Transcript for the Q4FY19 *Long-Term (LT) Acute Care Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

Welcome to this review of the PEPPER for long-term acute care 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 discussing the PEPPER for long-term acute care hospitals, the most recent version, which is Q4FY14 19.

Now there aren't any target area revisions that have been implemented in this release. So this is going to be a high-level review of the PEPPER. And then I will also include a walkthrough of PEPPER, a sample PEPPER, and we'll review the other resources that are available. Because this is going to be a high-level review of the PEPPER, if you are new to PEPPER or if you feel like you need more information or you still have questions after this session, I would encourage you to visit the PEPPER website — that's pepper.cbrpepper.org — and access the series of recorded training sessions that are available in the "Training and Resources" section for long-term acute care hospitals. Those are available as short segments that you can pick and choose and listen to at your leisure.

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 summarizes 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 claim was correctly coded and billed and whether the treatment provided to the patient was necessary and in accordance with Medicare payment policy. And in the PEPPER, we call these target areas.

The PEPPER summarizes your Medicare claims status statistics for these areas, and then it compares them with aggregate Medicare data for three different comparison groups. We have all providers in the nation, all providers in your MAC or Medicare Administrative Contractor jurisdiction, and then all providers in the state. And these comparisons are the first step in identifying where you might be at a higher risk for improper Medicare payments, which really, for the PEPPER, just means that your billing practices look different than most of the other hospitals in the comparison group. And I do want to stress, that the PEPPER itself cannot identify improper Medicare payments, but it can be really helpful in that it can alert you if your statistics look different. And then you can determine whether that's what you would expect to see or not.

Now PEPPERs been around for quite a few years. It was developed back in 2003 for short-term acute care hospitals and then a couple of years later for long-term acute care hospitals. And they were provided at that time by the quality improvement organizations, the state QIOs, and that occurred through 2008. And then, at the end of 2008, CMS made some changes to the program. And starting in 2010, TMF Health Quality Institute began distributing PEPPERs for all of the hospitals in the nation, and then they started to develop PEPPERs for other provider types, which you can see here on the slide.

Then starting in 2018, CMS again made some changes to the program, and they combined the comparative billing report program and the PEPPER program into one contract. The CBRs are focused

more on part B Medicare claims data or the outpatient providers, and the PEPPER summarizes Medicare Part A claims data. And so now the RELI Group and its partners, TMF and CGM, are producing CBRs and PEPPERs and making them available to providers across the nation.

So why does CMS feel that the provision of PEPPERs to providers is supportive of 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 and early detection through medical review, which might be conducted by the Medicare administrative contractors or the recovery auditors or some other federal contractor. And they also use data analysis activity.

The provision of PEPPERs to providers supports these strategies. The PEPPER is an educational tool that can help hospitals identify when they might be at a higher risk for improper Medicare payments. 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 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 can help support the auditing and monitoring component of a compliance program. So now let's focus more specifically on the PEPPER — the new PEPPER for long-term acute care hospitals.

This is version Q4 FY2019. Again, that means that the statistics are summarized through the fourth quarter of fiscal year 2019. This release of PEPPER has the statistics for three federal fiscal years — 2017, 2018, and 2019. And just as a reminder, the federal fiscal year starts October 1, and it runs through September the 30th of the following year.

Now each time we produce a PEPPER, we refresh the statistic for all three time periods for each release. And so if you're looking at your PEPPER from last year and comparing it with your new PEPPER, it's possible that there are going to be some small differences in the numerator or denominator counts or some of the other statistics in your PEPPER. And just remember that any corrected claims that have been resubmitted or late claims that were filed over the past year, all of that will be reflected in your new statistics and your refreshed statistics.

And so keep in mind that you certainly could see some slight changes compared to last year's release. In addition, the oldest fiscal year rolls off as we add a new one. So let's talk about the improper payment risks that are pertinent to long-term acute care hospitals.

