Transcript for the Q4CY22 *Home Health Agencies (HHA) Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

August 8, 2023

I would like to welcome you all to this review of the PEPPER for home health agencies, the Q4CY22 *Home Health Agency PEPPER*. My name is Annie Barnaby, and I work for the RELI Group, Inc. RELI Group is contracted with the Centers for Medicare & Medicaid services, or CMS, to produce and disseminate all PEPPER reports. For those of you who might be interested in live captioning of today's session, you can access that captioning by clicking on the link listed in the Q&A panel in the very first question that's listed.

Our agenda today will be focused on the most recent release of the PEPPER for home health agencies. That is the version of the fourth quarter for calendar year 2022. We will review all target areas, how each one is calculated. I do have a sample PEPPER that we'll look at, and we'll look at some other resources that you might find helpful. Those include the national and state level data reports that are reports that are available on the website and then the peer group bar charts.

Today's presentation will be a high-level review of the PEPPER. So, if you're familiar with PEPPER, this will be a nice refresher about the information, but if you're new to PEPPER, you might still have questions at the end of the session. We do have resources available to you to help if you do have questions. Those resources can be accessed through the PEPPER website in the home health agency "Training & Resources" section, and, of course, our website is PEPPER.CBRPEPPER.ORG.

So, let's start at the very beginning. What is PEPPER? Well, PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report. A PEPPER is a comparative report that summarizes one hospital's Medicare claims data statistics for areas that might be at risk for improper Medicare payments 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, these areas that might be at risk are called target areas.

The PEPPER summarizes your hospital's Medicare claims data statistics for these target areas and compares your statistics with aggregate Medicare data of other hospitals in three different comparison groups. These comparison groups are all hospitals in the nation, all hospitals that are in your Medicare administrative contractor or MAC jurisdiction, and then all hospitals that are in your specific state.

These comparisons are the first step truly in helping to identify where your claims could be at a higher risk for Medicare—excuse me—improper Medicare payments, which in a PEPPER world means that your billing practices are different from most other providers in that comparison group.

I do want to stress that the PEPPER cannot identify improper payments. The PEPPER is a summary of your claims data and can help you identify or alert you if your statistics look unusual as compared to your peers, but improper payments can only be confirmed through a review of the documentation in the medical record along with the claim form.

When I am referencing hospitals, I am referencing, in this case, for the *Home Health Agency PEPPER*, home health agencies. We do, we'll see this in a little bit, but we do distribute PEPPERs for many different types of facilities, but when I if I reference hospitals in this presentation, please know that I am referencing those home health agencies.

All right. Taking a look at the history of PEPPER, we can see that the program began back in 2003. TMF Health Quality Institute developed the program originally for short term acute care hospitals, and then later for long term acute care hospitals. In 2010, TMF began distributing PEPPERs to all providers in the nation and along the way he this developed for other provider types which you can see on this slide next to the 2010 date. Each of the PEPPERs that are created is customized to the individual provider type, the individual facility type, with target areas that are applicable to each of those settings. Then in 2018, CMS combined the comparative billing report or CBR and the PEPPER programs into one contract and the RELI Group and the partners TMF and CGS now produce all CBRs and PEPPERs.

While the CBR program produces reports that summarize Medicare Part B claims statistics, the PEPPERs summarize Medicare Part A claims data. These reports are produced for providers across the spectrum that help educate and alert providers to areas that are prone to improper Medicare payments. So, what does CMS feel these reports are valuable and support their agency goals? Well, CMS is mandated by law to protect the Medicare trust fund from fraud, waste, and abuse. They employ several strategies such as data analysis activities, provider education, and early detection through medical review, which might be conducted by the Medicare Administrative Contractor, the MAC, a recovery auditor, or another federal contractor. The provision of PEPPER is to support all those strategies, and the PEPPER is considered an educational tool that can help providers identify where they could be at a higher risk for improper payments. Providers can proactively monitor and take preventive measures, if necessary. I should also 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 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 your compliance program.

