



# Transcript for Q4CY18 Partial Hospitalization Program PEPPER Review July 17, 2019

Okay. I think we'll go ahead and get started. I would like to welcome all of you to this review of the PHP PEPPER, the PEPPER for partial hospitalization programs. 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.

For those of you who might be interested in live captioning of today's session, you can access the captioning by clicking on the link that is in the Q&A panel in the very first question there.

Today I'm going to be focusing my discussion on the most recent release of the PEPPER for Partial hospitalization programs, which is version Q4CY18, CY or calendar year 2018.

So today I'm going to be focusing on again the PEPPER for partial hospitalization program, the most recent release version Q4CY18. In this release we don't have any revisions to the target areas. There have been no target areas that have been retired and no new target areas, so we're going to have mainly a high-level review of the PEPPER. And then we'll also talk about the other resources that would be available for you.

So if you are familiar with PEPPER, there's probably not going to be a lot of new information covered today, but if this is your first experience with the PEPPER, I think you're going to find it to be a very nice orientation.

If after today's session you still have a number of questions about PEPPER or if you're new to PEPPER and you feel you need additional training or resources, I would encourage to you access the recorded training sessions that are available on the PHP training and resources page at [PEPPER.CBRPEPPER.org](http://PEPPER.CBRPEPPER.org). These have been put together in short segments that allow you to pick and choose the information that you're most interested in learning about. So feel free to access those recorded training sessions, again, on the PEPPER website.

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, again, summarizing those claims, and these are focusing on areas that have been identified as 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. In the PEPPER world we call these target areas. The PEPPER summarizes your Medicare claim state of statistics and then it compares them with aggregate Medicare data for other providers in the nation in your administrative Medicare contractor or MAC jurisdiction and also 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 simply means that you're billing practices look different from the majority of other providers in that comparison group. I do want to stress that the PEPPER cannot identify improper payments, but it can give you a head's up if the statistics look unusual.

The PEPPER was originally developed in 2003, so it's been around for a number of years. TMF Health Quality Institute developed the PEPPER and it was originally for short-term acute care hospitals, and a couple of years later long-term acute care hospitals. TMF began distributing the PEPPERS to all providers in the nation in 2010 and then along the way it developed PEPPERS for other types and as you can see the partial hospitalization program PEPPER has been available since 2012. Now, beginning late last year in 2018, CMS combined the Comparative Billing Report, or CBR, and the PEPPER program into one contract. For those of you who haven't heard of the Comparative Billing Report program, that--the CBRs summarize Medicare Part B claims data for areas that have been identified as prone to improper payments in the Medicare Part B world. And so now both of those programs have been combined into one contract, the RELI Group and its partners, TMF, and CGS and began producing CBRs and PEPPERS so now we are focusing on preparing reports for a wide range of providers.

Most of these changes should be really transparent to those of you in the PEPPER world. You might notice some formatting changes to the PEPPER as well as the new website that we have that our team is continuing to produce the PEPPERS and to provide the support that the provider community has become accustomed to.

Why are providers receiving PEPPERS? 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 and early detection through medical review, which might be completed by the Medicare administrative contractors, the recovery auditors or other contracting groups.

Also CMS looks at data analysis. The provision of PEPPER to providers supports these strategies. The PEPPER is considered to be an educational tool that can help providers identify where they could be at a higher risk for improper Medicare payments. So then they can be proactive and monitor and take any preventive measures that they find necessary. I'd also like to mention that the OIG or Office of Inspector General, 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 that auditing and monitoring component of the compliance program.

So let's move on now and focus specifically on the PHP PEPPER. The version Q4CY18 summarizes statistics for three calendar years. Calendar years 2016, 2017 and 2018. Now, for

those of you who are familiar with PEPPER you know that each time our team produces a PEPPER we refresh the statistics for all of the target areas and for all of the time periods in the PEPPER. So what that means is if you're looking at the newest PEPPER and comparing it to last year's release, you could see some slight changes in the numerator or denominator counts, perhaps in some of the 80th percentile numbers for the comparison groups and so on. And that would be due to the reflection of those refreshed statistics which may include revised claims that were submitted over the last 12 months, late claims, claim adjustments, those types of things. So just keep that in mind when you're looking at your PEPPER. And of course, the oldest fiscal year — I'm sorry — calendar year, that's a typo there, calendar year rolls off as the new one is added on.

