Welcome to this review of the PEPPER for skilled nursing facilities. My name is Kim Hrehor, and I work for RELI Group. RELI is contracted with the Centers for Medicare and Medicaid Services, or CMS, to develop, produce, and disseminate the PEPPERs. Today, I’m going to be focusing on the newest release of the PEPPER for skilled nursing facilities version Q4FY19. I will be reviewing this new version of the PEPPER.

We have added one new target area focused on three to five day readmissions, and so we'll be talking about that, as well as potential changes for the future releases of PEPPER reflecting the transition to the patient-driven payment model. I will also be reviewing a sample SNF PEPPER, as well as other resources that are available on our website, which include national and state level data and the peer group bar charts.

Now, this is going to be a high-level review of the PEPPER. If you're new to PEPPER or if you feel like you still have questions or need more information after today's review, there are a number of recorded sessions that go into great detail that are available on the SNF “Training and Resources” page of the PEPPER website. These are available as short chapters, different segments that you can review at your leisure. So I would encourage you to take advantage of those chapters. Not only will you have a better understanding of percents and percentiles, but also a careful review of how the SNF episodes are created for the PEPPER.

So what is PEPPER? PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report. And essentially, the PEPPER is a comparative report that summarizes one SNF's Medicare claims data statistics for areas that have been identified as at higher 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, we call these risk areas target areas.

Now, the PEPPER summarizes your Medicare claims data statistics for these areas. And then we compare that with aggregate Medicare data for other providers in three different comparison groups — all SNFs in the nation, all SNFs in your Medicare Administrative Contractor or MAC jurisdiction, and then all SNFs in your state. And these comparisons are the first step in identifying where you might be at a higher risk for improper Medicare payments, which really just means that your billing practices are different from the majority of other SNFs in the comparison group.

And I do want to stress that the PEPPER cannot identify improper Medicare payments. Those can only be confirmed through a review of the documentation in the medical record and the claim form. But the PEPPER can alert you if your statistics look unusual, so then you can decide if you need to take a closer look.

Now, the PEPPER has been available for a number of years. It was originally developed in 2003 for short-term acute care hospitals, and a couple of years later, then for long-term acute care hospitals. And back
then, the state quality improvement organizations made the PEPPER available to the hospitals in their state.

Starting in 2010, TMF Health Quality Institute began developing PEPPERS — I’m sorry, distributing PEPPERS to all providers in the nation. And along the line, they also developed other types of PEPPERS for other provider types. And you can see the Skilled Nursing Facility PEPPER was created in 2013. So the Skilled Nursing Facility PEPPER has been available since 2013.

Then, starting in 2018, CMS made some changes to the program, and they can combined the Comparative Billing Report program and the PEPPER programs into one contract. And now, the RELI Group and its partners, TMF and CGS, are producing CDRs and PEPPERS for all providers in the country. The CDRs primarily summarized Medicare Part B claims data, while the PEPPERS summarize primarily Medicare Part A claims data. And both of these reports are considered educational and supportive of CMS’s efforts to protect the Medicare Trust Fund.

So why does CMS feel that the provision of PEPPERS to providers is supportive of their agency goals? Well, CMS is mandated by law to protect the Medicare Trust Fund from fraud, waste, and abuse, and they employ a number of strategies to meet this goal, such as provider education, data analysis activities, and early detection through medical review, which could be conducted by the Medicare administrative contractors, the recovery auditors, or other federal contractors. The provision of PEPPERS to providers supports these strategies. PEPPER is an educational tool that can help SNFs identify where they might be at a higher risk for improper payments so then they can proactively monitor and take any preventive measures if necessary.

I’ll also mention that the Office of Inspector General encourages providers to have a compliance program in place to help protect their operations from fraud and abuse. An important component 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 the auditing and monitoring component of a compliance program.

So now let’s talk more specifically about this newest release of PEPPER for SNFs. This is a version Q4FY19, which means that it summarizes statistics for skilled nursing facility episodes of care that end or run through the fourth quarter of fiscal year 2019. And each of the PEPPERS summarizes statistics for three federal fiscal years. So this release summarizes statistics for fiscal years 2017, 2018, and 2019. And remember, the federal fiscal year starts October the 1st, and it runs through September the 30th of the following year.

