Transcript for the Q4FY22 *Long-Term Acute Care Hospital Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

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Let's go ahead and get started. I'd like to welcome you all to today's webinar, where we'll be discussing the Q4FY22 *Long-Term Acute Care PEPPER*. My name is Annie Barnaby. I work for RELI Group, Inc., who is contracted with the Centers for Medicare & Medicaid Services (CMS) to create and distribute PEPPER reports. Our agenda today will cover the following areas. We are going to review a sample PEPPER. There are no target area revisions on this PEPPER release. But we will look at the existing target areas. And then we're also going to look at some national level data. Today's presentation will be a high-level overview of the PEPPER. So, if you're familiar with PEPPER, this will be a nice refresher. But if you're new to PEPPER, you might still have questions at the end of the session, and we have several resources available to you to help if you have questions. These resources can be accessed through the PEPPER website in the "Training & Resources" section. And our website, of course, is PEPPER.CBRPEPPER.org.

Let's start at the very beginning. What is PEPPER? PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report. A PEPPER is a comparative report that summarizes one hospital's Medicare claims data statistics for areas that might be at risk for improper Medicare payments, primarily in terms of whether the claim was correctly coded and billed and whether the treatment provided to the patient was necessary and in accordance with Medicare payment policy. In the PEPPER, these areas that might be at risk are called "target areas." The PEPPER summarizes your hospital's Medicare claims data statistics for these target areas and compares your statistics with aggregate Medicare data of other hospitals in three different comparison groups. These comparison groups are all hospitals in the nation, all hospitals that are in your Medicare Administrative Contractor or MAC jurisdiction, and all hospitals that are in the state. These comparisons are the first step in identifying where your claims could be at a higher risk for improper Medicare payments, which in the PEPPER world means that your billing practices are different from most other providers in the comparison group. I do want to stress that the PEPPER cannot identify improper payments. The PEPPER is a summary of your claims data and can help you identify or alert you if your statistics look unusual as compared to your peers, but improper payments can only be confirmed through a review of the documentation in the medical record along with the claim form.

Taking a look at the history of PEPPER, we can see that the program began back in 2003. TMF Health Quality Institute developed the program originally for short term acute care hospitals, and later, for long-term acute care hospitals. In 2010, TMF began distributing PEPPERs to all providers in the nation, and along the way they developed PEPPERs for other provider types, which you can see on this slide here. Each of these PEPPERs is customized to the individual provider type with the target areas that are applicable to each setting. Then, in 2018, CMS combined the Comparative Billing Report, or CBR, and the PEPPER programs into one contract, and the RELI Group and its partners, TMF and CGS now produce CBRs and PEPPERs. While the CBR program produces reports that summarize Medicare Part B claims data, the PEPPERs summarize Medicare Part A claims data. These reports are produced for providers across the spectrum that help educate and alert providers to areas that are prone to improper Medicare payments.

So, why does CMS feel that these reports are valuable and support their agency goals? CMS is mandated by law to protect the Medicare Trust Fund from fraud, waste, and abuse, and they employ several strategies to meet this goal, such as data analysis activities, provider education, and early detection through medical review, which might be conducted by the Medicare Administrative Contractor, a recovery auditor, or some other federal contractor. The provision of PEPPERs to providers supports these strategies. The PEPPER is considered an educational tool that can help providers identify where they could be at a higher risk for improper payments the providers can proactively monitor and take preventive measures if necessary. I should also mention that the Office of Inspector General, or OIG, requires that providers have a compliance program in place to help protect their operations from fraud and abuse. An important piece of a compliance program is conducting regular audits to ensure that charges for Medicare services are correctly documented and billed and that those services are reasonable and necessary. The PEPPER supports that auditing and monitoring component of a compliance program.

Now that we have a sense of the history of the PEPPER program, and why it was created, let's talk specifically about the newest release of PEPPER, Q4FY22, the fiscal year 2022. Again, the PEPPER only summarizes Medicare fee for service Part A claims data and does not include any other payer types, such as Medicare advantage claims. Every time that a PEPPER is produced and released, the statistics are refreshed through the paid claims database. Therefore, if you're looking at a previous PEPPER release and comparing it to this release, you probably are going to see some slight changes in your numerator or denominator, your percentile, those types of things. That could be because there are late claims that are submitted, or corrected claims, which would both be reflected in the updated statistics. Any time we produce a report, the oldest fiscal year rolls off as we add the new fiscal year. Let's now talk about the improper payment risks that are pertinent to long-term acute care facilities. Long-term acute care hospitals are reimbursed through the LT prospective payment system, PPS. Those of you who have been working with PEPPER for a long time know that there have been changes in these target areas over the years, and some significant since we first started producing the reports in 2003. The original target areas were based on medical record reviews conducted by Quality Improvement Organizations, a review of literature about payment vulnerabilities, a review of the LT PPS, and analysis of national claims data. The target areas are evaluated every year so that we can ensure that all target areas included in the report remain applicable and beneficial.

