PEPPER

Transcript for the Q4FY19 *Inpatient Psychiatric Facility (IPF) Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

Welcome to this review of the PEPPER for inpatient psychiatric facilities. My name is Kim Hrehor, and I work for the RELI Group, which 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 my discussion on the newest release of PEPPER for inpatient psychiatric facility. This is version Q4FY19. There are no target area revisions that we need to cover for today's review, so I am going to focus on providing you with a high level review of the *IPF PEPPER*. I will include a quick walkthrough of a sample PEPPER, and then we will review other resources that are available on our website. If, after today's session, you still have questions about the PEPPER, if you are new to PEPPER, there are additional training resources that are available on the PEPPER.CBRPEPPER.org website. These are recorded sessions that are available in small segments — I call them chapters — that can help give you more information about the PEPPER. So I would encourage you to access these resources if you have questions about 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 data report that contains one hospital's Medicare claims data statistics for areas that might be at a higher risk for improper Medicare payment, primarily in terms of whether the patient's treatment was necessary and correctly coded and billed. We refer to these risk areas as target areas, and I'll be reviewing those in just a few minutes.

Now, the PEPPER compares your facility's Medicare claims data statistics with other — with aggregate Medicare data of other IPFs in three different comparison groups. All IPFs in the nation, all in your Medicare Administrative Contractor, or MAC jurisdiction, and then in your state. These comparisons allow us to identify where your facility might be at a higher risk for improper payments, which in PEPPER terms, simply means that its billing practices are different from other IPFs in the comparison group.

Now, I do want to stress that the PEPPER cannot identify the presence of improper Medicare payments. Those can only be confirmed through a review of the medical record. But the PEPPER can give you clues as to when your billing pattern looks different from those of most other facilities so then you can take the next action in determining whether any issues exist or not.

PEPPER has been available for several years now. It was originally developed in 2003 for short-term acute care hospitals and then a few years later for long-term acute care hospitals. Back then, the PEPPERs were made available to hospitals through the state quality improvement organization.

Then CMS made some changes to the program. And starting in 2010, TMF Health Quality Institute began distributing PEPPERs to all providers in the nation. And along the way, they started to develop PEPPERs for other provider types. And you can see that the *IPF PEPPER* has been available since 2011.

Then in 2018, CMS again made some changes to the program. They combined the comparative billing report program, or CBR program, with the PEPPER program into one contract. And now the RELI Group, along with its partners, TMF and CGS, are producing CBRs and PEPPERs for providers across the country.

The CBRs primarily summarize Medicare Part B claims data for areas — for topics that have been identified as at a higher risk for improper payments. And the PEPPER still focuses primarily on Part A claims data. So why are hospitals — or why is CMS making PEPPERs available to providers? Well, CMS is mandated by law to protect the Medicare Trust Fund from fraud, waste, and abuse. And CMS employs a number of strategies to meet this goal, such as provider education, data analysis activities, and early detection through medical review, which may be conducted by Medicare Administrative Contractors, recovery auditors, or other federal contractors. The provision of PEPPERs to providers supports these strategies. The PEPPER is considered to be an educational tool that can help providers identify when they might be at a higher risk for improper Medicare payments so then they can proactively monitor and take any preventive measures if necessary.

I should also mention that the Office of Inspector General, or OIG, encourages providers to establish a compliance program to ensure that their systems are established and in place to help protect their operations from fraud and abuse. As part of the compliance program, a provider should conduct regular audits to ensure that charges for Medicare services are correctly documented and billed and that those services are reasonable and necessary. The PEPPER is an educational tool that can help guide that auditing and monitoring process.

So let's turn now our focus more specifically on this newest release of PEPPER for inpatient psychiatric facilities. This PEPPER is version Q4FY19, which means that it summarizes statistics through the fourth quarter of fiscal year 2019. And so this version of PEPPER, as all versions do, summarizes statistics for discharges that end in the most recent three federal fiscal years. And so this one will summarize discharges ending in fiscal year 2017, fiscal year 2018, and fiscal year 2019. And the federal fiscal year, as a reminder, 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 the claims data from the paid claims database for all of the target areas and all of the time periods in the PEPPER. So we are refreshing those statistics with each release. So keep this in mind if you are looking at your PEPPER from last year and comparing it to the new release. You will likely see some slight changes in a numerator or a denominator count or other statistics in your PEPPER. And that would be reflected if there were any late claims submitted, any corrected claims. Those would all be reflected in these refreshed statistics for your PEPPERs. So just keep that in mind. And of course, the oldest fiscal year is going to roll off as we add a new year to each release of the PEPPER.