Now, each time our team produces a PEPPER, we download all of the claims data, the Medicare claims data, for all three years that are included in the PEPPER. We are essentially refreshing all of those statistics so that we can generate the PEPPER using the latest version of claims that are available.

So when you look at your new PEPPER, and if you’re comparing it with last year’s PEPPER, the Q4FY18 release, you may notice that there are some slight changes in numerator or denominator count or some of the other statistics in your PEPPER. And that would be expected, especially if there are late claims that could have been submitted over the past year, corrected claims, or any adjustments. Those would
be reflected in the refreshed claims data that we use to generate the PEPPER. Each time we release a PEPPER, the oldest fiscal year rolls off as the new one is added.

So let’s talk about improper payment risks for skilled nursing facilities. The skilled nursing facility Prospective Payment System or PPS is vulnerable to improper Medicare payments due to the incorrect reporting of information on the MDS or other documentation in the medical record. The skilled nursing facility target areas that you see in the PEPPER today were developed by reviewing the current literature on skilled nursing facility improper payments by studying the SNF PPS and by analyzing SNF claims data and consulting with CMS subject matter experts. Our goal is to provide statistics for areas that can help providers identify when they might be at a higher risk for improper Medicare payments.

Now, there has been a change in the reimbursement model for skilled nursing facilities. Previously, skilled nursing facilities were reimbursed through the SNFs PPS that was based on the Resource Utilization Groups, or RUGs. And a number of the SNF PEPPER target areas are designed to report on those payment vulnerabilities that were specific to the RUGs. The Q4FY19 release, which is this release, still includes these target areas because, remember, the PDPM goes into effect for fiscal year 2020. So we are including the target areas that have been historically included in the PEPPER, and we do anticipate that these target areas, the four that are listed on the slide here, Therapy RUGs with High ADL, Nontherapy RUGs with High ADL, Change of Therapy Assessment, and Ultrahigh Therapy RUGs, these will be phased out. They will be retired for the fiscal year 2020 release, which we anticipate will be available in approximately one year, April 2021.

The PDPM is designed to improve payment accuracy and appropriateness by focusing on the patient rather than on the volume of services provided. And so there are some vulnerabilities that are present in the PDPM. We have added a new target area to the SNF PEPPER, and I will be reviewing that a little bit more closely in just a couple of minutes. Moving forward, we will continue to examine additional target areas that could be identified and that might reflect other potential vulnerabilities related to the PDPM.

All right, so let’s talk about the target areas as they pertain to PEPPER. Essentially, a target area in the PEPPER is a service or a type of care that has been identified as potentially prone to improper Medicare payments. And in the PEPPER, again, we call these target areas. These are constructed as ratios, where the numerator is a count of RUG days or episodes that could be problematic. And then the denominator is a larger reference group that contains the numerator, and it allows us to calculate a target area percent.

As we walk through these next slides, you’ll see these are the target areas that are included in the current SNF PEPPER. Each of our target areas has a numerator and denominator definition, and we use these the numerator and denominator to calculate the target area percent. Again, these three target areas are still included in the SNF PEPPER even though we do expect that these will all be retired for the next release of the PEPPER next year. These are focused on RUGs, or the last one is focused on the Change of Therapy Assessment, which, as I understand, is no longer present.

The Ultrahigh Therapy RUGs target area will also be retired, but we will continue to include the 20-Day Episodes of Care target area, which looks at the number of episodes that end in the report period with a
length of stay of exactly 20 days. And then the denominator is the count of all episodes ending in the report period.

This target area is focused on the financial incentive for SNFs to keep patients for 20 days, even though it’s possible that beneficiaries may no longer require a skilled level of care because that SNF benefit does provide 20 days of 100% Medicare coverage. So we are going to keep that one in the SN PEPPER, as well as the 90+ Day Episodes of Care. Here, we are looking at the proportion of all episodes that had a length of stay of 90 or more days. Medicare does reimburse up to 100 days of skilled care per beneficiary spell of illness, so SNFs that have a high proportion of episodes of care with 90 or more days might want to think about ensuring that the beneficiarities still need that level of care for that amount of time.