Let's shift our focus now to the PEPPER for home health agencies, the most recent PEPPER release. This newest release was made available the end of July this year. This release summarizes statistics for three calendar years. We are looking at calendar years 2020, 2021 and 2022. The reason that we call this version Q4CY22 is because the report summarizes statistics through the fourth quarter of calendar year 2022.

Now, those of you who are familiar with PEPPER know that each time we produce a new report, we refresh the statistics for all time periods and all target areas. So, it is certainly possible that if you are looking at your new PEPPER and comparing it with the PEPPER that you received last year, you might see some slight changes in your numerator or denominator counts or maybe the state or national or jurisdiction percentile values. That's going to be expected because the refreshed statistics are going to reflect any corrected claims that may have been submitted, any late claims, those types of things. So, there will probably be or there could be some slight changes in those numerator or denominator counts.

Of course, each time we produce a PEPPER, the oldest calendar year rolls off as we add the new calendar year on.

Let's move on now to focus on the improper payment risks that are pertinent to home health agencies. Prior to January 1st, 2020, home health agencies were reimbursed through the home health PPS or Prospective Payment System which paid higher rates for services to beneficiaries with greater needs based on a 60-day payment. This has changed under the patient driven grouping model. The PDGM model has a 30-day payment period. The previous home health PPS had been identified for at-risk for improper payment. In particular, those of you who keep track of the improper payments report that is produced by the comprehensive error rate testing or the CERT contractor, those of you who follow that report know that the most recent estimate for actually, for 2019, was that 12.1% of home health claims were found to be in error resulting in an improper payment rate of over $2.3 billion. This high level of

projected improper payments most likely played part, and we can understand why, in the transition to the new payment model.

Prior target areas were developed based on a review of the home health PPS and with a focus on those areas that could be at a higher risk for improper Medicare payments. After reviewing studies related to improper Medicare payments, national level claims data, and an OIG report from back in 2012 that identified six measures of questionable billing, we worked in coordination with CMS subject matter experts to create the current target areas that we're going to see in our sample PEPPER. I also want to mention that all target areas are evaluated on an annual basis and can change over time as we work with CMS to continue to assess the home health improper payment risks.

As I mentioned before, the patient driven grouping model, PDGM went into effect at the beginning of 2020, and, again, our team coordinated with CMS to adjust the PEPPER accordingly. This PEPPER version, C4—excuse me, goodness—Q4CY22 does reflect the PDGM statistics and the modifications that were made to the PEPPER. CMS has developed resources related to the PDGM. You can find them through the link shown on this slide. These slides are available on a "Training & Resources" page for home health agencies on the PEPPER website. That link is in those slides as well.

The target areas in the current *HHA PEPPER* were created for the potential risk for Medicare payments and are calculated using a numerator and denominator. The numerator represents the episodes of payments—excuse me—the episodes or payments or other measures that might be problematic for improper payments, and then the denominator is a larger group.

Now, in the home health PEPPER, we have two different types of results. Some target areas have a result that is a rate. Those target areas are calculated with a calculation where the numerator and denominator are different units of measure. We'll see that in our sample PEPPER as well. Some of the target areas are reported as a percent, and in that calculation, the numerator and denominator are reported or measured using the same units, and the numerator is a subset of the denominator.

Here we have a list of the current target areas in the *Home Health Agency PEPPER*. We have the definition for each of those target areas listed as well. These continue on the next couple of slides, and this information that we see here for each of these target areas is also available in your user's guide. I'm going to show you a really handy tab in the *HHA PEPPER* here in just a moment that is going to also list this information for you. We currently have 10 target areas in the *HHA PEPPER*, and the target areas that are new as of the past several years, they are marked as such on these slides and, again, of course, in the user's guide and in the PEPPER in the sample PEPPER we're going to look at and your PEPPER when you download it. And again, we remember that any new target areas are created in response to either that PDGM model and then the potential threats to the trust fund.