I do want to talk a little bit about episodes of care because the PHP summarizes statistics based on episodes of care that are identified for each of the PHPs. Essentially, an Episode of Care represents an episode of treatment for an individual beneficiary. We do know that a beneficiary could receive PHP services for a varying length of time, which could be from one day to several months. So this episode is created for the entire course of treatment. To identify these episodes we obtain all of the claims that have been submitted by a provider for a beneficiary and we sort them from the earliest claim from date to the latest. And there cannot be any gap or break in service of more than seven days between one claim and the next. If there is a gap between one claim's through date and the next claim's from date, that's eight or more days, then we consider that to be a break in service and so the first episode would be ending and a new episode begins. We do summarize all of the statistics in that episode in the time period, which would be the calendar year in which it ends, that is the through date. So whenever that through date falls, that's the calendar year in which that episode statistics are going to be reported. We do look at the claims for one year prior to each time period so that we can evaluate those longer episodes of care.

I've included an example here to help give you a better understanding idea of how we create these episodes. So this is an example of claims that have been submitted from one partial hospitalization program for one beneficiary, just to show you the episode creation. You can see that in the first column these are all for the same beneficiary, beneficiary A, and we've numbered these claims submitted by the PHP in the second column so you can see that the PHP submitted 11 claims for this beneficiary over a span of about 10 months. The next two columns represent the from and the through date, followed by the gap in days between those claims. And then the next column identifies which episode it falls in. And the last column identifies the length of stay for that Episode of Care.

So you can see here that the first four claims are combined to form one episode because there was not a gap of eight or more days between any of those claims. However, there was a gap of 95 days between claims 4 and 5. So claim 5 represents the beginning of a new episode for this

beneficiary. The first episode ends January 20th, 2018, and that would be counted in calendar year 2018 even though it started in calendar year 2017. The second episode ends August the 26th, 2018, and so those statistics for the entire episode would also be counted in calendar year 2018.

So let's now talk about the improper payment risks that are pertinent to partial hospitalization program. The PHPs are reimbursed on a per diem basis under the Outpatient Prospective Payment System, OPSS, for care that they provide to Medicare beneficiaries. There are four separate PHP Ambulatory Payment Classification, or APC, payment rates. There are two for level one services, three services per day. There's one for um-one of those is for community mental health centers and one is for hospital-based PHPs. And there are two APCs for the level two which is four or more services per day. One is for CMCs and for hospital based programs. These target areas were identified or developed based on a review of the PHP reimbursement methodology. We also reviewed issues identified by other regulatory agencies such as the OIG, and we also consulted with CMS subject matter experts to identify these potentially vulnerable areas. We also looked at national level claims data to help support our assessment.

We do look at these target areas, the existing target areas, on an annual basis, to ensure that there are still sufficient claims that have been submitted, and that would be pertinent and useful information for the hospital-for the Partial hospitalization programs. Those of you who are familiar with the PEPPER may notice that we have retired some target areas over time and added new ones, and so over time the target areas can change. For this release, though, we have not implemented any revisions.

This is an OIG report that was actually released a number of years ago. This report reviews questionable billing by community mental health centers, and it includes nine questionable billing characteristics. The report can be found at the link on the slide. We do have two target areas in the PHP PEPPER that are really sort of related to the OIG's findings here. This report is focused on those PHPs that were administered through community mental health centers, but it would probably be applicable to all PHPs. So if you haven't had a chance to look this over, it might be a good read even though it is starting to get a little bit dated.

Now, in the PEPPER we do summarize these statistics for the target areas. The target areas are areas that have been identified again as potentially at risk. We structure these as a ratio with the numerator, including those episodes that are potentially problematic. The denominator is a larger reference group. And we report these numbers as a percent, so when you look at your PEPPER you are going to see your statistics reported as the target area percent.

There are four target areas that are still in the PEPPER. I'll review each of them briefly. The first one here is group therapy. We all know group therapy is less costly to provide than individual therapy, so this target area is looking at the financial incentives for a PHP to provide group

therapy when individual therapy might be more appropriate for the beneficiary. Here we're looking at the proportion of all of the episodes where the beneficiary received only group therapy. In other words, only if the beneficiary received any individual therapy, then their episode is not going to be included in this target area. So the beneficiary would have received no individual therapy during the entire episode in order to be included and counted in the numerator for this target area. The no individual psychotherapy target area similarly identifies the episodes where the beneficiary did not receive any individual psychotherapy during that episode.

So we are — I know that we've had some push back at times from some of the PHPs regarding the fact that the provision of individual psychotherapy is not a Medicare requirement, and that's true. PHP is in lieu of inpatient psychiatric hospitalization, but as we've coordinated with CMS we've learned that there is a general expectation that PHPs provide some amount of individual psychotherapy as well as a range of services during that Medicare beneficiary's course of treatment. Of course, everything being focused on what the beneficiary needs.