And then, we have our new target area focused on three to five day readmissions. Under the PDPM, there is a potential incentive for providers to discharge SNF patients from a covered Part A stay so that they can then readmit these patients to reset the variable per diem schedule. To mitigate this potential incentive, the PDPM includes an interrupted stay policy which combines multiple SNF stays into a single stay when the patient’s discharge and readmission occurs within a prescribed window, which is three consecutive calendar days.

Now, CMS evaluated and approved this new target area that looks at SNF readmissions following a three to five day gap. This new target area is intended to assess that potential circumvention of the interrupted stay policy and reset the variable per diem schedule. Now, again, while the PEPPER statistics will not reflect claims submitted under PDPM until next year’s release, this information could be helpful to SNFs because it’ll give you some historical perspective and insight about your practices before and then after the PDPM implementation.

So you can see now from all of those target areas again with that numerator and denominator definition, most of you can probably calculate your own target area percent for each of those areas. But the value of the PEPPER comes in the percentiles that are available for you in the PEPPER, which help give you some context about how your SNF’s target area percent compares to those of other SNFs in this nation, jurisdiction, or state.

Now, we calculate the percentiles, and we use percentiles in the PEPPER to identify what we call outliers. And we use the national 80th percentile to identify high outliers. And then we use the national 20th percentile to identify low outliers. Those are applicable only to those two target areas that are focused on the potential for over or under coding, which would be the therapy RUGs and the Nontherapy RUGs with High ADL.

Now, how do we calculate percentiles? What we do when we calculate percentiles is we take all of the target area percents for all of the SNFs in a group, so let’s just say all of the target area percent for all of the skilled nursing facilities in the nation for the Therapy RUGs with High ADL target area. And we sort those from highest to lowest. So you can see that here on this slide, we have the ladder. The target area percents are sorted highest to lowest.

Then we identify the points below which 80% of the target area percents fall. And that point or the percent associated with that point is identified as the 80th percentile. And any SNFs that have a target
area percent that is at or above the national 80th percentile, they would be identified as high outliers in the PEPPER. And they would see their target area percent displayed in red, bold font.

Now, for the coding focused target areas, we also look for the potential for under coding, and that would be identified through the 20th percentile. Any providers who have a target area percent that is at or below the 20th percentile would be identified as low outliers. And again, that’s only for those two coding focused target areas that are included in the SNF PEPPER. I want you to keep this ladder example in the back of your mind as we walk through a sample SNFs PEPPER.

Right now, you should be seeing on the screen here a sample SNF PEPPER. The PEPPER is distributed as a Microsoft Excel workbook. You navigate in the PEPPER by clicking on these worksheet tabs along the bottom of the screen.

When you first open your PEPPER, it opens to this Purpose tab. You will see your SNFs six digit CMS certification number here on row 8, followed by your name, your skilled nursing facility name. Below that, it tells us that this report summarizes the most recent three federal fiscal years through the fourth quarter of fiscal year 2019, some general information about the PEPPER.

Here on row 22, you will see the jurisdiction comparison group that’s applicable for you. The MAC jurisdiction comparison group is comprised of all of the SNFs that submit their claims to the same Medicare administrative contractor as you do. So if you’re wondering what makes up the MAC jurisdiction comparison group, it’s all of those SNFs that submit their claims to the same MAC as you do.

The next tab is the Definitions tab. And here, you will find complete numerator and denominator definitions for each of the target areas that are included in the PEPPER. This can be very helpful if you are looking at the target area reports in your PEPPER and trying to remember what the numerator count or the denominator count is representing. You can click on the Definitions tab and find those details.

The next report is called the Compare Targets Report. And I like to call this report the heart of the PEPPER. It is the only place in the PEPPER where you will be able to see all of your statistics for the target areas all on one page.

A couple of caveats — it reflects only the most recent fiscal year. So this report is for fiscal year 2019. And it will only include the target areas for which your SNF has reportable data. When I say reportable data, that means that there are enough discharges or episodes, rather, to generate statistics for that target area. There have to be at least 11 episodes in order for us to calculate statistics for these target areas.

So here, for example, is the first target area that’s listed. It’s the therapy high ADL target area. There’s a brief description of the definition. This SNF has a numerator count of 4,912. When we compare the numerator to the denominator, which is not included here but I’ll show you just a moment where you’ll find that information, we can see that we have a target area percent of 20.7%.

