circumstances may a qualified entity use Medicare data to create a report, use a measure, or share a report after the amount of claims data from other sources available to a qualified entity decreases until CMS determines either that the remaining claims data is sufficient or that the qualified entity has collected adequate additional data to address any deficiencies.

(1) If the qualified entity cannot submit the documentation required in paragraph (c) of this section, or if CMS determines that the remaining claims data is not sufficient, CMS will afford the qualified entity up to 120 days to obtain additional claims to address any deficiencies. If the qualified entity does not have access to sufficient new data after that time, CMS will terminate its relationship with the qualified entity.

(2) If CMS determines that the remaining claims data is sufficient, the qualified entity may continue issuing reports, using measures, and sharing reports.

§ 401.713 Ensuring the privacy and security of data.

(a) A qualified entity must comply with the data requirements in its data use agreement (DUA) with CMS. Contractors of qualified entities that are anticipated to have access to the Medicare claims data or beneficiary identifiable data in the context of this program are also required to execute and comply with the DUA. The DUA will require the qualified entity to maintain privacy and security protocols throughout the duration of the agreement with CMS and will ban the use of data for purposes other than those set out in this subpart. The DUA will also prohibit the use of unsecured telecommunications to transmit CMS data and will specify the circumstances under which CMS data must be stored and transmitted.

(b) A qualified entity must inform each beneficiary whose beneficiary
Centers for Medicare & Medicaid Services, HHS § 401.715

§ 401.715 Selection and use of performance measures.

(a) Standard measures. A standard measure is a measure that can be calculated in full or in part from claims data from other sources and the standardized extracts of Medicare Parts A and B claims, and Part D prescription drug event data and meets the following requirements:

(1) Meets one of the following criteria:

(i) Is endorsed by the entity with a contract under section 1890(a) of the Social Security Act.

(ii) Is time-limited endorsed by the entity with a contract under section 1890(a) of the Social Security Act until such time as the full endorsement status is determined.

(iii) Is developed under section 931 of the Public Health Service Act.

(iv) Can be calculated from standardized extracts of Medicare Parts A or B claims or Part D prescription drug event data, was adopted through notice-and-comment rulemaking, and is currently being used in CMS programs that include quality measurement.

(v) Is endorsed by a CMS-approved consensus-based entity. CMS will approve organizations as consensus-based entities based on review of documentation of the consensus-based entity’s measure approval process. To receive approval as a consensus-based entity, an organization must submit information to CMS documenting its processes for stakeholder consultation and measures approval; an organization will only receive approval as a consensus-based entity if all measure specifications are publically available. An organization will retain CMS acceptance as a consensus-based entity for 3 years after the approval date, at which time CMS will review new documentation of the consensus-based entity’s measure approval process for a new 3-year approval.

(2) Is used in a manner that follows the measure specifications as written (or as adopted through notice-and-comment rulemaking), including all numerator and denominator inclusions and exclusions, measured time periods, and specified data sources.

(b) Alternative measure. (1) An alternative measure is a measure that is not a standard measure, but that can be calculated in full, or in part, from claims data from other sources and the standardized extracts of Medicare Parts A and B claims, and Part D prescription drug event data, and that meets one of the following criteria:

(i) Rulemaking process: Has been found by the Secretary, through a notice-and-comment rulemaking process, to be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by standard measures, and is used by a qualified entity in a manner that follows the measure specifications as adopted through notice-and-comment rulemaking, including all numerator and denominator inclusions and exclusions, measured time periods, and specified data sources.

(ii) Stakeholder consultation approval process: Has been found by the Secretary, using documentation submitted by a qualified entity that outlines its consultation and agreement with stakeholders in its community, to be more valid, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by standard measures, and is used by a qualified entity in a manner that follows the measure specifications as submitted, including all numerator and denominator inclusions and exclusions, measured time periods, and specified data sources. If a CMS decision on approval or disapproval of alternative measures submitted using the stakeholder consultation approval process is not forthcoming within 60 days of submission of the measure by the qualified entity, the measure will be deemed approved. However, CMS retains the right to disapprove a measure if, even after 60 days, we find it to not be "more valid,"