Transcript for the Q4FY19 *Critical Access Hospital (CAH) Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

Welcome to this review of the PEPPER for critical access hospitals. My name is Kim Hrehor, and I work for the 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 most recent release of PEPPER for critical access hospitals. So my plan today is to review the Q4FY19 *Critical Access Hospital PEPPER*. I'll be reviewing a small change that was made to the *Single CC or MCC* target area, easy for me to say. And also some of the other resources that are available on our website.

I also will be reviewing a sample PEPPER, quickly. And so today, this is going to be a session that's going to be at a rather high level. So if after this overview, you still have questions about PEPPER, or if you feel you need additional information, I would encourage you to access the recorded sessions that are available on the "Training and Resources" page for critical access hospitals, at pepper.cbrpepper.org. This might be particularly helpful if you're new to 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 hospital's Medicare claims data statistics for areas that have been identified as at a 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.

We call these target areas, in the PEPPER. The PEPPER summarizes your hospital's Medicare claims data statistics for these areas, and then it compares them with aggregate Medicare data of other hospitals in three different comparison groups, all hospitals in the nation, all hospitals in the Medicare administrative contractor, or MAC jurisdiction, and in the state. These comparisons are the first step in identifying where you may be at a higher risk for improper Medicare payments. Which in terms of the PEPPER, really just means that your billing practices look different from most of the other hospitals in the comparison group.

Now I do want to stress that the PEPPER cannot identify improper payments. Those can only be confirmed through a review of the medical record and the documentation contained in it, along with a review of the claim. But PEPPER can alert you if your statistics look unusual, so then you can take any next steps as necessary.

The PEPPER was originally designed or developed in 2003. Originally, only for short-term acute care hospitals, and then a little bit later, for long-term acute care hospitals. At that time, the state quality improvement organizations made the PEPPERs available to the hospitals in their state. And that occurred through 2008.

Then in 2008, there was a change in the way CMS was developing these reports. And starting in 2010, TMF Health Quality Institute 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 the slide.

The *Critical Access Hospital PEPPER* has been available since 2011. Then in 2018, there were some additional changes made to the way the CMS administered this contract. CMS combined the comparative billing report and the PEPPER program into one contract. The comparative billing reports, or CBRs, summarized Medicare Part B claims data, and then the PEPPERs summarize Medicare Part A claims data. So the RELI group, along with its partners, TMF and CGS, are now producing PEPPERs and CBRs for all providers in the nation.

So why does CMS feel that the provision of PEPPERs to providers is supportive of their agency goal? 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 data analysis, provider education, and early detection through medical review, which may be conducted by the Medicare administrative contractors, recovery auditors, or other contractors. The provision of PEPPERs to these providers supports — or rather the provision of PEPPERs to providers supports these strategies.

CMS considers the PEPPER to be an educational tool that can help providers identify where they might be at a higher risk for improper payment. So then they can proactively monitor and take preventive measures, if necessary. I'd also like to mention that the Office of Inspector General, or OIG, encourages providers to 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 the auditing and monitoring component of a compliance program.

So let me now focus more specifically on the newest release of the *Critical Access Hospital PEPPER*. This is version Q4FY19, which simply means that it summarizes statistics through the fourth quarter of fiscal year 2019. Each of the PEPPERs summarizes statistics for discharges that end in the most recent three federal fiscal years, so this version includes or summarizes claims information for discharges in fiscal years 2017, 2018, and 2019. And as a reminder, the federal fiscal year starts October the 1st, and it runs through September the 30th of the following year.

Now each time our team generates PEPPERs, we refresh the data, the statistics, for all of the time periods. That means we go to the claims, the paid claims database, and we pull the claims data for these three fiscal years. So any claims that were submitted, late claims that were submitted over the past year, any revised claims, that would all be taken into account for the newest release of the PEPPER.

So as a result, it's certainly possible that if you're looking at your Q4FY18 PEPPER, and comparing it with your newer PEPPER from fiscal year 19, you could see some slight changes in numerator or denominator counts, or some of the other statistics in the PEPPER. And that would be due to the fact that, again, we do refresh all those statistics, so anything that has been resubmitted over the past year would be reflected in your new PEPPER. And just as a reminder, the oldest fiscal year is going to roll off as we add the most recent fiscal year statistics.