But when we just look at the number, it’s really hard for us to determine if we are high compared to other providers, low. Where in that distribution do we fall? And that’s where those percentiles come in very handy.
Here, we can see that our SNF is at the 18.0% national percentile, which means that 18% of the SNFs in the national comparison group have a lower target area percent than we do. So this 20.7% placed along that distribution along the ladder puts our SNF towards the bottom end there, just below the 20th percentile. We’re at the 18.0 percentile. So we're identified as a low outlier for this target area by that green italics.

Now, when we compare ourselves to all SNFs in our jurisdiction group, we see that we're at the 17.6% jurisdiction percentile. So 17.6% of the SNFs in our jurisdiction have a lower target area percent than we do. And then, for the state percentile, we are at 15.3%, even a little bit closer to that bottom of the distribution, when we're comparing ourselves to all SNFs in the state. So you can see how helpful these percentiles can in giving you that context of where your target area percent falls in relation to all the other SNFs in these comparison groups.

We can see that for the Ultrahigh Therapy RUGs target area, this skilled nursing facility is at the 93.6% national percentile. So that puts them pretty much at the top of that distribution. 93.6 percent of the SNFs in the nation have a lower target area percent than we do. Now, this is the only place in the PEPPER that you will see your exact percentile.

As we move into now a Target Area Report, we'll be able to see how each of these is structured. When you click on the tab for the target area, this one is Therapy RUGs with High ADL, you'll see a graph that shows your SNF's target area percent displayed as these three blue bars. It's really handy to be able to see how the target area percent may be changing over time.

Here, we see this SNF's Therapy RUGs with High ADL slowly decreasing over time. And now they're below the 20th percentile. The 20th percentile is represented by these three green lines here. The national 20th percentile is the solid line, the jurisdiction is the dashed line, and the state is the dotted line. These three red lines up here represent the 80th percentile for nation, jurisdiction, and state.

Below the graph is a data table that has the details behind the bars, the calculations. For each of these three fiscal years, we see the target or numerator count. Then we see the denominator count, which the numerator divided by the denominator gives us our target area percent. And this is the value that’s graphed as those blue bars above. We also include the average length of stay for the numerator and the average length of stay for the denominator.

Below is the comparative data table. Now, these are the target area percents that are at the 80th percentile for nation, jurisdiction, and state, and then the percents that are at the 20th percentile for nation, jurisdiction, and state. And these are the values that are graphed up here as the red and the green trend lines, the 20th and 80th percentile.

Lastly, below the comparative data on all of these Target Area Reports, we include suggested interventions. If you are a high outlier for this target area or if you were a low outlier, there is a very general statement as to what this could possibly indicate and what you might consider if you were going to take a closer look at records regarding this particular target area. And these suggested interventions are also included in the PEPPER User’s Guide.
Each of the Target Area Reports are formatted in the same way. So they are very easy to interpret once you get the hang of what you’re looking at. Now, if you see a target area report that looks empty, as this one does — there are no blue bars up here on the graph. There is no information in the data table.

This is an indication that you do not have episodes, the statistics are too small in order for us to calculate the numbers. And so there’s nothing wrong. There’s no error, nothing wrong with your PEPPER. It’s just that there was insufficient data to generate statistics. And you might see entire worksheets like this one where there may be some that have one or two time periods with reportable data and another time period is missing.

This SNF **20-Day Episodes of Care** are looks like slowly decreasing. Here is an example where there’s reportable data for one time period, 14 episodes here, but the other two are empty. This is a new target area. This SNF seems to have a fairly stable target area percent, well below the 80th percentile.

I always encourage folks, if they see significant changes in time periods, whether that’s an increase or a decrease, think about what factors might be causing those increases or decreases. There are lots of things to think about. Could be changes in your patient population, changes in the services that you provide, staffing changes. That could even be clinical coding, billing. All of those can have impacts on the way you see your PEPPER statistics and how they appear.

I always encourage folks if they see something that doesn't quite feel right to them, you've got that little voice in your head saying something's not right here. If that's the case, then you really owe it to yourself to coordinate with others in your organization and take a look. See if there's something that needs to be addressed.