Long-term acute care hospitals are reimbursed through the long-term Perspective Payment system or PPS, which is almost identical to the acute care PPS for short-term acute care hospitals. The main difference is that the DRG waits for long-term acute care hospitals are greater to compensate for the increased complexity of the types of patients that they serve. Now that being said, long-term acute care hospitals are at risk for improper payments in several of the same areas as short-term acute care hospitals, for example, *Excisional Debridement* and *Septicemia*.

Originally, the PEPPER target areas for long-term acute care hospitals were developed based on findings from medical record reviews that were conducted by the QIOs. We also review literature about payment vulnerability. We look at the long-term PPS, and we analyze national-level claims data to help guide the development of the target areas. And occasionally, we also receive valuable feedback from the long-term acute care hospital community that helps us revise or refine the target areas. So these target areas in the PEPPER have changed over time as new information about payment vulnerabilities comes available or is those error rate change and those types of things.

I'd also like to mention that the Comprehensive Error Rate Testing contractor or the CERT contractor. They review records every year, and they estimate improper payment for CMS for all different provider types. And annually, they publish a report that summarizes their findings with regards to improper payments.

The 2019 CERT Medicare Fee-For-Service Improper Payments Report showed that for long-term acute care hospitals, there was a 1.7% error rate with a projected $64 million in error. Now that is a decrease from 2018. So that's good news for long-term acute care hospitals if you're interested in seeing the reports — and again all of them are out there, the newest one all the way to the oldest — they're on the CMOS website at cms.hhs.gov/cert, and that's C-E-R-T. Now let me move into a discussion about the target area what a target area is as it pertains to the PEPPER.

Basically, a target area is a service or type of care that's been identified as potentially prone to improper Medicare payments. And again, in the PEPPER, we call those target areas. And they're constructed as ratios, where the numerator is the count of discharges that could be problematic. The denominator is a larger reference group that contains the numerator and also allows the calculation of a target area percent. We'll talk more about that as we get into the review of the sample PEPPER.

Now in the long-term acute care hospital PEPPER, we have two types of target areas. One is focused on coding errors, DRG coding errors, and the other is more focused on unnecessary admissions or services. We will take a quick look at the target areas that are included in the *Long-Term PEPPER*. These first two target areas here — the *Septicemia* and the *Excisional Debridement* target area — these are focused on coding-related issues. And so if a hospital has a higher target area percent, they might be identified as a high outlier, and that could mean that they are at risk for over-coding or overpayment related to DRG coding.

Now on the other hand, if the hospital's target area percent is really low compared to everybody else, they might be identified as a low outlier, and that could be an indication of potential under-coding or where the hospital is receiving an underpayment. So we'll talk a little bit more about that as we get into the review of the sample PEPPER.

But as you see, these target areas, they all have a numerator definition and a denominator definition, and we use the numerator and denominator to calculate that target area percent, which then we use to identify the percentiles. The *Short Stays* target area here is focused on short stays. The long-term acute care hospitals receive a reduced DRG payment when the length of stay for a patient is less than 5/6 of the average length of stay for the DRG.

So there is an incentive a financial incentive to keep that patient until the short-stay outlier threshold is met so that the full DRG payment is received, and that's what the *Short Stays* target area is looking at. We also have a target area that looks at short stays for these respiratory system diagnoses. There's a target area that looks at outlier payments.

30-day readmissions — there has been a big focus over the years on reducing readmissions, and this is something that CMS looks at in the number of settings of care. Readmissions represent potential quality of care or billing errors. So it is something that hospitals want to try to prevent when at all necessary or when at all possible.

And the last target area that's listed here — short-term acute care hospital admissions following a discharge from a long-term acute care hospital — this target area is really more related to quality of care. Here we're looking at the percent of benes who are admitted to an acute care hospital — a short-term acute care hospital within 30 days of being discharged. And so I think the concern here is that if there's a high proportion of these admissions to short-term acute care hospitals occurring, it could mean that the patients are not medically stable, or maybe they're not ready for discharge. Maybe their families are not ready to handle the patient care following the discharge. So those are some of the things you can keep in mind there.