Before we move into looking at our sample PEPPER, I want to talk about percentiles because the term percentile plays a very, very important part in the PEPPER and in looking at your data and your statistics within your PEPPER. This slide can help us understand how those percentiles are listed in the PEPPER and how they're calculated. We use the ladder image because it's a great representation of how we calculate those percentiles. Next to the ladder is a target area percents from highest to lowest. The first step our team takes to calculate a percentile is to take all of these target area percents for a target area and a time period, one of the calculating data analysis years. We sort the target area percents from highest to lowest. Of course, again, that's what the ladder represents. You can see those percents listed from highest to lowest down the ladder. Next, we identify the point below which 80% of those percents fall. That point is identified as the 80th percentile. So, any facility that has a target area percent that is at or above the national 80th percentile will be identified in the PEPPER as a high outlier. A high outlier, we'll see, is in the tab data by red bold font. That high outlier outcome could potentially mean

overcoding or it could just mean that your statistics look different for a different justifiable reason. So, there's no need to panic when you see any percentiles or any high or low outlier markings. We'll talk about that again when we look at the PEPPER. But it is an indication that you should take a look at some of your claims and, again, when we get to the sample PEPPER, we'll see that we have that information available to us as well.

Before we go to that sample PEPPER, though, I want to talk about, on the flip side of the 80th percentile, the 20th percentile. In addition to the 80th percentile, we also identify the point below which 20% of those hospitals, the home health agency values fall. That's the 20th percentile. That could mean that the facility could have some under-coding concerns, again, or it could mean that the statistics look different for a different reason. So, it is important to always remember when we're talking about percentiles, that the PEPPER is always going to identify the top 20% as high outliers in the PEPPER and the bottom 20% for low outliers. These percentiles are a good way to get some context and think about how our target area percent compares to other facilities in the nation or in the jurisdiction or state. That can help us think about whether that difference is something we can expect to see or if there's something else that we should be concerned with.

So, before we go on to the PEPPER, let's review the comparison groups that we're going to see listed in each PEPPER target area tab. This slide is a visual representation and reminds you that we do have those three comparison groups, the nation, the jurisdiction, and the state. Sometimes the MAC jurisdiction group is difficult for people to understand, so, to simplify, think of it as all providers who submit their claims to the same MAC. Those are the providers in the MAC jurisdiction comparison group. That's a way of giving us a smaller group to compare with than the nation, but of course it's larger than the state comparison. We get three really great representations of different sizes of groups for our comparisons. You can see those MAC jurisdictions marked on this map on the slide.

Okay. So, let's head over to our sample PEPPER so we can see how all of this data is documented.

Let me get to our first tab here. Okay. Perfect. This is the sample PEPPER. Again, it is available on our website, PEPPER.CBRPEPPER.ORG, under that home health agency listing the “Training & Resources” page. This sample PEPPER is available to you, and of course, if you work for a home health agency, you can download your own PEPPER and take a look. But this is a great representation of what we're going to see when we're looking at our PEPPER. So, let's get started.

We can see the PEPPER is an Excel-a Microsoft Excel file. It's downloaded as this file. So, everyone will see the same type of file and Excel tabs that we can see are list down here at the bottom of the Excel spreadsheet. We start with the purpose tab. This is basically an introduction. It's I see someone's raised their hand. Again, I apologize that I'm not able to slip back, especially when I'm sharing my screen, with the Q&A panel. If you would please submit any questions you have on that Q&A panel within WebEx, and I will review them, and we can discuss them at the end of the presentation as time allows. Thank you so much.