So let's talk about the improper payment risks that are pertinent to critical access hospitals. Because critical access hospitals treat many of the same types of patients, and provide many of the same types of services as short-term acute care hospitals, the *Critical Access Hospital PEPPER* includes many of the same target areas as the Short-term Acute Care Hospital PEPPER. The primary difference for critical access hospitals is that they are reimbursed based on cost, rather than prospectively through the IPPS, or inpatient prospective payment system, DRG model. Also critical access hospitals do have shorter lengths of stay, being limited to an overall average length of stay of 96 hours.

Now that being said, critical access hospitals are at risk for medically unnecessary admissions. And although coding errors do not affect or impact critical access hospital reimbursement, correct coding is still an important factor. So that's why we have continued to include these target areas in the *Critical Access Hospital PEPPER*.

In addition, there are some resources that can help you get a handle on *Critical Access Hospital PEPPER* improper payments. The comprehensive error rate testing contractor, the CERT contractor, samples and reviews records every year to develop an estimate of improper payments for CMS. And the 2019 Medicare Improper Fee-for-Service Payments Report identified that critical access hospitals have a relatively low error rate. They are down coding errors at 0.3% improper payment rate, representing $21 million. And then other errors, 0.5% improper payment rate, representing $29 million.

And so critical access hospitals have traditionally had a relatively low improper payment rate. If you're interested in looking at these reports, they are published every year, and you can find them on the CMS website cms.hhs.gov/cert. That's C-E-R-T.

So in the PEPPER, we have, again, these target areas which are basically a service or a type of care that's been identified as prone to improper Medicare payments. In the PEPPER, we construct the target areas as ratios, where the numerator is a count of discharges that might be problematic, and then the denominator is a larger reference group that contains the numerator, and allows us to calculate a target area percent. We'll talk about that a little bit more in just a few minutes.

We generally have two types of target areas in the PEPPER. We have target areas that are primarily concerned with coding errors. So there could be over coding, which would result in an increase, in an overpayment, or under coding which would really, would result in an underpayment. Now recognizing that coding errors don't affect critical access hospitals, this information is really just more for your own internal consideration.

And then the second type of target areas that we have, are those that are focused more on admission necessity. Here is a listing of the current target areas that are in the *Critical Access Hospital PEPPER*. The first few target areas there, starting with *Stroke Intracranial Hemorrhage*, and running through the *Single CC or MCC* target area, those are the target areas that are focused more on proper coding. The potential for over coding could be identified if you are a high outlier. The potential for under coding, if you are a low outlier for these target areas. And we only identify low outliers for the coding-focused target areas.

The remainder of these target areas are focused on admission necessity or quality of care issues. And again, all of these target areas are included in the PEPPER for short-term acute care hospitals, with one

exception. The *Swing Bed Transfers* target area is unique to critical access hospitals. And that's been available for some time. CMS was interested in looking at transfers to swing bed, as many critical access hospitals do have their own swing bed.

There was, as I mentioned earlier, one revision to the PEPPER for this release, and that was in the single CC, MCC target area. Our team was performing an audit of the target area statistical programs, and during that audit we identified an issue with the programming logic for the *Single CC or MCC* target area. And this resulted in an undercount of the target, or numerator discharges, for the single CC, MCC target area.

The previous logic evaluated the count of CCs and MCCs for DRGs, whether the DRG was assigned on the basis of a CC, an MCC, or either a CC or an MCC. Now the revised logic evaluates three different and distinct scenarios. The first, the count of CCs for DRGs that are assigned on the basis of a CC. Second, the count of MCCs for DRGs assigned on the basis of an MCC. And last, the count of CCs and MCCs for DRGs that are assigned on the basis of a CC or an MCC.

So most hospitals will be observing an increase in their target discharges. The claims most likely to be missed in the previous report, or not counted, were those that were assigned on the basis of an MCC. So please do keep this in mind if you're looking at your statistics for this target area. Most hospitals will see an increase in their target area of discharges.

I do want to just share and walk through an example, again, of how we structure these target areas. This is the *Septicemia* target area. You can see each of our target areas has a numerator and denominator definition.

For *Septicemia*, in the numerator we're counting those three DRGs that are related to *Septicemia*, DRGs 870, 871, and 872. Then in the denominator, we are comparing — in the denominator we're including not only those *Septicemia* DRGs, but also DRGs for urinary tract infections, simple pneumonia, and respiratory system diagnoses with ventilator support. When we calculate the target area percent, we're simply dividing the numerator count by the denominator count, and multiplying by 100.