Now as I mentioned, we use that numerator and denominator in the target area definition to calculate a target area percent. We use percentiles in the PEPPER to help us identify outliers. And I want to spend just a little bit of time here clarifying the difference between percent and percentiles and how we use them in the PEPPER. So we calculate percentiles, and we use the 80th percentile — the national 80th percentile — to identify providers who are high outliers for a target area. And then we use the 20th percentile to identify when a provider would be a low outlier, and low outliers are applicable only for those coding-focused target areas.

Now here we have a ladder. And in this ladder, we have associated with each rung a target area percent.

Let's just say that these are the target area percents for all of the hospitals in the nation. And we sort them from highest to lowest. And so this might be for the *Septicemia* target area. We take those target area percents for all the hospitals, and we sort them from highest to lowest.

And the point below which 80% of the target area percent fall, that is identified as the 80th percentile. And any hospitals will have a target area percent that is at or above that percent value, would be identified as high outliers in the PEPPER, and you would see the target area percent displayed in red, bold font. Now on the other hand, if you were at the bottom end of that distribution, we identify hospitals whose target area percent is at or below the 20th percentile as low outliers, and you would see your target area of percent in green italics, in that instance. This is going to be a good spot for me to move into a sample PEPPER.

So you're seeing on your screen now the first page of PEPPER. If you haven't seen a PEPPER before, the PEPPER is a Microsoft Excel workbook. You will navigate within the PEPPER by clicking on these worksheet tabs along the bottom of the screen.

When you open your PEPPER, you will see your six-digit CMS certification number here and then your provider name. On the next row, it's going to identify that this is the most recent three federal fiscal years through the fourth quarter fiscal year 2019. It will identify for you over here what MAC jurisdiction your jurisdiction group is compared to. And the MAC jurisdiction simply represents all of the hospitals that submit their claims to the same MAC as you do for Medicare reimbursement.

We have a Definitions tab where you can see the complete numerator and denominator definition for each of the target areas that are included in the PEPPER. So if you're looking at your statistics and you're trying to figure out what is summarized in the numerator or the denominator, you can click over to the Definitions tab and get the definition of how we're calculating or identifying those discharges.

The next tab is called the Compare Targets Report, and I like to call this the heart of the PEPPER. It is the only place within the PEPPER that you will be able to see all of your statistics for the target areas all in one view. Couple of caveats — we will only include your statistics on this report if you have reportable data. That would be a numerator count of at least 11.

For the most recent fiscal year, this information here is representing only the most recent fiscal year. So this is for fiscal year 2019. So let me go over and do a quick review of this. For the *Septicemia* target area, we have a brief description of the numerator and denominator.

Here is going to be our number of target or numerator discharges. So we know that this hospital has 72 discharges for DRGs, 870, 871, or 872. When we compare this numerator to the number of discharges in the denominator, which is not on this report, but I'll show you that in a moment, we can calculate our target area percent.

But standing alone just looking at this number, the target area percent, we really don't have any way to gauge how our percent compares with those of other hospitals, and that's where the percentiles really come in very handy. The percentiles will help us give us some context, so we can understand where in that distribution of that target area percent — think about that ladder from highest to lowest. Where do we fall? So our hospital here with our percentile of 70.6 places us at the 93.5 national percentile.

So what does that mean? When we look at all of the target area percents for all of the hospitals in the nation — we sort them from highest to lowest — our target area percent is at the 93.5 national percentile. So we're pretty far up there towards the top of that distribution because 93.5% of the hospitals in the nation have a lower target area percent than we do. So it doesn't necessarily mean that we're doing anything wrong. It just means that our statistics look really different.

Then when we compare ourselves to all of the hospitals that are in our MAC jurisdiction, we see that all of them have a lower target area percent than we do. And then compared to the state, we are at the 83.3 state percentile. 83.3% of the hospitals in the state have a lower target area percent.

And then this last column here identifies the amount of Medicare reimbursement that our hospital received for these numerator discharges. So we receive just over $2.2 million for these 72 discharges for the *Septicemia* target area. Now you'll see that our target area percent is displayed here in red, bold font. We are above the national 80th percentile. So our target area percent is displayed in that red font.