Back to the sample PEPPER. We start with the purpose tab. As I said, it's basically an introduction tab. We have our provider number listed here so that we can make sure we're looking at the correct PEPPER. We have a reminder of the three calendar years that are analyzed in this PEPPER for the home health agency. We just have a little bit of information about PEPPER, about the time frames, any general questions that you have are going to be answered on this first purpose tab. Also, down at the bottom here, we do have our jurisdiction listed so that if we are ever if we ever have any questions about which of those MAC jurisdictions we fall under, that is shared with us here on the purpose tab. All right.

So, this next tab, the definitions tab, is a really, really valuable resource that is included in all the PEPPERs, and when I—when we were looking at the slides earlier, we saw a list of all of the target areas

that are included in this *Home Health Agency PEPPER*. They are listed for you here as well. They are also listed in the user's guide. Again, if you have—excuse me. If you have experience with PEPPER, if you're looking at the *Home Health Agency PEPPER* specifically for many years in a row, you might be very, very familiar with all of these calculations and all of the data that's shown here. But we all need reminders sometimes, and if you're new to PEPPER, this is a wonderful tab to use at any time when you're looking through the PEPPER. Because we're going to see listed on the target area tab the terms numerator. We're going to see denominator. This definitions tab lets us know when we see numerator for each of the target areas, what is included in that number on that target area tab when we see the term denominator. So, any time we have any questions or if we get a little bit ahead of ourselves or mixed up, it's great to click back to this definitions tab and take a look and have this information at our fingertips.

Okay. Moving on to the compare tab, this compare tab displayed statistics for the target areas for the home health agency that have reportable data. Any time we're talking about reportable data with the PEPPER reports, we are talking about 11 or more target discharges for the most recent time period. So, if there was ever a target area whose calculation, if we have any questions, we can flip back to the definitions tab, but if the calculation is not 11 or more, then that is going to be indicated on the target area tab. Again, we'll get to each specific one. Then if that number is 11 or lower, you're not going to see that target area listed here on the compare tab. We're only looking at those with 11 or more target discharges. That's just simply a basis and a threshold that we set when we create the PEPPERs. So that's what you're going to be looking at here.

Now, we have each of the target areas listed here. Then we also have the numerator count or the amount. For each of these target areas, when we get into the specific tab, we're going to have a lot more information listed. But this is kind of a summary tab. When I say that, I mean that the numerator count is listed. If we look at low comorbidities as an example, 1,410, so 1400 is their numerator count. Their percent or rate is their percent for this target area, 52.8. We're going to see that again on the *Low Comorbidity* tab. But this is, again, a great summary area and a great summary tab that also provides us with the national percentile, the jurisdiction percentile, and the agency percentile. You can see those in columns, D, E, and F. What are we looking at when we see those national jurisdiction agency percentiles? Well, if we look at the home health agency national percentile for this low co morbidity, we see 73.5. Now, that is specific to this sample home health agency, and that means that 73.5% of the home health care agencies in the nation have a lower percent value than this sample HHA. The same goes for the jurisdiction. 69.1% of the HHAs in this sample agency's jurisdiction have a lower percent value. If we want to remind ourselves what that percent value is, it's 52.8 listed here in column C for us. Then of course we have the state as well. We do have the sum of payments. Columns B, C, and G are all going to be on that target area tab as we go through this PEPPER, but it is very nice to have this compare tab as a bit of an introductory, a bit of a summary, wet our beaks a little bit before we go into the high detail of each of the target area tabs.

So, let's do that now. Let's go to low co morbidity. This is the first target area tab on our *HHA PEPPER* for our sample provider. Now, all of the sample, excuse me, all of the target area tabs are going to be set up in the same format as what we see here with low co morbidity. I'm going to go through this first target area, the low co morbidity target area in depth, and we'll go through some others in depth as well. I don't want to bore everyone to tears by going through every single one as in depth as we're going to start with low co morbidity because, as I said, we're going to take a really in depth look at how this tab is set up and then we can have that information and apply it when we look at all the other target areas that do have this same formatting. So, we begin on the target area tab with our home health agency data. This first table is focused completely on us, on my home health agency. It has listed the three years that are represented in the PEPPER data, so 2020, 2021, 2022. You can look at each calendar year

individually. When we do that, we can see that this home health agency, the sample home health agency, was not an outlier for 2020 or 2022, but in 2021, they were a low outlier. So they fell, when we were looking at that ladder visual, they fell below that 20th percentile line. So, let's dig deeper and see why that happened and see how that data played out for each of those three years.