As new risks are identified by recovery auditors or Medicare administrative contractors, or as policy changes are implemented, the target areas change to accommodate those risks. The target areas within the PEPPER pertain to a service or a type of care that's been identified as prone to improper Medicare payments. We construct these target areas as ratios, where the numerator is a count of discharges that could be problematic, and the denominator is a larger reference group that also includes the same numerator discharges. This calculation allows us to calculate a target area percent; we'll talk about target area percents here in just a moment. Here we have a list of the target areas that are included in the *LT PEPPER*, and as I mentioned before, there are no new target areas for this release.

So how do the percentiles work? This slide can help us to understand how the percentiles are calculated. The ladder image is a great representation of how we do that. Next to the ladder is a list of the target area percents sorted from highest to lowest. The first step our team takes when we calculate your hospital's percentile is to take all of these target area percents for a target area and a time period. We take the target area percents for all the hospitals in the nation and we sort them from highest to lowest, and that is what the ladder represents; you can see the percents listed from highest to lowest down the ladder. Next, we identify the point below which 80% of those hospitals fall, and that point is identified as the 80th percentile. So, any hospitals that have a target area percent that is at or above the national

80th percentile will be identified in the PEPPER as a high outlier. A high outlier is identified in the PEPPER target area tab data by red bold font. A high outlier outcome could potentially mean over coding, or it could just mean that your statistics look different for a justifiable reason. Now, on the flip side, we also identify the point below which 20% of the hospital's value fall which is the 20th percentile, and that could mean that the hospital has some under-coding issues.

It is important to remember, when we're talking about percentiles, that the PEPPER always identifies the top 20% as high outliers in the PEPPER, and, for the coding focused target areas, the bottom 20% for low outliers. These percentiles are a good way to get some context and think about how our target area percent compares to the other hospitals in the nation or in the jurisdiction or in the state. This context can help us think about whether that difference is something we expect to see or if there's something that, perhaps, we should be concerned with. I'm going to go to our sample PEPPER now, so we can see in an actual document how all of this data is presented. We can see that it is in an Excel spreadsheet format. And down at the bottom of the Excel file, we have these different tabs. We'll take a look at each of these tabs and what information is on each one in just a moment. But let's start with the first tab here, the purpose tab. I like to think of this as kind of an introductory tab. It has information for us about our provider number. This is a sample PEPPER. This is completely sample, made up information and data so that we can look at what a real PEPPER will look like, but we are looking at sample information. We have our jurisdiction listed here. So, we can make sure that we are looking at the correct jurisdiction comparison information. We do have a little bit of information about PEPPER. And then we have the PEPPER release which, of course, is version Q4FY22.

After the purpose tab, we have the definitions tab. When we were talking about each of the target areas and the target area percents, we were talking about a numerator and a denominator. This definitions tab gives us that information so when we're looking at the calculations and the data for each target area, we have this handy guide to flip back to so that we can see the information that is included in those numbers when we see a numerator number and a denominator number. This information is actually also in the user's guide. So, if you have the user's guide up while you're looking at your PEPPER, of course, you could reference that as well. But this tab is really very helpful because you can just easily flip back and see the information that's used in the calculations for the percents for each of the target areas. Next, we have the compare tab. Now, the compare tab is going to give us statistics for target areas in the most recent time period. So, for this PEPPER release, that is going to be Q4FY22. And we can see here, percentiles indicate how a hospital's target area percent compares to the target percents for all the hospitals in the nation, in the jurisdiction, and in the state. And they have an example up here in the description, but let's skip down to a target area that's listed for this sample facility, *Septicemia*. We have some information on the target discharges. When we see the word "target," we're usually talking about the numerator. So again, if we wanted to flip back to the definitions tab to see what is included in the target discharges for the *Septicemia* target area, we could do that. But we have 17 here. Our percent is 17.3. So, on that list next to the ladder, our number would be 17.3. Now, on the compare tab, we are going to see hospital national percentile. Listed here, it's 9.9. So that means 9.9% of the hospitals in the nation have a lower percent value than my hospital in the *Septicemia* target area. We also have 4.3 for the jurisdiction. So, 4.3% of the hospitals in my jurisdiction have a lower percent than my hospital in this target area. We also have a sum of payments for this target area, and this is a handy tab to look at. It's kind of easing you in to the very targeted data that we're about to see on the target area tabs. But it is a nice overview, and you can see here on this tab where you fell on your percent calculations for each of the target areas in one spot.