So if we just look at the rest of the target area numbers here, here's the target area where we are at the 9.4 national percentile. So for the *Outlier Payments*, we are at the very bottom of that distribution. Now, since this target area is not a coding-focused target area, we don't see that green italics. But again, these percentiles will give us the context how we compare to all the other hospitals in those comparison groups. One other note is that this is the only place within your PEPPER that you are going to see your exact percentiles for these comparison groups.

So then we move on into the PEPPER. And for each of the target areas, there is a tab, a Worksheet tab. And on this tab is — there's information that will show us our statistic.

The first thing your eyes are probably drawn to is this graph. These blue bars represent our hospital's target area percent over the past three fiscal years. So this is fiscal year 2017, 2018, and 2019. We can see that for the *Septicemia* target area, our hospital's target area percent has been steadily increasing.

Now that doesn't necessarily mean that anything wrong is happening, but it probably would be a good idea to figure out what is behind this increase. Maybe we were missing some diagnosis coding before, and now we're more accurately capturing those diagnosis codes. Maybe our patient population has changed. Maybe our referral sources have changed, but there might be something going on in the background that resulted in these increases.

You'll also notice that we have these trend lines are the red trend lines represent the percents that are at the 80th percentile for nation, which is the solid line; jurisdiction, which is dashed; and state, which is the dotted. And then this for the coding focus, we see the 20th percentile for nation, jurisdiction, and state.

Below the graph is a data table that shows us our hospital's statistics. This is the drill-down for these target areas. So we see our numerator count here. This is our denominator count. Target area percent is here.

And again, you'll see that color coding if you're at or above the national 80th percentile. We include some other statistics for average length of stay for the numerator discharges and for the denominator discharges. We also calculate for you the average amount of Medicare reimbursement for the numerator discharges and then the total amount of Medicare reimbursement for those numerator discharges, and that can be helpful if you're tracking and trending those types of metrics.

Below your hospital's data table are the comparative data. These are the percents that are at the 80th percentile and at the 20th percentile for nation, jurisdiction, and state for these three time periods. And these are the values that are graphed up here in the graph as these red and green trend lines. And then lastly, below the comparative data, we have a section that includes suggested interventions.

If you were a high outlier for this target area, what might it mean? What might your next step be? If you were a low outlier, similarly, there are suggested interventions for that, and these suggested interventions are also included in the PEPPER user's guide, which you can find on our website. So each of these target areas — these reports are all formatted in the same way. So once you get used to looking at them, you'll notice that they are very easy to understand and get used to.

Now if you do notice that you're missing some bars on the graph and data in the data table, what does that mean? That means that there was not sufficient number of discharges in these time periods to calculate statistics. Remember we have to have a numerator count of at least 11 in order for us to calculate and display those statistics if the numerator count is less than 11, we cannot display the statistics.

Hospitals seeing some reductions in readmissions to same hospital or elsewhere. So if that was something that they were working on, looks like they're having some positive impact there. All right, so those are all the target areas.

There are a couple of supplemental reports in the PEPPER that don't have any impact on outlier status, but rather they just provide additional information that you might find helpful. On the top DRGs tab, we are summarizing the top DRGs for your hospital over the most recent fiscal year. We will list up to 20 here. But again, there have to be at least 11 discharges.

And here we're focusing this on short-stay outlier count. So at least 11 must be included here for short-stay outliers for these discharges. We do show you your short-stay outlier count, the total number of discharges for these DRGs, and then the proportion of short-stay outliers to total discharges and then the average length of stay.

This is for your hospital. Scroll down a little bit. We do have some summary rows here that roll things up for the top DRGs and then for all.

And then on the National Top DRGs tab, this is summarizing discharge data for all hospitals, for all long-term acute care hospitals in the nation. And so if you were wanting to get some comparative data, this would be helpful for that. But that's a quick review of the PEPPER — come back to the presentation now and continue on.

