PEPPER Sessions Chapter 3 Target Areas
Critical Access Hospitals

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, the DRG model. Also, critical access hospitals do have shorter lengths of stay, being limited to an average---excuse me—to an overall average length of stay of 96 hours.

Now with 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 have down coding errors at 0.3% improper payment rate, representing $21 million. And then other errors at 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. And that's C-E-R-T.

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 that 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 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.

Let's start with the coding-focused target areas. These are areas that have been identified as prone to incorrect coding, which results in an overpayment or an underpayment. Most of these have areas--- most of these areas have been under review by the Recovery Auditor for several years.

So, for the coding-related target areas, we identify the potential for over-coding as well as potential for under-coding. If the target area percent is at or above national 80th percentile this would represent over-coding. If the target area is at or below the national 20th percentile, then there is a risk for under-coding. So, when you look in your PEPPER, you'll see that we do identify potential high outliers, which are at or above the national 80th percentile, as well as low outliers, at or below the national 20th percentile.

This is only a listing of the target areas. For a complete definition of the target area numerator and denominator refer to the Critical Access Hospitals PEPPER user's guide, which is available on pepper.cbrpepper.org, or the definitions report in your hospital's PEPPER. You will also see complete DRG descriptions included here – these are not included on these slides due to space limitations. These are the target area definitions we use to determine the claim counts and calculate your hospital's target area percent for each target area and for each time period.

The areas of Stroke and intercranial hemorrhage, respiratory infections, simple pneumonia, and septicemia are areas have been problematic for quite a while. They are mainly concerned with the correct assignment of the principal diagnosis code and that it is supported by the physician's documentation in the medical record.

Continuing on with the target areas that are related to coding focus issues, we have three target areas that are looking at DRGs with CCs or MCC. So, the medical DRGs with CCS or MCCs, looks at the number of discharges for the medical DRGs that have a CC or an MCC as a proportion of all the medical DRGs. Similarly, the surgical DRGs, looking at the surgical DRGs with a CC or MCC, as compared to all surgical DRGs. CMS has found an increasing trend in the assignment of DRGs with a CC or MCC. Those DRGs do tend to have a higher reimbursement than DRGs without a CC or MCC, so there is some financial incentive for holding those CCs or MCCs.

Also, when you're looking at these Target areas it's important that you keep in mind your patient population and whether you expect to see the DRGs that have CCs or MCCs, because your patient population is more compromised. If you have a fairly healthy patient population, then you may expect to see lower target area percents for some of these target areas. So it is important to assess the target area specific to the context of what you expect to see for your hospital, given your patient population, the types of treatments that you offer, the physicians that you have on staff, etc.

We also identify the proportion of claims when there's only one CC or MCC coded. The concern here is that the hospitals may be seeking to a CC, so that they can obtain that higher weighted DRG payment.

Moving on to the target areas that are focused more on admission necessity issues, we have a chronic obstructive pulmonary disease. This has been a continued focus for recovery auditors. And the question here would be whether these patients required an inpatient admission. So, if you have a high target area percent there, that might be something to look into.

We have a target area also that is focused on three-day skilled nursing facility qualifying stays. So, to qualify for a skilled nursing facility admission, a patient has to have had a three-day inpatient day. And it's been identified by some reviewers that some of these three-day stays are not medically necessary. And as a reminder, at this time, outpatient observation stays are not considered part of the three-day intake admission. And this is something that's come into more focus as external reviewers expand into looking at this admission. So, if you have a high proportion of three-day skilled nursing facility stays, the question would be there whether that three-day stay was medically necessary.

Now, the Swing Bed transfers target area is the only target area here that is specific to the critical access hospital PEPPER. This target area looks at the percentage—excuse me—the percent of three and four-day stays that are transferred to the swing bed. Because many critical access hospitals have swing beds so that they can provide the skilled level of care, CMS asked us to add this target area as another way to monitor three-day stays to qualify for swing bed or skilled nursing facility admission.

We have two target areas that look at readmissions. Readmissions are a focus across the board to CMS. They know that readmissions represent expensive care to the Medicare program. And so, CMS is focused on reducing readmissions across the board. These two target areas look at readmission within 30 days of discharge to either the same hospital or to another short-term, acute-care, PPS hospital in the numerator. And, in the second target area, we're just focused on readmissions to the same hospital.

Now, you'll notice that in these two target areas, we do not identify index admissions when the patient is transferred to an acute-care hospital. That would be discharge status code 02 and 82. And we also exclude instances where the beneficiary leaves against medical advice. That is discharge status code 07. These target areas do match as closely as possible the CMS readmissions quality indicators, although they are including all of the DRGs. They are not specifically focused on any particular diagnosis.

Some of the concerns if you have high readmission rates would be billing errors, such as billing admissions to a distinct part unit, to the hospital provider number, incorrect patient discharge status code assignment, and of course, quality of care concerns related to premature discharge or incomplete care. I do want to stress, though, that these target areas are not calculated in the same manner that CMS readmission specifics are. Primarily, they're not risk adjusted. We don't exclude plans readmissions, and there are some other minor differences as well.

And lastly, we have four target areas that assess or focus on short stays. This is primarily concerned with the two midnight rules, which CMS implemented in October of 2013. And we are looking at, in these two, in these target areas, the two-day stays for either medical DRG or for surgical DRG. For both of these target areas, we include instances where the patient was transferred to acute care. We exclude patients who expired. And we also exclude patients who left against medical advice.

More recently, we are excluding claims where there is a current span code 72, which indicates outpatient time associated with an inpatient admission, with a through date either on or the day before

the inpatient admission. And the reason that we're making that exclusion is to help the hospitals monitor short stays more efficiently. And we don't want to include in the numerator for any of these target areas discharges that may meet that two midnight rule.

Our goal here is to make these target areas for short stays as clean as possible, so that we really and truly are only looking at those two-day stays or, in the case of these target areas, one-day stays. And these target areas are intended to help hospitals monitor those one-day stays and two-day stays. And of course, the question there is, did the patients require inpatient admission for those short stays, or could their care have been delivered more efficiently in a different setting?