Skipping Beneficiaries

ID	Question	Answer
1.	When is it appropriate to skip reporting on a beneficiary? System "skip" vs. Manual "skip" by abstractor for reasons outlined here.	Each disease module or patient care measure in the GPRO Web Interface has a sample of beneficiaries to be reported on that is chosen from the pool of beneficiaries assigned to the organization.[1] CMS claims data are used to determine if a beneficiary meets the criteria to be included in a given disease module/patient care measure's sample.[2] However, due to the timing of quality sampling, a full 12 months of claims are not available for analysis when the quality samples are created. The result is that a beneficiary may lose eligibility for the quality sample in general, or a particular measure denominator, between the time the sample is generated and the end of the performance year. It is also possible that data derived from the claims cannot be substantiated by information in the medical record. For these reasons, as well as the possibility that a medical record cannot be located, the GPRO Web Interface allows an organization to remove ("skip") a beneficiary from the sample if he/she does not meet one or more of the quality sampling and/or disease module or patient care measure-specific criteria. Organizations can skip beneficiaries in the GPRO Web Interface using one of several options. If an appropriate skip reason is entered for a sampled beneficiary, that beneficiary is considered completed, but not confirmed. This means the beneficiary will not be counted towards the reporting requirement of 248 consecutively confirmed and completed beneficiaries, and will be replaced with the next consecutively ranked beneficiary who in turn must be reported on, or, if they do not meet criteria for quality reporting, skipped. Some skip reasons remove a beneficiary from all disease modules and patient care measures, and other skip reasons only remove the beneficiary from that specific disease module or patient care measure. Specific skip reasons are discussed in this document. They include: Medical Record Not Found, Not Qualified for Sample, Diagnosis Not Confirmed, measure-specific exclusion criteria, and Other CMS Approved Reason.

[1] For the Shared Savings Program, refer to the Shared Savings and Losses Assignment Methodology Specifications. Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Financial-and-Assignment-Specifications.html

For the Pioneer ACO model, refer to the Alignment and Financial Reconciliation Methods. Available at: http://innovation.cms.gov/Files/x/PioneerACOBmarkMeghodology4to5.pdf

For Next Generation ACO model, please refer to your Participation Agreement.

For PQRS, refer to the GPRO Web Interface Assignment Methodology Specifications. Available at: https://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2016_PQRS_Assignment-.pdf

[2] Refer to the GPRO Web Interface Sampling Methodology, available at: https://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2016_WebInterface_Sampling-.pdf

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2.	Are there repercussions for skipping a lot of patients in our sample (i.e., if we are not able to locate their medical records)?	Patients for whom the ACO or PQRS group practice has selected no medical record found, diagnosis not confirmed, or not qualified for the sample (for CMS approved reasons, deceased, entered hospice, enrolled in an HMO, moved out of the country) are considered "skips". The GPRO Web Interface will produce a warning when 10% of a given sample has been skipped. However, this is only a system warning and the system will continue to allow you to skip patients. ACOs and group practices will not be penalized for skipping 10% of a given disease module or patient care measure's sampled patients. As long as you have met the minimum requirement of 248 consecutively completed patients (or 100% of the sample if fewer than 248 are available), then you will have completely reported on the disease module/patient care measure. ***ACOs only**: If you skip reporting on a large percentage of beneficiaries you may be selected for the quality audit and/or for targeted education with your ACO.*
3.	When can I use "Medical Record Not Found?"	The Medical Record Not Found option should be used only if there is truly an inability to locate and access the beneficiary's medical record after concerted effort is put forth. CMS expects that beneficiary medical care is being coordinated, that the organization make every effort to locate and obtain access to the medical record, and that providers share the necessary records for the purposes of coordinating care and reporting quality data. CMS encourages organizations to put systems and processes in place so that patient care is more coordinated for the dual purposes of patient safety and quality improvement. It is likely that data for sampled patients are available from medical records maintained by the organization's providers because sampled patients are those with: 1. the largest share of their primary care services provided by the organization (i.e., they have been assigned to the organization), and 2. at least 2 primary care office or other outpatient visits billed by the organization[3] during the reporting period. CMS expects organizations to make a **concerted effort** to obtain medical records for their assigned and sampled beneficiaries. This includes collaborating with physicians and/or other clinic staff both inside and outside the organization (including but not limited to the three NPIs provided in the GPRO Web Interface), as well as facilities both inside and outside the organization, with such collaboration attempts being repeated throughout the course of the data collection period, if needed. Medical Record Not Found is not an appropriate response when you are able to locate and access a medical record, but are unable to locate certain data within it. Refer to Appendix B, Table B-1 for examples.

[3] For ACOs, the ACO's participants would have billed for these services.