We're looking next at the target area percent. That is our outcome. That is our percent. That is the number listed next to that ladder for us, for our home health agency. In 2021, the target area percent, that outcome, was 24.7%. So that 20th percentile line, that green line, was drawn across the list from highest to lowest of percents of the outcomes above that 24%, excuse me, that 24.7% because we fell in that list lower than that 20th percentile line. We don't want to just give you your percentile. We don't want to just give you this ending number. We want to show you how we got there. We're always going to give you the target count. We're talking about target count; we're talking about numerator. Again, the numerator for our calculations as we talked about in the slides is a representation of those areas that might be at risk. So that is the target for this target area. Our numerator for 2021, we had 563 in our numerator. If we have any questions, we can always go to the user's guide or click on back to the definition to see what these numbers represent.

In our denominator count for low co morbidities in 2021, we had about 2200, almost 2300. Actually, yes, almost 2300. Sorry. Then a little bit higher actually in 2022, our denominator was 2,668. When you take that target count and the denominator count, you end up with the target area percent, your outcome. Now, we give you that information, but we also want you to have information about the average length of stay. So, we want you to have the average length of stay for each time, excuse me, each group that we're looking at, the target, the numerator, and then the denominator. The average length of stay for those that were included in that numerator count was 2020, it was about 27; 2021, it was about 25, almost 26; and then in 2022, it was almost 25.

We do the same with the denominator. We take the average length of stay for everyone that was included in that denominator count and we give you that length of stay as well. So, as I said, we want you to have the most detailed information that you possibly can, and we certainly want you to have the information and the numbers that we use to make those calculations for the target area outcomes and the target area percents.

We also provide the average payment for the numerator and then the sum of payments for the numerator. It always kind of amazes me, you know, we did talk about in the slides how these areas are at risk for vulnerabilities for improper payments to or from the Medicare trust fund. Just this one sample PEPPER, but sample home health agency, for one target area, the sum of those payments just for this one target area was, in 2022, $2.7 million. So, you can imagine the scale at which these vulnerabilities and that sum of payments that have a possibility of having an improper payment across all home health agencies, across all the target areas, obviously, it's staggering. So, when we break it all down into these kind of bite size pieces for our target areas, it's a wonderful way to look at, you know, our imprint and our impact, but also, we have the information that, you know, if we can extrapolate or think on a grander scale, we really do have the scope of what it can be when we're looking at vulnerabilities.

We do have a note down here, if the target or the denominator is less than 11, then you're going to see an N/A in this chart listed instead of, you know, any of these numbers or percents or dollar amounts. We know from the previous tabs that that 11 is that threshold that we have. So, we have this information here. If you do see that N/A, don't be alarmed. It means that one of the target areas, the target calculation or the denominator calculation was not 11 or more.

All righty. So, moving forward and moving down into the tab, we have the comparative data. Now, all of that information that we have up here is wonderful information to have about us individually and our

home health agency, but how do we compare to other home health agencies. We have that comparative data down here. We have the national 80th percentile, jurisdiction 80th and state 80th, and then the national jurisdiction and 20th percentile. To be identified as a high outlier or low outlier, the 20th and 80th percentile are going to, those are going to be the thresholds that indicated a high or lower outlier status. So, the jurisdiction in the state are listed here for you, and obviously it's great data to have, but when we're talking about the status, we are referencing the national 80th and 20th percentile. So, we have all that listed here. If we scoot back up, we can look at calendar year 2021. We were a low outlier there. The target area percent, our target area percent was 24.7. So, on that list next to the ladder, we were at 24.7. What was the national 20th percentile? 27.8. So that line was drawn through 27.8, and, obviously, 24.7 is lower than that. That's why we were indicated as a low outlier.