All right, now let's talk about the improper payment risks that are pertinent to inpatient psychiatric facility. IPFs are reimbursed through the IPF prospective payment system. And just as in other inpatient settings of care, IPFs are at risk for unnecessary admissions, as well as incorrect coding, which can affect whether reimbursement is correct.

The target areas that are included in the *IPF PEPPER* were developed through a review of the IPF PPS — also through coordination with the CMS IPF subject matter experts. And we also analyzed national level claims data. We continue to coordinate with CNS. And year after year, we do evaluate these target areas to ensure that they are still relevant. And there have been some changes to the target areas over time. And that is certainly a possibility as we move forward.

So let's talk now about target areas. I've used this term a few times now. And basically, in the PEPPER world, a target area is a clinical condition or a type of admission that's been identified as prone to unnecessary admissions or incorrect coding or billing.

And the PEPPER includes two types of target areas — those that are focused on admission necessity issues and those that are focused on coding-related issues. In the PEPPER, we construct these target areas as a ratio, where the numerator is a count of discharges that may be problematic from either an admission necessity or a coding standpoint. And then the denominator is the count of discharges of some larger reference group. The numerator and denominator allow us to calculate a target area percent. And we'll talk about that in just a few minutes. We can do a quick run through now of the target areas that are included in the *IPF PEPPER*.

You can see that each of our target areas has a numerator and a denominator definition. And we use these definitions to determine the numerator count, the denominator count. Then when we divide the numerator by the denominator and multiply by 100, that gives us the target area of percent. And we'll be talking about that more closely here in just a moment.

The *Comorbidities* target area is the only target area in the PEPPER that is focused on coding-related issues. And here we're looking at the percentage of claims that have at least one comorbidity on the claim. Now remember, IPFs do receive payment adjustments for a number of comorbid conditions. So if a IPF has a high percent for this target area, it could be an indication of potential over-coding. Or, if there is a very low percentage of patients with comorbidities, it could possibly be an indication of potential under-coding.

So you also want to keep in mind your patient population or other factors, such as your billing system, which could affect the numbers in this target area. We do identify high and low outliers only for this target area. *No Secondary Diagnoses* will calculate the percentage of claims for discharges.

Where there are no secondary diagnoses coded, this target area is focused on encouraging providers to ensure that they include all additional and coexisting diagnoses on that claim. Even if they're not necessarily psychiatric diagnoses, but if they are active medical conditions, they should be coded as additional diagnoses on the claim. There is a target area that's focused on outlier payments, which calculates the percentage of total Medicare reimbursements comprised by outlier payments.

And IPFs that have a high percentage of patients with a high percentage of outlier payments may wish to examine those cases to ensure that the care was necessary and correct — the claim was correctly submitted. Just recently, very recently, actually, there was an OIG report that was released. And the OIG studied IPF outlier claims, or claims that have outlier payments, and found that 87% of those claims did not meet medical necessity or documentation requirements. So this target area reflects the concern that is certainly still on the radar. This target area is still certainly relevant. So please do keep that in mind. This OIG report was released April the 9th of 2020, and you can find it on the OIG website, OIG.HHS.gov. And the title of the report is "Estimated 87% of IPF claims with outlier payments did not meet Medicare's medical necessity or documentation requirements." A very interesting report.

OK, moving on, we also have a couple of target areas that look at readmissions in a couple of different ways. The *3- to 5-Day Readmissions* target area calculates the percentage of patients who are

readmitted within three to five calendar days. And this target area is intended to assess the risk for potential circumvention of the interrupted stay policy, where patients readmitted within three consecutive days are treated as a continuation of the initial admission for reimbursement purposes. And then the *30-Day Readmissions* target area looks at readmissions within 30 days, either to the same IPF or to another IPF. CMS has had an ongoing focus on reducing readmissions in many — many settings of care, so we have included this target area in the *IPF PEPPER*.

Just a word about the comorbidities — you can find the diagnosis code that have been identified as comorbidities on the CMS website at this link in the download section. So if you're looking for that information, you can find it on the CMS website.

So we've just gone through the target area definitions, and we see how we have a numerator and a denominator. Using that numerator-denominator, you likely can all calculate your own target area percent. The value in the PEPPER is that we also calculate percentiles, which give you some context as to how your target area percent for a given target area compares to those of other IPFs in the nation, in the jurisdiction, or in the state.

I'm going to spend just a few minutes now talking about how we calculate those percentiles and what they mean in the PEPPER. When we calculate percentiles, the first thing that we do is we take the target area percents for all of the IPF in a target — in a comparison group for a particular target area and time period, and then we sort them from highest to lowest.