The target area that's looking at 60 plus days of service. Again, as I mentioned, there's not a limit on the length of time that a beneficiary could receive PHP, so there is the risk that there might be services continued beyond the point where they're necessary or advantageous for the bene. So the PHP PEPPER is identifying here the beneficiaries who receive greater than 60 days of service, and we are counting the actual days of service in this target area. Not the difference between the from and the through date. This is one of those that was identified in the OIG study that was mentioned a couple of slides ago, along with the group therapy issue.

And the last target area is looking at 30-day readmissions. Reducing readmissions is of course a continuing focus of CMS. Readmissions can be an indication of incomplete care, premature discharge, inadequate patient discharge instructions or patient noncompliance. So we do include this readmission measure that looks at the proportion of beneficiaries who are readmitted either to the same or to another PHP within 30 days of the last date of their episode.

Now, aside from the target area percents in your PEPPER that you will see calculated using the numerator and the denominator definitions for each of those target areas, we also calculate percentiles. And percentiles help us identify how different our statistics look from the majority of other providers in the comparison group.

So how we calculate percentiles is we take the target area percent for a given target area. So let's just say we're looking at group therapy and we take the target area percents for all of the PHPs in one of the comparison groups. So let's just say nation. All of the PHPs in the nation, we take their target area percents and we sort them from highest to lowest.

To identify the 80th percentile, which is an important point in that distribution, we identify the point below which 80% of those target area percents fall. And that point in the distribution is called the 80th percentile. Now, why is the 80th percentile important? In the PEPPER we use the 80th percentile to identify what we call outliers in the PEPPER. These are the providers whose target area percent is either at or above the national 80th percentile.

So if your target area percent is greater than that point there where we've identified at the 80th percentile, then in the PEPPER you're going to see your statistics identified in red bold font. That's the visual cue that your statistics look different from most of the other providers in that comparison group.

And I want you to keep this image of the ladder in your mind as we walk through a sample PEPPER here in just a moment.

The other thing you're going to notice in your PEPPER is we have these statistics, the comparisons for the three groups. The first one is national. Of course, that's all of the PHPs in the nation. And we use the national percentile, the national 80th percentile, to identify outliers. But you will also see the MAC jurisdiction comparison group, which is comprised of all of the PHPs that submit their claims to the same Medicare administrative contractor. And then we also have the state comparison group, which is the smallest.

Let me go now to my sample PEPPER. We'll do a quick review.

So this is a sample PEPPER for Partial hospitalization programs. Now, remember the PEPPER is distributed electronically. It is a Microsoft Excel workbook that you will navigate in by clicking on the worksheet tab along the bottom of the screen.

The first page here is called the purpose page. It's going to identify your CMS certification number here on row 8. You will see your provider name next to it. And below that we'll see the most recent three calendar years through the fourth quarter of calendar year 2018. So that tells us that this report summarizes data through calendar year 2018.

Here's the version and then here is the jurisdiction. This is where you would see your Medicare Administrative Contractor's name as the jurisdiction.

We include in the PEPPER a definitions tab where you can find the complete numerator and denominator definitions for all of these target areas that are included in the PEPPER.

This might be handy if you're looking at your statistics and you are asking yourself what does this numerator count include, what does the denominator include? So you can come to the definitions tab and get that information quickly.

The next tab is the compare targets report. And I like to refer to this report as the heart of the

PEPPER. It is the only location or the only report where you can see all of your statistics for all of the target areas all in one view. It is representing only the most recent calendar year, so keep that in mind. And also, you'll notice that in this particular compare targets report we only see three target areas. And the fourth one is not on here because this provider does not have sufficient data to generate statistics. And so you're only going to see the target areas on this report that you have sufficient claims or sufficient data to generate statistics. I'll talk about that a little bit more.

Now, in a quick review here for this target area, no individual psychotherapy, you'll see a brief description of the numerator and denominator. And the target count here, the numerator count, this tells us the number of episodes in the numerator. So this would tell us we have 345 episodes where there was no individual psychotherapy received by the beneficiary during their entire course of care. Now, when we compare this — when we divide the numerator by the denominator, which is not on this report, but it's on another report in the PEPPER, we calculate a target area percent of 85.6%.

Now, just looking at this number, we don't have really any way to gauge whether this makes us high as compared to all other providers or where our target area percent might fall in that distribution of target area percents. Again, thinking about that ladder image from the earlier slide. And so that's why we calculate the percentiles and the percentiles can be very useful.