So sometimes I'm asked, do I have to use my PEPPER, or do I have to take any reaction? Or do I have any response based on what I find in my PEPPER? And hospitals, I want to stress hospitals are not required to use their PEPPER. They're not required to take any action in response to their PEPPER statistics.

The PEPPER is really just a roadmap. It's an informational tool that can help you identify where you could potentially be vulnerable for improper payments. I do want to remind everybody that there are other contractors that are out there sifting through the claims data, perhaps looking to identify providers who could benefit from some focused education or maybe medical record review or something like that.

And so the PEPPER can give you a heads up to let you know that your statistics do look different compared to others, and then you can decide if there's something that you need to be concerned with when you look at your PEPPER data or if it's simply a reflection of your patient population, the treatment that you provide, your clinicians, those types of things.

How do you obtain your PEPPER? Again, the PEPPER is distributed once a year. And all of the long-term acute care hospital PEPPERs are available on the PEPPER portal.

You would visit our website. The link is there on the slide. Click on the PEPPER distribution, Get Your PEPPER tab, review the instructions there, and access your PEPPER through the portal. Each PEPPER is available for approximately two years from the date it was released.

When you do visit the portal, you will need two pieces of information. You will need your six-digit CMS certification number, and you will also need either a patient control number or a medical record number from a claim of the traditional Medicare fee-for-service beneficiaries who received services between July 1 and September 30th of 2019. And we use that as a validation code so that you can access your PEPPER.

We do change the validation codes each time we put a new release of PEPPER out there. So if you used the validation code last year to get your PEPPER, it will no longer be accepted, and you will need a new validation code. I do want to just mention that, currently, our team is having some internal discussions, and there may be a modification to the validation code process at some point in the future.

We are considering emailing a validation code to providers using the contact person that is listed in the Provider Enrollment Chain and Ownership system, which is also called PECO, or the National Plan and Provider Numeration System. That's called NPPNS. So this would be a good time for you to make sure that the contact information in PECOs and in NPPNS is updated and current — more information to come on that later.

So once you receive your PEPPER, let's say that you see a lot of red or a lot of green. What should you do? First thing I want to stress is do not panic. Just because you're an outlier does not necessarily mean that anything — that there's anything to be concerned with. It doesn't mean that there are compliance issues that exist.

By design, 20% of the providers are always going to be high outliers, and 20% are going to be low outliers. But if you are an outlier, think about why that could be.

Again, do the statistics that you see in your PEPPER reflect your operation, your patient population, your referral sources, your health care environment? Verify any changes by maybe sampling claims, reviewing the documentation, review the claim. Was everything coded and billed appropriately based upon the documentation in the medical record?

Some other things that can change your statistics is if you got — if you have had changes in the people who are doing your coding, people who are doing your billing. Some of those things can really make your PEPPER statistics look different. The bottom line is make sure that you're following the best practices, even if you're not an outlier in your PEPPER.

There are some resources that are available on our website that I just want to remind you of. We have national-level data for the target areas and for the top DRGs. That is available on the website on the Data page. And we do update these resources annually following each report released, so keep that in mind.

We also have a number of resources on the “Training and Resources” page of the website. I mentioned the user's guide. It's a great resource. We have a spreadsheet that identifies the number of hospitals in each of those MAC jurisdictions in total and by state, the recorded PEPPER training sessions.

There's a sample PEPPER that's out there. And also if there have been any changes to the target areas, there's a document there that knows the history of those target area changes and the impact.

If you feel that you need some help interpreting your PEPPER or if you need help obtaining your PEPPER, visit our Help Desk. That's the Help/Contact Us tab on the website. There is a form there that you will complete, an online form, and a member of our team will respond promptly to assist you.

Please don't contact other organizations for assistance with PEPPER. Our team is the official source for assistance, interpretation, and guidance.

So please do contact us. That's why we're here. We want to help you. And this is just a screenshot of the website, our home page. And you can see there are the resources for long-term acute care hospitals are easily accessible straight from the home page.

I encourage you to take advantage of everything that's out there. And, of course, if you do have questions, you can submit them at our Help Desk at pepper.cbrpepper.org. Thank you very much.