Now most of us can calculate our own target area percents using our own claims information. But the real value in PEPPER comes through the use of percentiles. We use the percentiles to help give us context, to tell us how our target area percent compares to that of other hospitals in the nation, in the jurisdiction, or in the state.

I'm going to use this ladder example to help you understand the difference between the percent and the percentiles, and how we use those in the PEPPER. So, here we have a ladder, and you can see associated with each of the rungs on the ladder is a target area percent. Now these are target area percent, let's just say that they're target area percents for all hospitals in the nation for the *Septicemia* target area for fiscal year 19.

We take all of those target area percents and we sort them from highest to lowest. We identify the point below which 80% of the target area percents fall, and the target area percent that is at that point, is identified as the 80th percentile. So any hospitals that have a target area percent that is at or above

the percent at the 80th percentile in the PEPPER, they are identified as high outliers, and they would see their percent in red bold font. And that could be an indication of potential over coding.

Now on the flip side, for the coding-focused target areas, we also look at hospitals that could be low outliers, which could mean under coding. So you can see that, down at the bottom we identify the percent that is at the 20th percentile, which means that 20% of the hospital's target area percents fall below that point in the distribution. And hospitals whose target area percents are at or below the national 20th percentile are identified as low outliers. And again those are identified for coding-focused target areas only.

I want you to keep this ladder example in your mind as we move to a sample PEPPER. What you're seeing now on your screen is the first page of the PEPPER for critical access hospital. The PEPPER is distributed as a Microsoft Excel workbook, and you will navigate within the PEPPER by clicking on these worksheet tabs along the bottom of the screen.

When you open your PEPPER, it opens to this purpose page. You will see your hospital's six digit CMS certification number here on row 8, along with your hospital name. Below that, it's going to indicate that this report summarizes the most recent three federal fiscal years through the fourth quarter of fiscal year 2019.

You will see your hospital MAC jurisdiction identified here. The jurisdiction comparison group is comprised of all of the critical access hospitals that submit their claims to the same MAC that you do for Medicare reimbursement. So that's what the MAC jurisdiction comparison group is comprised of.

In each PEPPER, we also include for each of the target areas, a complete numerator and denominator definition. This can come in handy if you are looking through your PEPPER, and you're curious about what the numerator count or the denominator count is representing. You can flip to the Definitions tab, and see the numerator and denominator discharge — I'm sorry, definitions, for each of these target areas.

The Compare Targets Report, I like to call this report the heart of the PEPPER. It is the only place in the PEPPER where you can see your hospital's statistics for all of the target areas, all in one view. Now it is only representing the most recent federal fiscal year, so this report is for the fourth quarters, four quarters ending Q4FY19, or basically for fiscal year 19. It will also help you identify, at an easy glance, which target areas your hospital is identified as a high outlier or a low outlier for.

So very quickly, this is the first target area listed on this report. Here's a definition of the numerator and denominator. In this cell, we see the number of target or numerator discharges. So this is the number of discharges that meet the numerator definition for this target area.

And when we compare the numerator to the denominator discharges, which are not included here, but I'll show you where we'll find those in a moment, we calculate our target area percent at 82.4%. But when we look at this percent, just looking at it standing alone, we really don't have any idea how do we compare to other hospitals in the nation, the jurisdiction, or in our state. And that's where those percentiles come in very handy.

So thinking about that ladder, we take the hospitals, all hospitals, let's say, in the nation, we sort them from highest to lowest. Our hospital's national percentile is 28.7. So that tells us that 28.7% of all hospitals in the nation have a lower target area percent than we do.

Again, thinking about that ladder, our hospital's target area percent is somewhere about 25%, 28%, from the bottom of that ladder. So you can see that we're not high, we're not low. We're on the lower end of the scale, but we're not below the 20th percentile.

When we compare ourselves to all of the hospitals in the jurisdiction, our jurisdiction percentile is 33.3. So about a third of the hospitals in our jurisdiction have a lower target area percent than we do. And then when we look at ourselves compared to all hospitals in the state, 27.3% have a lower target area percent than we do. So you can see how it's really handy to get this context of the percentiles to help you understand where in that distribution your target area percent fall.