So let's look at this example on the side. This is a ladder, and we have these target area percents. Let's just say they're for the *Comorbidities* target area. We take all those — all the target area percents for fiscal year '19, for all the IPFs in the nation. We sort them from highest to lowest.

We identify then the points below which 80% of those target area percents fall. And the target area percent that is at that point is identified as the 80th percentile. In the PEPPER, we use the 18th percentile to identify those providers who are going to be identified as outliers in the PEPPER.

This means that their target area percent is greater than at least 20% of all the other IPFs. And in the PEPPER, they will see their target area percent displayed in red bold font when that is the case. Now, for the *Comorbidities* target area, we also identify what we call low outliers, those providers whose target area percent is at or below the national 20th percentile.

So we see here, in this example, the 20th percentile is 12%. So any IPFs that have a target area percent of 12% or less will be identified as low outliers for that target area. And again, this helps give us some context to think about where in that distribution of target area percent our particular IPF falls.

This is a good point during the presentation to switch to reviewing a sample PEPPER for IPFs. You are seeing now on your screen a sample PEPPER. 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 first open your PEPPER, it opens up to this page. This is the Purpose page. You will see your facility's six-digit CMS certification number here, on row eight. And then you'll also see your provider

name. Right below that, there is this a statement that identifies that this report summarizes the most recent three federal fiscal years through the fourth quarter of fiscal year '19.

Some other information here, general information about the PEPPER, the user's guide. On row 22, you will see your hospital's Medicare Administrative Contractor jurisdiction identified. And the MAC jurisdiction comparison group is comprised of all of the other IPFs that submit their claim to the same MAC as you do. So that's the MAC jurisdiction comparison group.

The next tab is the Definitions tab. And here, you will find the complete numerator and denominator definitions for all of the target areas in the *IPF PEPPER*. This can be handy if you are looking at your target area report, and you're trying to determine what the numerator count is representing or what the denominator count is representing. You can simply flip to the Definitions tab, and here is your complete definition.

Then we move on to the Compare Targets Report. I like to call this report the heart of the PEPPER. It is the only place within your PEPPER that you will be able to see your IPF statistics for all of the target areas all in one view. Now, it is only representing statistics for the most recent fiscal year. And also, you'll notice that for this IPF, there are only three target areas listed on the report. The report is only going to show us the target areas that you have sufficient data to generate statistics for the most recent fiscal year. So if you're not seeing all of the target areas on this report that would be the reason, because your numerator count is less than 11 for the target areas that aren't here, that we don't see on this report. And we cannot calculate the statistics.

So let's walk through this real quickly. For the *Comorbidities* target area, this IPF has 96 discharges that have at least one comorbidity coded on the claim. Now, when we compare the numerator to the denominator — but the denominator is not on this report, but I'll show you in just a moment where you can find it — we have a target area percent of 22%.

Now, if we just look at that number, 22%, how do we know if we're relatively high compared to other IPFs, or low? That's where that percentile comes in very handy. I want you to think about that latter example as we talk about these percentiles. Our target area percent of 22% places us at the 34.0 national percentile. That means that 34% of the IPFs in the nation have a lower target area percent than we do. So if we're thinking about that ladder and the distribution of the target area percent from highest to lowest, our percent is about 1/3 of the way up from the bottom. So we're kind of in that middle zone there for this particular target area. Now, when we compare ourselves to all of the IPFs in our jurisdiction, we are at the 38.1 jurisdiction percentile. So 38.1% of the IPFs in the jurisdiction comparison group have a lower target area percent than we do. And then when we look at ourselves compared to other IPFs in our state, 35.8% of them have a lower target area percent than we do. This last column, the sum of payments, identifies the total amount of Medicare reimbursement that our IPF received for these numerator discharges.

So we can see that this hospital — I'm sorry, this IPF is identified as a high outlier for the *30-Day Readmissions* target area. Their national percentile is 94.2. So thinking again about that ladder, our target area percent of 27.6 is pretty high, close to the top of that ladder because 94.2% of all IPFs in the nation have a lower target area percent than we do.

So you can see how this can be really helpful in, again, giving you that context, thinking about where you're IPF falls in comparison to all IPFs in the nation, in the jurisdiction, and in the state. And also, this is the only place in the PEPPER where you're going to see your exact percentile.

All right, let's move on now. Let's talk about or review each of this reports for the target area. This is the *Comorbidities* target area. We have a graph here that shows us our IPF target area percent over the past three fiscal years. So this is fiscal year '17, fiscal year '18, and fiscal year '19.