Let's move forward to the *Septicemia* target area tab. Each of the target area tabs is going to be displayed in this format. We start at the top with your hospital, statistics and data. It is in table format.

You can see fiscal year 2020, 2021, and 2022. This is a great target area for the sample provider to take a look at because this hospital was an outlier, a high outlier in fiscal year 2020 and a low outlier in fiscal year 2022. So, they dropped in their target area percent drastically over those three years. The information that is in this top table is, as it is, focused completely on your hospital. Let's look at fiscal year 2022 as we go through each line. The target area percent, we already know from the compare tab, is 17.3. That is the outcome of the calculation for us for *Septicemia*. Our target count was 17. That's our numerator. Our denominator count is 98. We also provide the average length of stay for the information and the data that is included in the numerator, and then in the next row down, in the denominator. We also provide some money figures. A lot of people like to look at these money figures before looking at the target area percents or vice versa. But these data points are looking at the average payment for the target area numerator and then the sum of payments. And we can see over these three years even the sum of payments has dropped considerably for this hospital, for Septicemia.

The second table right underneath is going to show us our comparative data. Again, fiscal year 2020, '21, '22. We have the national 80th percentile. So, while this table up top showed us the number that we are going to be falling at on that list down the length of the ladder, these—excuse me, this data, the national 80th percentile and the national 20th percentile, is going to show us where we draw that line, that line that was drawn across the ladder and across that list was for the nation for the 80th percentile was at 50.4%. Then for the 20th percentile, it was drawn across 20.6%. When we compare these numbers from what's above for fiscal year 2022, our target area percent was 17.3. Of course, that is lower than 20.6. We're lower on that list next to the ladder. We'll talk about what that means in just a second. But I want to look at this graph that we provide as well, and again, all of the target areas—we'll look at the others briefly, but they're all going to be displayed in this format. You'll have your hospital data, the comparative data. And then we have a graph that shows you all the data in graph form. Everyone learns differently. Some people like to look at data visually. Some people like to look at the numbers. So, we want to provide you with as much information as possible so that you can understand where you fall for each of these target areas. On the graph, these blue bars, the bar graph, is our target area percent. That's our number from this top chart. And we can see the bar graph is dropping considerably just like we saw up here in our table. Let's look at the 80th percentile first for each of the three years. Now, outlier status is identified using only the national 80th percentile. We do give you information on that second table that includes the jurisdiction and the state 80th percentile and the 20th percentile. But outlier status is tied just to that national 80th percentile.

So, when we look down here at the 80th percentile, we want to be looking at the solid line with the triangles or the diamonds, I should say, excuse me—the diamond that has—for plot points. In 2020, we were a high outlier. That diamond plot point for the national 80th percentile falls within our bar chart, and that is what we would expect to see. We were above the 80th percentile. Our line here is above this plot point. Now, in 2021, we were not an outlier. In 2022, we were not an 80th percentile outlier. Looking really quickly at the other 80th percentiles, the jurisdiction is this dashed line with a square for the plot points, and the state is the dotted line with the triangle plot points.

Let's drop down to the national 20th percentile. Let's look at the national data. In 2020 we were a high outlier, so we were well above the 20th percentile. That is the plot point that is there, though, we can still see it. 2021, the same. It basically was very—oh, it was exactly the same. I was going to say it was very close in those two years, but it was exactly the same. It was a little bit higher in fiscal year 2022, and that is where we are identified as a low outlier. So, we have this diamond plot point that is above our plot point, our bar graph. We can get a great visual representation of all this data when we look at this graph down here. I personally like to look at the graph when I am looking at my target area information. But we like to provide everything for you. Underneath all this information, we also give you

some suggested interventions. We don't want to just give you this data and say, "good luck to you," we want to help you use the data to get out of a high outlier or low outlier situation. We want to tell you how you can improve or what you might be able to do in your facility if you find yourself being a high or a low outlier.

So, we have these suggested interventions. You can read through those yourself. I'm not going to read them. That's boring. But we do talk about sampling medical records, reviewing them, taking a look at the data that's included in this target area. You can take your data that you have and apply it directly to your compliance program, and that's what we want to achieve with the PEPPER. We want to help you remain as compliant as possible with those best practices. As I said before, the target area information is listed in the exact same manner for all the target areas, so we have the same format for *Excisional Debridement*, *Short Stays*. This hospital was a high outlier all three years for *Short Stays* and quite considerably because we can see in the graph this diamond plot point for the national 80th percentile is well below the hospital's outcome and percent outcome for *Short Stays*. *Short Stays*, respiratory system diagnoses, same information in the same format. Looks like we are a high outlier in 2021 and 2022 for this target area, *Outlier Payments* target area, *30-Day Readmissions to The Same Hospital or Elsewhere*, and *Short-Term Acute Care Hospital Admissions Following Long-Term Care Hospital Discharges*. Those are our target area tabs. The last two tabs that we have on the PEPPER are the top DRGs. Now, these are the hospital's top DRGs. So, we have pulmonary edema and respiratory infections. This information is great to have when you are reviewing that target area information, when you're doing your medical records review. This is great information to have so that you can see how your top DRGs compare to the nation. On this last tab, we have our nationwide top DRGs. We have 189 at the top for here, and that was our top DRG as well. 177 was our top DRG. It is a little bit further down on the list in the nation. But again, this is just great comparative data that you can use and that is split in between these last two tabs.