The last column here identifies the amount of Medicare reimbursement that your hospital received for these 14 numerator discharges. And that can also help you with prioritizing areas for review. So as I slowly scroll down here, we can see that, for example here, our hospital is a high outlier for *Medical DRGs with CC or MCC*. We are at the 88.6 national percentile.

So our target area percent is towards the top of that distribution. 88.6% of the hospitals in the nation have a lower target area percent than we do. So we're a high outlier for this target area.

When we look at *Single CC or MCC*, we are at the 14.4 national percentile. So on the low end, and so we've been identified here as a low outlier. Now this is the only place in the PEPPER where you will see your exact percentile.

OK. Let's move on. Take a look at a few of the target area reports. For each of the target areas, there is a report in the PEPPER that will show you both graphically and tabular format, your hospital's information.

So here, for *Stroke Intracranial Hemorrhage*, we can see our hospital's target area percent displayed by these blue, 3 blue bars, for the three fiscal years. We can see that the target area percent has not changed very much over the past three years. We can also see that we're hovering right above, or right around, the 20th percentile.

And it's a little hard to see on this graph, but we have three percentiles lines. We have the national 20th percentile, which is the solid line. The jurisdiction is the dashed line. And the state is the dotted line.

So we see those target area percents that are at the 20th percentile, and then at the 80th percentile, the red trend lines represent the 80th percentile, on the graph. So it's easy to see how your target area percent compared to those percentile boundaries, and also how if there are any changes in the statistics over time.

Below the graph is a data table where you can find all the numbers behind the percent. So you'll see your numerator count here, this is the target count. Here's where you're going to find the denominator count. Numerator divided by denominator calculates your target area percent, which will be color coded if it's high or low compared to the national percentile.

We also include the average length of stay for the numerator discharges, the average length of stay for the denominator discharges, as well as the average amount of Medicare reimbursement for these numerator discharges, and the total amount of Medicare reimbursement for these numerator discharges. Below that are the comparative data. These are the percents that are at the 80th percentile for nation, jurisdiction, and state. And then for the coding-focused areas, we include those that are at the 20th percentile for nation, jurisdiction, and state.

Lastly, each of our target area reports includes, at the very bottom, suggested interventions for hospitals that might be high outliers or low outliers. Very general suggestion of what it could mean, and what you might think about looking at if you were a high outlier or a low outlier. So once you get used to looking at these target area reports, each of them are formatted in the same way.

Now, if you come across a target area report that appears to have missing data, such as this one, this simply means that there were not sufficient discharges for the target area to calculate statistics. We have to have a numerator count of at least 11 in order to calculate this statistic. So if you see something like this where there are report data for your hospital for only one or two target areas — I'm sorry time periods — then that simply means there was not enough data to generate this statistic.

And also, you'll see here we only have the national 80th and 20th percentiles. The percentiles will not be calculated if there are fewer than 11 hospitals in the jurisdiction or in the state that have sufficient data to generate statistics. We don't calculate the percentiles in those instances.

I'll just click through a few of these. Here we can see that this hospital had previously been identified as a low outlier for *Septicemia*, and now they are somewhere between the 20th and the 80th percentile.

This hospital is a high outlier for the *Medical DRGs with CC or MCC*. Rather on the low end for the *Surgical DRGs with CC or MCC*. Sometimes that could be — when the hospital's statistics for medical and surgical with CC look different, I encourage them to think about if there are differences in their patient population for their medical patients versus their surgical patients. Could that mean that the physicians, the surgeons, are doing a better or worse job at documenting CCs, MCCs, those types of things.

You'd have to think about the statistics in context with your hospital, and your operation, and your patient population. There are a number of factors that can play in here. Here's the *Single CC or MCC* target area.

Click through. Here, this hospital doesn't have any information for *Swing Bed Transfers*. There's no information there. Now also, quickly, each of our PEPPERs includes additional information for that summarizes your hospital's statistics.

The hospital top DRGs report identifies the top DRGs for your hospital for the most recent fiscal year. So we see the DRG, the description of that DRG, the total number of discharges for that DRG, proportion of discharges for each DRG to total, and then your hospital's average length of stay for that DRG. This report is supplemental. It does not have any impact on outlier status, but it is for your information only. We will list up to 20 DRGs on this report. They do have to have at least 11 discharges in order to be included here.

We also include a jurisdiction top DRGs report that summarizes for your hospital's jurisdiction, all of the hospital's statistics in this jurisdiction. Again, that's for comparison purposes only.