OK, the **SNF PEPPER** also includes a couple of reports that are supplemental in nature. They don't have any bearing on whether you're identified as an outlier in the PEPPER. They're provided for your own information.

And the first one is a summary of the top RUGs for all episodes of care for the most recent fiscal year. And this is for your SNF. We identify the RUG and the description, the number of RUG days billed, the percent of RUG days to total days, the percent of episodes with that RUG that are billed to total episodes, and the average number of days by RUG. And here we will list up to 20 RUGs on this report as long as there are at least 11 RUG days billed.

The second report is very similar to the top RUGs, but this one focuses only on the episodes of care that are 90 or more days in length. And so we can see here, for this SNF, they don't have any RUGs to report for this time period. And that may certainly be the instance for some other SNFs. But the information here that’s included would be very the same format as to what’s on the top RUG report. And then, the last two worksheets summarize the top RUGs for all episodes at the jurisdiction level, and then the top regs for all episodes with 90 or more days at the jurisdiction level. And again, comparative data that you might find helpful.

OK, let’s go back to the presentation. So how does PEPPER apply to providers? Do you have to use it? Do you have to take any action? Or is there a response that’s expected if your statistics look different?
The answer to both of those questions is no. You’re not required to use your PEPPER. There’s no need for you to feel you must take some action in response to your PEPPER. Remember, the PEPPER statistics aren’t telling you that you’re doing anything wrong. It’s just identifying when you look different compared to other providers. And that can be really helpful to your understanding.

Remember that there are other federal contractors that are out there reviewing through the Medicare claims data, perhaps trying to identify providers that could benefit from some educational intervention or perhaps a focused medical review. So it’s really handy for you to know when you might look different from other providers. And that way, you have a heads up there is an opportunity for you to determine if your PEPPER reflects what you expect to see given your operation or if there’s something that you should be more concerned about. So I would encourage you to use this free report, to examine how your statistics look compared to others, and then you can be ready if there were some auditors that would come knocking.

How do you obtain your PEPPER? The PEPPER is distributed annually in an electronic format. And currently, the distribution method is different for hospital based SNFs or swingbed units than it is for freestanding SNFs. And I’ll talk about that in just a moment. We cannot send the PEPPER through email. It is considered sensitive information, and we only make the PEPPER available to the individual provider. The swingbeds or units of hospitals will receive their PEPPER through QualityNet uploaded to the hospital QualityNet administrators, as well as those that have basic user accounts with the PEPPER recipient role. QNet is a secure system that’s established by CMS. They do have security around it. The file is available for 60 days from the day that we upload it. We can re-upload it if you missed that time period, but you will need to contact us through our Help Desk to do so.

I want to make a comment here about swingbed units of critical access hospitals. The critical access hospitals are not reimbursed through the SNF PPS, and so there are not PEPPERs available for swingbed units of critical access hospitals.

Now, the freestanding skilled nursing facilities receive their PEPPER through the PEPPER Portal. That’s through our website, pepper.cbrpepper.org. If you’re new to this process, there is some information that you can review to help you understand how you access your PEPPER. Each of those PEPPERs is available for approximately two years from the original release date.

When you visit the portal to get your PEPPER, you will need two pieces of information. You will need your six digit CMS certification number, sometimes also referred to as a provider number or PTAN. And you will also need a patient control number or a medical record number from a claim for a traditional fee-for-service Medicare beneficiary who received services between July 1 and September 30 of 2019. And this is for validation purposes. This is a validation code that will help us ensure that the PEPPER is accessed by people who have the right to do so. Now, this validation code does change for each release, so a validation code that you used last year to access your PEPPER will no longer be valid. It will not be accepted for this year’s release.
Some folks struggle with this accessing the PEPPER. If you are having trouble, please contact us through our Help Desk. We do not want you to be frustrated and give up. We want you to get your PEPPER. So if you're struggling with that piece, please let us know. Contact us for assistance.

Now, we are aware that the QualityNet system is being phased out later this year in late 2020. And so we are examining alternatives for distributing the PEPPER through the PEPPER Portal for those providers that currently receive their PEPPER through QualityNet. And again, there is the information on how to get the PEPPER through the portal.