We have those two tables full of the information and full of those calculations in the data points that led us to the calculation outcomes.

Also, included on all the target area tabs is this graph that represents the information that we just went through. Everyone learns different. Everyone visualizes data differently. So, we want to make sure that everyone has the most beneficial way of listing this data. So, we do include this graph. So, let's take a look at it. This is for the co morbidity target area, of course. We have, obviously, as you can see, line graphs and bar graphs. These blue bars represent our data. Actually, if you hover over, you can see it pops up. Value, 52.85. That was for calendar year 2022. Well, let's head up here. Same as we have here, 52.8. So, this information up here in our table data is going to match what we have down here. It disappeared for a second. It's on the bar graph on this chart that we include for each of the target areas. We have for 2020 and 2021.

Now, that lets us visualize our outcome and our data. And then these red and green line graphs will show you where we fell. Excuse me. Where the national state and jurisdiction 80th and 20th percentiles fell according to our outcomes as well. So, what we want to look at is, well, if we look at those line graphs, you can see the national 20th percentile, excuse me, the national 80th percentile is indicated by the solid red line with a diamond. The jurisdiction is this dashed red line with a square. Then the state is a dotted red line with a triangle. National 20th percentile is a solid green line with a square. Jurisdiction, 20th percentile with a dashed line with a circle and then the state 20th percentile, green dotted line with a square. Obviously, you can see those all marked up here. Those, all of those plot points represent what we've already seen right up here in this table.

We were a low outlier in 2021. Looking down here on the graph, national 20th percentile is this solid line with the square. That's the national 20th percentile. Where does our value fall? Below that because we're below the national 20th percentile. This is a great visualization, as I said, of all those plot points and data that we looked at in the tables above.

Let's move on to each of the other target areas. I'm not going to go through, like I said, in quite so much detail because they all are set up the same way. The high co morbidities, this simple provider, the sample home health agency, was a low outlier in 2020 and 2021, but not in 2022. We have all that information that we did see in the last target area tab. We have target area percent. That's our outcome. That's where we fall on the ladder. The target count, the denominator count, as you can see, we have all that data listed here again. As always, on the lower table, we have listed the comparative data information. Then we have the graph, as we saw before. We have the calendar year 2020, 2021. Our bar graph falls under that national 20th percentile. I didn't scroll down far enough on that first target area tab for low co morbidity, but I can see you here, and all the tabs are going to have this as well. We give you all this information. We have the tables up top with our information, with comparative data. We have the graph that shows us everything. So, what are we supposed to do with that information?

Well, the PEPPER helps you to answer that question. They have the suggested interventions here. We have suggested interventions of when you fall above the 80th percentile. What am I supposed to do next? How do I take this information and help? Well, it says right here, that could indicate a potential overcoding for secondary diagnoses. Review the medical records to consider and determine if the coding of the diagnosis was substantiated by the medical record. Let's go look at the comorbidity suggested interventions. They're all listed here. Not only do we give you all that data and information, but we also tell you what to do with it. We don't want it to just sit here. We want you to be able to take it and run with it so that you can have a great idea of how this data compares to your documentation and your information and your claims data.

Okay. Let's move on to functional impairment level medium. This one is new as of last year's release, the Q4CY21 release. This sample provider was not an outlier for this target area in any of the three years, but we still have all this data here no matter what. We still have the graph. We still have those suggested interventions. Same for the functional impairment level high. That's also new as of last year's release.

So, let's look a little bit closer at *Average Case Mix*. This sample provider was not an outlier for any of these three years. We see something a little bit different on this target area rate, and we're going to see it again on this next target area for *Average Number of Periods*. But *Average Case Mix* and *Average Number of Periods*, those are, these are the target areas that are calculated as a rate, not a percent.

