PEPPER Sessions Chapter 3 Target Areas
Skilled Nursing Facilities

In this session, I'll be discussing target areas for skilled nursing facilities. I'll talk about how the *SNF PEPPER* target areas were identified for inclusion and what they could indicate for the facility. As a reminder, PEPPER does not identify improper payments. Those can only be confirmed through a review of the documentation in the medical records to support the treatment provided and the services billed by the SNF. So let's talk about SNF improper payment risks.

The SNF PPS is vulnerable to improper Medicare payments due to incorrect reporting of therapy services and misreporting of information on the MDS, so that can result in an incorrect RUG assignment or PDPM classification. The original SNF target areas were developed by reviewing the current literature on SNF improper payments by studying the SNF PPS, by analyzing national level SNF claims data, and by consulting with CMS subject matter experts who identified potentially vulnerable areas. Moving forward, the target areas will change as the PDGM implementation proceeds and new payment vulnerabilities are identified that could be included in the PEPPER. Our goal is to provide statistics in areas that can help identify a higher risk of improper Medicare payments.

The Patient Driven Payment Model (PDPM) — effective Oct. 1, 2019 — is designed to improve payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided. Several of the *SNF PEPPER* target areas were designed to reflect payment vulnerabilities that were specific to the RUGs. Several of these target areas will be phased out for the FY20 release, which is anticipated to be released in April 2021. These include *Therapy Rugs with High ADL*, *Nontherapy Rugs with High ADL*, *Change of Therapy Assessment*, and ultra-high rugs.

Included in the Q4FY19 release is a new target area, *3- to 5-Day Readmissions*, that was added following a review of the PDPM and in coordination with CMS subject matter experts. Each year, the team evaluates the PEPPER target areas, and so the target areas have changed and will continue to change over time to reflect Medicare vulnerabilities pertinent to SNFs.

The CERT contractor — performs random reviews to estimate improper Medicare payments for CMS. According to the 2019 Medicare Fee-for-Service Supplemental Improper Payment Data, SNF services had an improper payment rate of 8.7% with a projected improper payment amount of approximately $2.6 billion, and you can find the current CERT report at CMS.gov/cert.

As a reminder, critical access hospitals with swing beds are exempt from the SNF PPS, and so therefore, there is not a PEPPER available for swing bed units of critical access hospitals.

For more information and additional resources regarding the PDPM, visit the skilled nursing facility prospective payment systems page on the cms.gov website.

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

Let's review the SNF target areas. The first target area is *Therapy RUGs with High ADLs*. You can see that our target areas are structured with a numerator and denominator.

For this target area, we are counting the number of days filled where the rug is equal to RUX, RVX, RHX, RMX, RUC, RVC, RHC, RMC and RLB. And these are the therapy RUGS with high ADLs. In the denominator, we're counting all of the days billed for all of the therapy RUGs. So we're calculating the percentage of all the days billed for the therapy RUGs that have these high ADLs.

This target area will be removed for the Q4FY20 release.

The second target area, *Nontherapy RUGs with High ADLs*, calculates the percentage of days billed for the nontherapy RUGs for those RUGs that have high ADLs, again as noted by the numerator definition on the slide. So these two coding areas focus on the potential for the misreporting of the beneficiary's ADL score on the MDS. SNFs that have a high proportion of RUGs with high ADLs may report on the MDS that beneficiaries need more assistance than was actually needed, resulting in higher-paying RUGs. And then the SNF would receive an overpayment in that instance.

Conversely, SNFs that have a low proportion of RUGs with high ADLs may report on the MDS that beneficiaries need less assistance than was needed. And in this case, the SNF would be underpaid. So for these two target areas, we're considering that they are coding-related.

We're identifying when SNF percent is at or above the national 80th percentile, which could identify potential over-coding and/or also identify when the SNF target area percent is at or below the national 20th percentile, which could represent potential undercoding. I encourage SNF to think about these statistics in light of their patient population. And if they are concerned with their statistics as reported on the PEPPER, they might need to take a look at a few medical records to see if the documentation matches what is reported on the MDS, as far as the activities of daily living. This target area will also be removed for the FY20 report.

The *Change of Therapy Assessment* target area calculates the proportion of assessments performed by the SNF that will change a therapy assessment. SNFs completed a change of therapy assessment when the amount of therapy provided no longer reflects the RUG. SNFs that have a high proportion of change of therapy assessments may want to investigate whether there are barriers preventing the provision of anticipated services for beneficiaries, care of planning, or other issues that result in a high rate of change of therapy assessments. This target area will be removed for the FY20 release.

The fourth target area, *Ultrahigh Therapy RUGs*, calculates the proportion of days billed for all therapy RUGs that were for the ultrahigh therapy RUG. Medicare payment rates for therapy RUGs are typically higher than those for nontherapy RUGs. Medicare typically pays more for higher levels of therapy, and pays the most for ultrahigh therapies. SNFs that have a high proportion of ultrahigh therapy RUGs should ensure that the amount of therapy beneficiaries receive is appropriate and necessary, and that documentation in the medical record supports the level of care and services provided. And again, this target area will be removed for the FY20 release.

The *20-Day Episodes of Care* target area calculates the percentage of all episodes of care that were exactly 20 days in length. The SNF benefit provides 20 days of 100% Medicare coverage, after which

coverage drops to 80%. SNFs have a financial incentive to keep patients for 20 days, even though beneficiaries may no longer require skilled care. SNFs that have high proportions of 20-day episodes should ensure that beneficiaries do require a skilled level of care the entire duration of their SNF stay.

The *90+ Day Episodes of Care* target area identifies the proportion of all episodes of care where there is a length of stay of 90 or more days. Medicare reimburses up to 100 days of skilled care per spell of illness. SNFs that have a high proportion of episodes of care with 90 or more days should ensure that beneficiaries are receiving services that are necessary. The SNF should also ensure that beneficiaries receive skilled care during the entire duration of their SNF stay.

Both of these target areas focused on the length of stay for the episode will continue to be included in the PEPPER.

3- to 5-Day Readmissions: Under the PDPM, there is a potential incentive for providers to discharge SNF patients from a covered Part A stay so that they can then readmit these patients to reset the variable per diem schedule. To mitigate this potential incentive, the PDPM includes an interrupted stay policy, which combines multiple SNF stays into a single stay when a patient's discharge and readmission occurs within a prescribed window (three consecutive calendar days). CMS evaluated and approved a new target area focused on SNF readmissions following a three- to five-day gap. This new target area is intended to assess the potential for circumvention of the interrupted stay policy and reset the variable per diem schedule. While the PEPPER statistics will not reflect claims submitted under the PDPM until the Q4FY20 release (scheduled for release in April 2021), this information could be helpful to SNFs because it would provide historical perspective and insight about their practices before and after the PDPM implementation.