How does PEPPER apply to providers? The PEPPER can help a facility to identify areas where they may be outliers, and if that outlier status is something that should prompt an internal review within these target areas. We often get the questions do I have to use my PEPPER, and do I need to take any action in response to my PEPPER? The answer to that question is no. You're not required to use your PEPPER, though it's helpful information and we would encourage you to at least download it and take a

look. You're not required to take any action.

However, it is important to remember that other federal contractors are also looking through the entire Medicare claims database. They might be looking for providers that could benefit from some focused education or maybe even a record review. And so, from your perspective it would be nice to

know if your statistics look different from others so then you can decide if there's something to be concerned about and if you need to take a closer look, or if what you're looking at is what you expect to see in your PEPPER. The PEPPERs are distributed in electronic format, in a Microsoft Excel workbook and are available for two years from the original release date. We cannot send PEPPER through email. Because of the sensitive data housed within the PEPPER, we have to be judicial in the way that we distribute the PEPPER. And it cannot be sent through unsecured emails. With this in mind, we do have a portal online that you can use to access your PEPPER, and we encourage you to go to the portal and download your PEPPER so that you can have it in your files for your use. You will need to enter some

information to access your PEPPER through the portal. First, you'll be asked to enter your six-digit CMS Certification Number, which is also referred to as the provider number or Provider Transaction Access Number [PTAN]. This number is not your tax ID or an NPI number. For long-term acute care hospitals, the third digit of this number will be a "2."

For the validation code on the portal access page, you will enter either a patient control number, found at form locator 03a on the UB04 claim form, or a medical record number, found at form locator 03b on the UB04 claim form, for a traditional Medicare Part A Fee for Service patient who received services From July 1, 2022, through September 30, 2022, which would be the “from” or “through” dates on a paid claim.

Alternatively, the validation code will be emailed to the contact listed in the Provider Enrollment, Chain, and Ownership System, commonly known as PECOS. Please note that these validation codes are updated for each release, so you won’t be able to use a validation code that you received for a previous PEPPER release. Now once you receive your PEPPER, and let's say you see a lot of red in there, what should you do? First thing, what you should not do is panic. Remember, outlier status does not necessarily mean that compliance issues exist. By design, 20% of the providers are always going to be identified as an outlier for each of the PEPPER target areas. But if you are an outlier, I want you to think about why that might be. Again, do the statistics in your PEPPER reflect what you know, given your operation, your patient population, referral sources, your external health care environment, any changes in services or staffing? If you have any concerns, sample some claims. Make sure the

documentation in the medical records supports the services that were submitted. Review the claim, and ensure it was coded and billed appropriately based upon the documentation in the medical record. The bottom line is to ensure that you're following the best practices, even if you're not an outlier. We have a number of resources that are available publicly on our website, PEPPER.CBRPEPPER.org. One of those resources is national level data for the Target areas and top DRGs. This information is updated each time we have a PEPPER release.

A number of other resources can be found on the PEPPER website. Of course, there's the user's guide, the PEPPER training sessions, a demonstration PEPPER, a spreadsheet that will identify the number of hospitals in each of those MAC jurisdictions in total and by state. And some testimonials and success stories. There are some really nice success stories out there. One in particular from a Kentucky hospital that used their PEPPER to help them identify under-coding.

As always, if you need assistance with PEPPER and do not find the answer you need in the User’s Guide, please visit the pepper.cbrpepper.org website and click on the Help/Contact Us button, then click on the Help Desk button. Complete the online form, and a member of our staff will respond promptly to assist you. Please do not contact any other organizations for assistance with PEPPER. RELI Group is contracted with CMS to support providers with obtaining using PEPPER. If you have questions, please contact us – we are the official source of information on PEPPER. Please do not pay consultants to help you with PEPPER – we provide support at no cost to the provider.

And you need to be aware that not all consultants provide accurate information on PEPPER. This is a screen shot of our home page. You can see all the different facilities that we have for our PEPPER releases.

I'd like to thank you all for joining me again today. If you have any questions, please feel free to reach out to us at the Help Desk, and we'll be happy to help you in a prompt manner. I hope you all have a great day.