We are also discussing sending a validation code that providers can use to access the PEPPER through email to the provider contact that's listed in the National Plan and Provider Enumeration system or NPPES, or the Provider Enrollment Chain and Ownership System, PECOS. And this would be not only for the providers that receive their PEPPER through QualityNet, but it would be for all SNFs. So were considering getting rid of that PCN/MRN validation code piece. The reason I’m saying this now is because I want all of you to ensure that the information in these systems, the contact information is current and updated so that if we do decide to move in this direction, we’ll be emailing that validation code to the correct person.

Now, once you receive your PEPPER, if you see a lot of red or see a lot of green, what should you do? Well, one thing you should not do is panic. Remember, just because you're an outlier, it doesn't mean that you're doing anything wrong or that compliance issues exist. By design, 20% of the providers are going to be identified as a high outlier in the PEPPER.

But I do want you to think about why you would be an outlier. Do you expect to be high or low for some of these target areas? Do the statistics in your PEPPER reflect what you know about your organization given your operation, again, any specialized programs or services, patient population, referral sources, activities that are going on in your external health care environment?

If you have any concerns, I encourage folks to conduct an internal review, sampling claims, reviewing the medical records, making sure that everything is coded and billed in accordance with the Medicare payment policy. The bottom line is to ensure that you're following best practices even if you are not an outlier.

All right, as we move towards the end of the session, I want to review some of the aggregate information that's available on the website. On the pepper.cbrpepper.org website, on the Data page, you will find national level and state level information for each of the target areas in the PEPPER, as well as for the top RUGs and the top RUGs for 90+ Day Episodes of Care.

We make this information available also at the national level for all SNFs, and then break it out for free-standing and units. These data are updated each year following each report release. And so you may find that aggregate information handy.

We also prepare peer group bar charts, and these are updated on an annual basis as well. We do understand that sometimes providers would like to compare themselves with a group that they would consider to be more like them. So for each of the target areas, these bar charts will identify the 20th, 50th, and 80th national percentile for SNFs in three different categories.
We look at size, which is based on number of episodes. Location — that would be either urban or rural. And then ownership type — profit or physician owned, non-profit or church owned, or government owned. There are a couple of additional documents that go into more detail as to how we put these peer group bar charts together. That would be the methodology.

And the SNFs by Peer Group file will tell you in which of those categories your SNF has been identified. And if you disagree with your ownership type or location, you will need to work with your CMS regional office. We obtain that information from the CMS Provider of Services file, which is maintained by the CMS regional offices. So if there's something there that you disagree with, coordinate with your regional office to make those updates.

This is an example of peer group bar charts for the 20-Day Episodes of Care target area. These three categories are size, which is the top blue. Location is the middle pink. And ownership type is the bottom green.

You can see how the 80th, 50th, and 20th percentiles are very different for some of these subcategories. For example, the smallest one third has the highest percentiles, and the rural providers have the highest percentile, and the — I'm having trouble reading the bottom one, but it's the middle bar, the middle category. Now, our team is working on making some adjustments to the format for these bar charts. So the newer versions once they're posted may look different from this, but they will still have the same information.

I want to remind you of those other resources that are available on the “Training and Resources” page, which includes the PEPPER User's Guide. There is a spreadsheet also that identifies the total number of smiths in each jurisdiction in total and by state. We of course, have those recorded PEPPER training sessions. You will find a sample PEPPER, and there are success stories that are out there, as well as a video that we prepared a few years ago with a SNF in Michigan.

If you find that you need assistance, whether it's accessing your PEPPER, if you've got a question about the data in the PEPPER, if you have a question about using your PEPPER, please contact us through our Help Desk. There is an online form that you'll complete, and a member of our team will reach out promptly to assist you. Please do not contact other organizations or associations for assistance with PEPPER. Our team is the official source, and we will be sure to help you with your question or issue.

This is a screenshot of our website, the home page of pepper.cbrpepper.org. You can see the blue arrow there on the right pointing to the skilled nursing facilities section. This is on our home page, so easy access to the User’s Guide, to the “Training and Resources” section, to the distribution Get Your PEPPER page, and to a map of downloads for PEPPER by state.

And of course, if you have questions, please do submit those to the Help Desk at pepper.cbrpepper.org. Thank you for joining us today.