Was a quick review of a sample PEPPER. I'll go back to my presentation. So, now that we've reviewed a PEPPER, a lot of times I get questions about, do I have to use the PEPPER? Do I need to take any action if my statistics look different?

Well, no, you're not required to utilize your PEPPER. Certainly you're not required to take any action in response to the statistics you see in your PEPPER. I want you to remember, though, that there are other contractors that are sifting through the claims data looking for providers who could, perhaps, benefit from some education, maybe a focused medical review, maybe some other activity. And the PEPPER is a good way to help give you a heads-up that your statistics look different. So then you can decide if what you're seeing in your PEPPER is what you expect to see, or if there's something that concerns you that you might want to take a closer look at.

How do you obtain your PEPPER? The PEPPER for critical access hospitals is distributed annually in an electronic format. And it is now available through the PEPPER portal. Each release of the PEPPER will be available for approximately two years from the day that we distribute it.

In order to access your PEPPER, you will need two pieces of information. One is your six digit CMS certification number, also known as the PTAN. It is not the same as your tax ID or your NPI number. And you also will need the validation code that is mailed to the critical access hospitals QualityNet Administrator, so please be on the lookout for that.

I do want to give you a heads-up that we are exploring some possible changes to the way we make this validation code available. Nothing is set in stone yet, but in the future it might be mailed to the hospital's contact that is listed in the NPPES or in the PECOS system. So please, please make sure that the information is current in these systems, in the case that we do move in that direction in the future.

OK, so once you receive your PEPPER, first of all, don't panic. Especially if you see a lot of red or a lot of green. Remember, outlier status does not necessarily mean that compliance issues exist.

But if you are an outlier, try and think about why that might be. Again, some of the points we've talked about, thinking about your operation, any specialized programs or services that you provide. Again, your patient population, referral sources can be an impact, the external health care environment. If you have any concerns, sample some claims, review the documentation in the medical record, make sure that everything is coded and billed appropriately. The bottom line is to make sure that you're following best practices, even if you're not an outlier.

Some of the other resources now, that are available for you on our website, on the same page we put together national level and state level data for the target areas and for the top DRGs. Those are updated annually with each release. We also have peer group bar charts that are available for your comparison. It helps you compare your statistics to the group that you might consider your peer.

And for each of the target areas, they identify the 20th, the 50th, and the 80th national percentile for critical access hospitals in three different categories. We look at size, which is based on number of

discharges. We look at location, urban or rural. And then also ownership type, for profit or physician owned, nonprofit, church, or government.

We do plan to update these on an annual basis. There are some resource documents there, a methodology, and critical access hospitals by peer group, that can help give you some additional details. If you disagree with your ownership type or location, that information is assembled through the CMS regional offices. So please contact your CMS regional office coordinator if you have any updates or corrections.

This is an example of the 30 day readmissions, the same hospital or elsewhere peer group bar chart. We can see how those percentiles differ based on the breakouts within those three areas. I do want to let you know that we are currently revising the format for these peer group bar charts. So they may look different, they may have a different structure for fiscal year 19. This is an example for fiscal year 18.

We have a number of resources on the PEPPER website, including the PEPPER users guide, which I would encourage you to refer to if you do have some questions about the PEPPER. There is a spreadsheet that identifies the number of hospitals in each of those MAC jurisdictions, in total and then by state. We have those recorded PEPPER training sessions. There's a sample PEPPER for critical access hospitals. And also, we include a history of target area changes, and the expected impact that hospitals may see based on those changes.

If you need assistance with your PEPPER, please contact us through our Help Desk. We have a team that is ready to assist you with any of your questions, whether it has to be trouble accessing your — if you need help accessing your PEPPER. Or if you just have a question about the data in your report, or perhaps, how to use your PEPPER.

So please contact us through the Help Desk. There is a online form that you'll complete, and a member of our team will reach out promptly to assist you. This is a screenshot of our website home page. You can see the resources for critical access hospitals are easily accessible straight from the home page. There's the user's guide, a link to the “Training and Resources” page, and then the PEPPER distribution, get your PEPPER page, where you can go to obtain your PEPPER.

Again, if there are any questions, submit them to our Help Desk, at pepper.cbrpepper.org. And that completes the update, or the review, of the Q4FY19 PEPPER for critical access hospitals.