The graph shows us how our target area percent has changed over time, so we can see that we have had a gradual increase in the claims or the discharges with at least one comorbidity coated on the claim. Whether this was related to a change in patient population or perhaps documentation improvement or coding accuracy is for this IPF to consider, but they have been — they have seen a gradual increase here, in their discharges.

And so anytime you see increases or decreases in your PEPPER, you might want to think about some of the factors that could be feeding into that. What might be some of the source causes? And if something makes you feel a little bit uneasy, then that's the time when you would want to take a closer look, review some medical records and some claims and make sure that everything is functioning as you would expect it to.

Below the graph is the data table that gives us the numbers behind the statistics. So for each of the three fiscal years, we have our numerator count. Here is where we'll find the denominator counts. Then we also give you the average length of stay for the numerator discharges and the average length of stay for the denominator discharges.

We calculate the average amount of Medicare reimbursement that you received for these numerator discharges and then the total amount of Medicare reimbursement for these discharges. Then below that data table is this comparative data table that shows us the target area percents that are at the 80th percentile for nation, jurisdiction, and state, and the percents that are at the 20th percentile for nation, jurisdiction, and state.

And these values are graphed up here in this graph as the red and the green trend lines. The red are the 80th percentile. Green are 20th. The solid line is the national 80th percentile. The dashed line — little bit hard to see it — that's the jurisdiction. And the dotted line is the state, 80th percentile. And then similarly, national, 20th, jurisdiction, 20th, and dotted is state, 20th.

The last thing at the very bottom of all of these target area reports are suggested intervention. If you are a high outlier or a low outlier for this target area, these are suggested interventions, what it could mean, and what next steps might be if you decide to take a closer look if you wanted to audit some records. These suggested interventions are also included in the *IPF PEPPER User's Guide*.

All of the target area reports in the PEPPER are formatted in the same way. Now, this one is *No Secondary Diagnoses*. And you can see here that this looks like it's missing some information. There's only one very small blue bar on the graph. And there's only data in this table for the oldest time period.

Remember, we only calculate statistics if the numerator count is 11 or greater. So when we see empty cells, missing bars on the graph, that just means that there was not sufficient data to generate statistics.

If the discharge — target discharge count is less than 11, then we are not able to calculate those statistics. So you'll see blanks. *Outlier Payments* — this IPF does not have very many outlier payments. And so this target area report is completely empty. *3- to 5-Day Readmissions*, we can see there's been a little bit of change over time. 30-day readmission — this IPF looks to have been consistently above the national 80th percentile, has had a little bit of an increase over the past year, might be something that they want to take a closer look at.

OK, also included in the PEPPER is a supplemental report. This report doesn't have anything to do with outlier status, but it does give you some additional information. This top DRGs report will identify for you the top DRGs for your hospital, for your IPF, for the most recent fiscal year. We identify the DRG and the DRG description. This is the total number of discharges for the DRG, proportion of discharges to total, and the average length of stay for that DRG. Now we will include up to 20 DRGs on this report. There does have to be at least 11 discharges for the DRG in that fiscal year for us to include it on the report. We do have some summary information here for the top DRGs and then for all. And lastly is a tab that includes the same type of information but summarized at the jurisdiction level. So this information is representative of all of the IPFs in your jurisdiction. And if you were interested in the nation, that information's on our website. And I'll be covering that in a few minutes.

All right, so we'll go back to the presentation and continue on. Sometimes I get the question from providers, do I have to use my PEPPER? Do I have to take any action in response to the statistics in my PEPPER? And the answer to both of those questions is no. You are not required to use your PEPPER. You're not required to take any action or put together a report or do anything in response to your PEPPER statistics. I do want you to remember that there are contractors out there that are looking through claims data. They have access to the entire Medicare claims database.

They're trying to identify providers, perhaps, that may be aberrant, maybe for educational intervention, maybe some focused case review. And so the PEPPER can be a heads up, for these particular target areas anyway. The PEPPER can be a flag for you to give you a heads up that these target areas — you look different for these target areas.

You can determine if that's what you expect to see for your IPF or if there's something that you might want to take a closer look at. It's simply a very nice comparative data report that's made available to you at no charge by CMS. So I would encourage you to access your PEPPER and to review it at least once a year.

How do you obtain your PEPPER? The *IPF PEPPERs* are distributed, currently, through QualityNet to the QualityNet administrators and to those that have basic QualityNet accounts with the PEPPER recipient role. The PEPPER is not publicly available, and we will distribute these PEPPERs only to the individual IPF through QualityNet. The file will be available for 60 days from the date it was uploaded. And we can upload it if you miss that time period, but you will need to contact us through our Help Desk. There are a certain number of units, IPF units of critical access hospitals. And those IPF units will need to access their PEPPER through the PEPPER Portal. The critical access hospitals now receive their PEPPER through the PEPPER Portal and so will their IPF unit.