So when we are comparing our target area percent to all of the target area percents for PHPs in the nation, we see that our percentile is 23.6. So that means that 23.6 percent of all PHPs in the nation have a lower target area percent than we do. If we think about the distribution from highest to lowest, this places us up about one fourth of the way from the bottom. So our target area percent is really not all that high when we compare it to all of the PHPs in the nation, even though 85.6 percent might sound a little bit high when you're just looking at the number, when we compare ourselves to all PHPs in the nation, about three fourths of them have a higher target area percent than we do.

When we compare ourselves to all of the PHPs in our jurisdiction, our percentile is 22.8, so that means 22.8 percent of those PHPs had a lower target area percent. Again, we're about in the same position in that distribution. And looking at comparison to all the PHPs in our state, 31.3% have a lower value, lower targets area percent. So we're about one third of the way up from the bottom.

So you can see how these percentiles can give us some context and help us understand where in that distribution our PHP's percent falls and then that in turn can give us some information as to whether there's something there that we might should take a look at.

You can see for these other target areas none of these national percentiles are 80 or higher. So

you — we don't see that our PHP is identified as a high outlier for any of these target areas. So that is a nice way to get a quick look at all the target areas for the most recent time period and just get a quick look at how our statistics compare to these three different comparison groups.

I'll also say that this is the only place in the PEPPER where you are going to see your exact percentile. Nowhere else will you see these numbers in the PEPPER.

The last column here, the sum of payments, represents the amount of Medicare reimbursement that your PHP received for these numerator episodes.

I usually like to encourage providers to prioritize target areas for review based on the percentile value. The greater the percentile value, the more different your statistics are from the majority of other providers. And then also those that have large sums of payments. So those are a couple of factors to think about.

Moving on to the target area reports, there is a report such as this for each of the target areas in the PEPPER. Now, some of you may see empty target area report such as this one, that is going to occur when there are fewer than 11 episodes either in the numerator or denominator, which precludes us from calculating statistics for that target area. So if there are not enough — there's not enough volume, then we cannot calculate the statistics and this provider does not have sufficient data for any of these three time periods.

We do include on the graph the values that are at the 80th percentile for nation and jurisdiction and state, and those are going to be the redlines that you will see here on the graph. A little hard to identify them in this graph, but we'll talk about that maybe in another.

And then at the very bottom of the report are the suggested interventions when you're above the 80th percentile. These are general guidelines, things that you could think about, what it might could mean if you are an outlier and what might you look at when you're, if you decide to take a review of claims.

This is the no individual psychotherapy target area. And here you can see that our graph is populated with these blue bars. These blue bars represent the PHP's target area percent. So we could see if there was change over time, if so, what was the magnitude of that change? And we can also see how our percent compares to the 80th percentile, which is the red trend line here.

Generally you'll see 80th percentiles for the three different comparison groups, national being the solid line, jurisdiction is the dashed, and state is the dotted. And here they are all on top of one another. So it's a little hard to tell them apart.

Below the graph is a data table that identifies for us all the numbers behind the graph. We see our target area percent. This is what is graphed there is the blue bar. Here we see our numerator count. And then the denominator count. We also see the average length of stay for

the numerator episode, the average length of stay for the denominator episodes, the average amount of Medicare reimbursement for these numerator episodes, and the total amount of Medicare reimbursement, again, for those numerator episodes.

These are those percentiles, these are the values that are at the 80th percentile for nation, jurisdiction and state. Again, these are all lying on top of one another in the graph so it's really hard to distinguish them, but that's what these values in the comparative data table are, and then again the suggested interventions.

For this report, for this target area report, it's a little bit easier to see the different percentile values for nation, jurisdiction, the dashed one, and the state, which is the dotted. You can see this provider has a little bit of change over time for the 60 days, 60 or more days of service target area. Certainly not approaching the 80th percentile, so that's nice to see. And 30 day readmissions, not a significant change here.

There are a couple of reports that are also included in the PEPPER that are supplemental and do not have any bearing on your outlier status. We have one that summarizes the top diagnoses for your PHP for the most recent calendar year. These are based on clinical classification software diagnoses categories. We do identify the category here. The total number of episodes for that category. The proportion of episodes to total. And then the PHP's average length of stay.

There are some summary reports here for the top categories versus all, and then there's also a report that has the same type of information, but at the national level. So if you wanted to look at the information for your PHP and see how does that look when you compare it to the national statistics, that's something you can do. This is the national average length of stay for each of those categories, for all 10 categories and then for all categories nationwide.