So, with that, we have some information here that is not calculated because of that calculation information, and we are looking at a rate instead of a percent. But the information is set up in the exact same way. We have our target area rate. We have that target count. We have the denominator count. We have some information on the denominator length of stay. The same information goes for that comparative data table underneath. Instead of percents, we're seeing rates. And the graph as well.

As always, we have those suggested interventions.

Similar situation here for the *Average Number of Periods*, we do have some extra calculations that are able to be taken from this information and from this data, but we do see these rates listed instead of percentages and percentiles. Then we have the national 80th percentile, jurisdiction. We have the graph, and then we have those suggested interventions.

All righty. Moving on to the *Periods with Low Visits*, this one was revised a couple years ago, but when we take a look at the sample provider, we're back to percent calculations and percent outcomes, but we do not have an outlier status for this target area for the sample provider. Even if you are not an outlier in any of the target areas, it really is a great thing to still go back through and take a look and review your claims. You know, maybe place a little bit more emphasis or detail in your review of those when you are an outlier. This is all wonderful information as we've been saying, with the comparative information and with your claims data. So, it's always interesting to kind of take a look at those claims and at the documentation, at those diagnoses, and see practically where those play out with the numbers as well. All right. We've got the national 80th percentile. Then those suggested interventions.

The *Non-LUPA Payments*, we are back to percentiles. Again, just take a look at those numbers. That target sum of payments, just for that one PEPPER, this one target area, $4 million, $3 million for every year we're seeing this. So, it really is a lot of money that's going through that we want to make sure that we are on the right side of things and that we're not contributing to any of those improper payments.

We have that comparative information and the suggested interventions. We have two more target areas, *Outlier Payments* and *Admission Source*.

Let's take a closer look at this *Admission Source*. We can see that the sample provider was a high outlier all three years for that target area. 41%, 48%, 52%. So even their percent outcome has been climbing. Big, big numbers for the sum of payments. Let's look at the national percentile. That national 80th percentile has been holding pretty steady. Even if it was growing, it might not be growing at the same rate as our target area percent as a sample provider. Let's take a look at what that looks like on this graph when we are above the 80th percentile for all three years. We have these blue bars representing our data. The national 80th percentile is the solid line with the diamond. We can see we are smack dab in the middle of the bars for 2021 and 2022 and we are close to the top for 2020, but we're still, our outcome is still higher. That's why we were indicated as a high outlier.

The last two tabs on your PEPPER are going to be the top clinical groups for your home health agency. You can see those listed here. You have some data that goes along with it. So, you can, again, this is kind of a summary tab. You have the clinical group summarized here, the total period for the clinical group, the proportion of that clinical group to the total periods, number of visits, and then the average number of visits. So, this gives you a great breakdown for your own home health agency, and then that last tab is the jurisdiction tab clinical groups. So, you can take a look. What was my list? What did my list look like? How does that compare to the jurisdiction that we can see the first one is the musculoskeletal rehabilitation, that's number one for both of us. Those are two great tabs that, again, have a wealth of information. They can be used to compare against each other there.

All righty. Okay. Let's get through the rest of these slides, and then I will answer your questions.

So, as we said before, the PEPPER can help a facility, home health agency to identify areas where there may be outliers. If that outlier status is something that should prompt an internal review within the target areas. We often get the question; do I have to use my PEPPER? Do I need it take any action in response to my PEPPER? The answer to those questions is no. You're not required to use your PEPPER, though it is helpful information, and we would encourage you to at least download it and take a look. But you're not required to take any action. However, it is important to remember that other federal contractors are also looking through the entire Medicare claims database. They might be looking through the, for providers that could benefit from focused education or maybe a record review. From your perspective, it is nice to know if your statistics look different from others so you can decide if there's something to be concerned about and if you need to take a closer look or if what you're looking at is what you expect to see in your PEPPER.