Moving forward, we do know that QualityNet is being phased out. And it will not be in operation after late 2020. So in the future, the PEPPER distribution may be completed through the PEPPER Portal, for all of the IPFs. And if that happens, you'll go to PEPPER.CBRPEPPER.org. And you will review some information there and access your PEPPER.

We are considering, at this point, sending a validation code to access your PEPPER via email to the provider contact that is listed in the National Plan and Provider Enumeration System, or NPPES, or the National — I'm sorry, the Provider Enrollment Chain and Ownership System, or PECOS. So please, please, take this opportunity over the next year to ensure that your contact information in these systems is current and correct because we may be sending that validation code to that contact, that identified contact, through email in the future.

OK, so let's say you have your PEPPER. And you see some reds, some greens — what should you do? The first thing you should not do is panic. Remember, just because you're an outlier, it doesn't mean that you're doing anything wrong. It doesn't mean that any compliance issues exist.

By design, we are always going to be identifying 20% of the IPF as high outliers, and for *Comorbidities*, 20% as low outliers. But I do encourage you to think about why you are an outlier if that is the case. Ask yourself if the statistics in your PEPPER reflect what you expect to see given your operation, any specialized programs or services, patient population, referral sources, anything going on in your external health care environment.

If you have any concerns or if anything makes you feel a little bit uneasy, sample some claims, review that documentation in the medical record. Coordinate the review with the claim to make sure everything was coded and billed appropriately based on documentation in the medical record.

The bottom line is to ensure that you are following best practices, even if you're not an outlier. OK, moving on now to some of the other information that you might find helpful, this is all information that's publicly available on our website. On the data page, we make available information at the national level and at the state level for all of the target areas and then also for those top DRGs.

We also have information at the national level for IPFs, broken out into three ways. One is looking at all IPFs, and then we're looking at freestanding IPFs, and then also the IPF distinct part units. And we do update this information following each report release. You'll find that on the website.

We also have put together peer group bar charts. We have heard, and we do understand, that providers might like to compare themselves to a group that they would consider to be their peers. So then for each of the target areas, we have put together these peer group bar charts that identify the 20th, the 50th, and the 80th national percentile for IPFs, looking at three categories — size, which is based on number of discharges; location, which is either urban or rural; and then ownership type, which is for-profit or physician-owned, non-profit or church-owned, or government-owned.

These are also available on the PEPPER.CBRPEPPER.org website. We do update these on an annual basis. There are a couple of documents that give additional details as to how these bar charts were put together. There's a methodology document, as well as an IPF by peer group file where you can see in which of those categories your IPF is categorized.

If you disagree with your ownership type or location, you will need to work with your CMS regional office to make corrections. We do utilize the CMS provider of services file to make these categorizations. And that information is maintained and updated by the CMS Regional Offices.

This is a screenshot of what the current bar charts look like. This is an example for *Outlier Payments*. You can see, for example, when we're looking at the size variable there, the very top chart, blue bar, the smallest 1/3 of IPFs have a much greater 80th and 50th and 20th percentile than the other segments do.

You can see also there are some differences for location. Rural tends to have higher percentiles. And then for ownership type, it looks like the government-owned have higher percentile. And we are working on making some updates to the format. So the format may not look exactly as what you're seeing here on the slide. But those will be available on the website.

There are a number of other resources that you will find on the PEPPER website on the "Training and Resources" page. Those include the User's Guide, the PEPPER User's Guide, a spreadsheet that identifies the total number of IPFs in each jurisdiction in total and then by state. We have those recorded PEPPER training sessions. There is a sample *IPF PEPPER*, and also you'll find a history of target area changes and impact.

If you need assistance with PEPPER — if you're trying to obtain your PEPPER, and you're having some trouble getting your PEPPER, if you have questions about the information, the data, or just questions about how you use it and you're not finding what you're needing in the PEPPER User's Guide, just contact us through our Help Desk.

There's a form that you'll complete. A member of our team will respond promptly to assist you. And just remember, we are the only official source of assistance for PEPPER. So please contact us. That's why we're here. We want you to get the PEPPER. We want you to use your PEPPER. And we want to make sure that you're comfortable with the information that's in there.

Just a screenshot of the PEPPER website home page. The blue arrow is pointing to the IPF section. You can see you can easily access the User's Guide, "Training and Resources" and the PEPPER Distribution page right there from the Home page. And as always, if there are any questions, those can be submitted through our Help Desk at PEPPER.CBRPEPPER.org. Thank you for listening.