PEPPER Sessions Chapter 3 Target Areas
Long-Term Acute Care Hospitals

In this session, I'll review the target areas for long term acute care hospitals. I'll talk about how these target areas were identified and what they could indicate for hospitals.

Please know that the PEPPER does not identify improper Medicare payments. Those can only be identified through a review of the documentation and the medical records to support the treatment and diagnosis and procedure codes that were submitted on the claim.

Long-term acute care hospitals are reimbursed through the long-term prospective payment system or PPS, which is almost identical to the acute care PPS for short-term acute care hospitals, the main difference being that the DRG weight for long-term are greater to compensate them for the increased complexity of the type of patients they serve. Now that being said, long-term hospitals are still at risk for improper payments in several of the same areas as short-term, for example: excisional debridement and septicemia.

Originally, uh the long-term hospital target areas were developed based on medical record reviews conducted by the quality improvement organization, a review of literature regarding payment vulnerabilities, a review of the long-term PPS, and analysis of national claim data. We've also received feedback from the provider community that has helped shape these target areas. The target areas have changed over time as new information regarding payment vulnerabilities changes and also in response again to feedback that we receive from providers.

I'd also like to point out that we do monitor the improper payment error rate for long-term acute care hospitals through the comprehensive error rate testing report which is released annually**.** The most recent report for the 2019 Medicare fee for service improper payments report identified that long-term acute care hospitals have an error rate of 1.7% with a projected 64.6 million dollars in error.

Now let's move into a discussion of what a target area is as it pertains to a PEPPER. Basically, a target area is a service or type of care that has been identified as potentially prone to improper Medicare payments. In PEPPER, target areas are constructed as ratios where the numerator is a count of discharges that may be problematic, and the denominator is a large reference group that contains the numerator and allows the calculation of a target area percent.

Coding-focused target areas can help identify potential over-coding or potential under-coding, while the admission necessity target areas could identify overutilization of services or potentially unnecessary admissions.

So let's review the target areas in the long-term PEPPER. The first target area focuses on septicemia-related coding issues. Now for the coding-focused target areas, we identify when the provider's target area percent is at or above the national 80th percentile, which could be an indication of potential over-coding. And we also identify when the provider's target area of percent is at or below the national 20th percentile, which could represent potential under-coding.

So with regards to septicemia, which has been an ongoing issue, not just for long-term but also short-term, here we are calculating the percentage of discharges for several DRGs that are septicemia DRGs.

The denominator includes DRGs to which a septicemia DRG is commonly revised: DRGs 689 (kidney and urinary tract infections with MCC), 690 (kidney and urinary tract infections without MCC), simple pneumonia (DRGs 193, 194, 195) or respiratory system diagnosis with ventilator support (DRGs 207, 208), in addition to the septicemia DRGs 871, 870, and 872.

A high target area percent for this target area could represent potential over-coding in particular related to the principle diagnosis and/or complications in co-morbidities. A low target area percent may represent under-coding.

The *Excisional Debridement* target area focuses on those discharges for the DRGs affected by the procedure codes for excisional debridement. We are looking at the discharges for DRGs that could be impacted by an excisional debridement code, and determining what percent of those discharges have an excisional debridement procedure coded.

The *Short Stays* target area is focused on its admissions necessity. This is the question of whether the beneficiary needed in-patient admission for treatment of their condition. Here we are looking at the number of discharges that were discharged on the day after the short stay outlier threshold was met as a proportion of all discharges. Long-term 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 a financial incentive to keep the patient until the short stay outlier threshold is met in order to receive the full DRG payment. So this target area is focused on the potential for manipulating length of stay to receive the full DRG payment instead of receiving a short stay outlier payment.

Moving on, we have a target area that looks that short stays for respiratory system diagnoses. Here we're looking at the number of these charges for DRGs 207, 208, 177, 189, and 193 that occurred on the day of or the day after the short stay outlier threshold was met. And we're comparing that count to all discharges for those DRGs. This target area was added a few years ago based on reviews that found high error rates for these DRGs.

We also have a target area that is looking at outlier payments. Here we are looking at the number of discharges that have an outlier payment as the proportion of all discharges. When a provider has a high percentage of outlier payments, that could represent overly long lengths of stay or perhaps over-utilization within the organization.

We have another target area that looks at 30-day readmissions to the same hospital or elsewhere. And CMS is concerned with readmissions in a number of different providers settings. And so we do have a target area that looks at readmissions for the long-term acute care hospitals. Here we are counting the number of admissions, the index admission, which is the first admission, for which a readmission occurred within 30 days of discharge to either the same hospital or to another long-term hospital.

We do not include when the patient discharge status code of the index admission is equal to 63 or 91 or 07, indicating that the patient left against medical advice or was transferred. We're comparing that to all discharges excluding those patient status codes, as well as patients who expired. When a provider has a high readmission rate, that could represent quality of care issues or perhaps utilization issues.

One last target area that's included in the long-term PEPPER is looking at short-term acute care hospital admissions following long-term discharge. And this is a target area that was actually added after we received some feedback from the provider community. It is also more related to quality of care issues. We are calculating the percent of beneficiaries admitted to a short-term acute care hospital within 30 days of discharge from the long-term acute care hospital.

A high target area percent here could indicate that patients are not medically stable or prepared for discharge. You would want to ensure that patient discharge planning is initiated early during patient's admission and that patients and their families are prepared to handle those patient care following discharge. Some of this will also relate to the readmissions target area.

One other note. Long-term acute care hospitals that are co-located within a short-term acute care hospital, may wish to identify admissions to your short-term acute care hospital within 30 days of discharge and review medical records for those patients. That could give you some clues as to why those patients are requiring transfer back to a short-term acute care hospital.

Lastly, I'd just like to review a little bit about short-stay outliers. As defined by Medicare, long-term acute care hospitals should have an average length of stay of greater than 25 days. And their DRG payments are adjusted for this expected longer length of stay. When a patient has a shorter length of stay than expected, the long-term acute care hospital receives the short-stay outlier payments instead of the full DRG payment.

A short-stay outlier occurs when the patient is discharged on or before 5/6 of the geometric mean length of stay for the DRG has been met. A few OIG studies have found that long-term acute care hospitals held their patients for discharge until after the short-stay outlier threshold was met. Again, so therefore they receive that full DRG payment. So that short-stay target area, the two short-stay target areas the we have in the PEPPER, identify the number of patients who were discharged on or the day after the short-stay threshold was met to assess that risk for that issue.

More information on short-stay outliers is available on the CMS website at CMS.Gov by searching for short-stay outlier.