As we saw, the PEPPER is distributed in an electronic format in Excel workbook. They are available two years from the original release date. We cannot send PEPPER through e mail. Because of that sensitive data that's housed within the PEPPER, we have to be judicial about the way we distribute the PEPPER, and it cannot be sent through e mail. With this in mind, we do have a portal online that you can use to access your PEPPER. We encourage you to go to the portal and download your PEPPER so that you can have it in your files ready for your use.

There are specific people who are authorized to receive a PEPPER. We don't give access to just anyone. We only release a provider's PEPPER to that provider, which is why we have the portal and the specific validation code requirements so that not just anyone can come to the website and get your PEPPER.

The PEPPERs are not available for public release. We do not provide PEPPERs to other contractors. We do provide a Microsoft access database which is called a FATHOM, and we make that available to contractors and to recovery auditors. They can be used to produce the PEPPER. While that might sound scary to people, I want to point out that it is important to remember that federal contractors have access to much more claims data information and providers than what is included in the PEPPER. They also have access to sophisticated data mining tools that may assist them with their effort.

Let's look in detail about how to access your PEPPER. When you access your PEPPER, you will be asked to enter data and information. So, in preparation to go to the portal to get your PEPPER, you'll need, first, to have your six-digit CMS certification number. The third digit of this number will be a 0. This is also referred to, sometimes referred to as the provider number or the PTAN, and it is not your tax ID number or NPI number. A validation code has been emailed to the PECOS contact on file for your facility. A new validation code is required each time a PEPPER is released. The validation code you used to successfully access your PEPPER in a previous area or early release will no longer be valid or accepted for any new releases.

Again, when you get your PEPPER, if you see a lot of red or green, don't panic. Remember that just because you're an outlier doesn't mean the compliance issues exist. It doesn't mean that you're doing anything wrong. But, again, we encourage you to think about why you might be an outlier and why the statistics in the PEPPER might reflect what you would expect to see. If something doesn't feel right, coordinate with others in your hospital. Share the PEPPER information. Put your heads together and think about some factors, pull some records and claims, and evaluate to make sure that you're following all best practices.

We have a number of other resources that are available publicly on our website, PEPPER.CBRPEPPER.ORG. One of those resources is aggregate information for the target areas both at the national and state level. Also, there is aggregate information regarding the top diagnoses, top therapy episodes, and target areas. This information is updated each time we have a PEPPER release.

We also have peer group bar charts which are updated on an annual basis. We have providers ask us to make available comparisons that would be applicable to what they consider their peer group, and so these peer group bar charts enable providers to look at that type of information. We have four categories. They are listed here. The peer group bar charts are updated annually. If you find that you do not agree with how we are representing your hospital's ownership type or location, that information will need to be updated through CMS. We utilize the CMS provider of services file, and that's maintained by the CMS regional offices. So, you'll need to contact them for any informational updates.

A number of resources can be found on the PEPPER website. Of course, there is your user guide, the training sessions, a demonstration PEPPER, a spreadsheet that will identify of number of hospitals in the MAC jurisdiction in total and by state, and some testimonials and success stories. As always, if you need assistance with PEPPER and you don't find the answers that you need in the user's guide, please visit the PEPPER website and click on the help/contact us button. Submit a Help Desk ticket, and a member of our staff will respond to assist you. Please do not contact any other organizations for assistance with PEPPER. RELI Group is contracted with CMS to support providers with obtaining and using your PEPPER. If you have questions, please contact us. We are the official source of information on PEPPER. Please do not pay consultants to help you with PEPPER. We provide support at no cost to you, and unfortunately, not all consultants provide accurate information on PEPPER.

This is a screenshot of our website. You can see the home health agency section with that arrow there.

All righty. Thank you, again, for joining us on this webinar session. I hope you found it to be beneficial. If you have any questions, again, please submit them to, submit a Help Desk ticket, and we'll be happy to help you out.