Okay. That was a quick review of a sample PEPPER, so I'm going to go back to my presentation and now we're going to talk a little bit about what does the PEPPER mean to you?

A lot of times I get questions from providers, do they have to use their PEPPER? Are they expected to take some action or make some change based on their PEPPER? Actually, some years ago I had several pointed questions from PHP providers as to what we expected them to change. And in reality the providers are not expected to make any changes. There's no requirement to use your PEPPER. There is no expected response for whatever your PEPPER statistics show.

The main thing I want to imply or to point out is that this PEPPER is really a roadmap that can help you identify when you might be at a higher risk for improper payments. It's a free report that's made available to you by CMS. Remember also that there are a lot of other federal contractors that are looking through Medicare claims data, databases, in an effort to identify

providers that could benefit from perhaps educational outreach, from perhaps a medical record review or some other focused intervention. So it is helpful to know that your statistics look different from other providers and just know that just because they look different doesn't mean you're doing anything wrong. It's just an indication that your numbers look different.

And that way when you're looking at your PEPPER data, if something doesn't quite look right in your mind, you have the opportunity to dig a little bit and see if there's something going on there that needs your attention.

How do you get your PEPPER? We distribute the PHP PEPPER annually. Some providers get their PEPPER through the PEPPER resources portal. I'll cover this a little bit more in detail later. Most of the providers are going to be receiving their PEPPER through QualityNet because most of the PHPs that receive a PEPPER are a unit of either a short-term acute care hospital or an IPF. And those PEPPERS are distributed through QualityNet to the hospital's QualityNet administrators and those that have a basic user account. The file is available for 60 days from the date that it's uploaded in the QualityNet system, and if you for some reason haven't yet downloaded your PEPPER, I would encourage you to do so. After 60 days the file will be moved out of the QualityNet system, but we can upload that file again, you will just need to contact us through the Help Desk and make that request.

The community mental health center PHPs are going to get their PEPPER through the PEPPER resources portal. You will click on the PEPPER distribution, get your PEPPER link. There are some instructions there to access the portal. And each release is going to be available for approximately two years. So if you didn't get last year's PEPPER and you — you're still in luck, you can get last year's PEPPER through the portal. You will need a couple of pieces of information to access your PEPPER. You will need your six-digit CMS certification number as well as either a patient control number or a medical record number from a claim for a traditional fee for service Medicare beneficiary that received services during the last three months of 2018. So during that time period.

Before I move on, I want to also mention that if you're trying to get your PEPPER through the PEPPER resources portal, and if you're struggling to do so, the last thing that we want you to do is to do is to be frustrated and give up. Contact our Help Desk. We have a great team there. They will help you access your PEPPER.

Once you get your PEPPER, if you do see that you've got some red numbers here and there, first thing I want you to not do is panic. I want you to remember that just because you're an outlier, again, it doesn't mean that there are any compliance issues that exist. It doesn't mean that you're doing anything wrong, but think about why you are an outlier. Do those statistics in your PEPPER, expect what you — reflect what you expect to see given your operation, your patient population, your referral sources, the staff that you have on board, your health care

environment. There are a lot of factors that can make your statistics look different from others. So just think about that.

If you do feel that something looks unusual, I always encourage providers to run some samples and look at documentation in the medical record, compare that with what was submitted on the claim, was everything coded and billed appropriately based on the documentation within the medical record. Ultimately you just want to make sure that you're following those best practices, even if you're not an outlier in your PEPPER.

Every year we do put together aggregate data on the target areas as well as the top diagnosis. These are updated on the data page at [PEPPER.CBRPEPPER.org](http://PEPPER.CBRPEPPER.org). These have been posted and made available for the PHP so you will find the calendar year 18 data there now.

Other resources that you will find on the website include the user's guide. There is a spreadsheet out there that identifies the total number of PHPs and each MAC jurisdiction in total and by state. Of course, those recorded PEPPER training sessions. And a sample PEPPER if you're interested.

If you find that you need assistance, please contact us through our Help Desk, which is on the website. There is a form that you will submit and a member of our team will contact you promptly.

And just a reminder to not seek information from other associations or other organizations. Our team is the official source for information on PEPPER and so we want to make sure that you're getting the right answer and the guidance that you need.

A screenshot here of our website, the homepage. You can see the partial hospitalization program, the blue arrow pointing to it at the middle bottom part of the screen here where you can access the user's guide, the training and resources, as well as a link to that distribution page.