



# **Transcript for the Q4FY22 *Critical Access Hospital (CAH)* *Program for Evaluating Payment Patterns Electronic Report* (PEPPER) Review**

**May 16, 2023**

I want to welcome you all today to this webinar where we will be reviewing and discussing the Q4FY22 *Critical Access Hospital PEPPER*. My name is Annie Barnaby. I work for RELI Group, Inc., who is contracted with Center for Medicare & Medicaid Services (CMS) to produce and distribute PEPPER reports.

Before we move on to the content of today's webinar, let's review some housekeeping items to ensure that the session runs smoothly. If you would like to utilize live captioning for today's presentation, please access the captioning by clicking on the Q&A panel. Your lines will be muted during the presentation. If you have questions, submit them at any time. I will answer questions verbally at the end of the session as time allows, and a Q&A document will be created and posted for your reference. If you have questions about the statistics in your individual PEPPER, I encourage you to commit your question through our Help Desk instead of addressing your question during this webinar. The Help Desk can answer specific questions and ensure we're looking at the same report in your PEPPER to answer your question.

Here you'll see the Q&A panel that you can use if you have a question during the presentation. Please submit your question to all panelists. Here are the instructions if you are viewing the webinar in full screen mode. Again, please make sure, whichever mode you are watching in, that you submit your question to all panelists.

Our agenda today includes a review of the most recent release of the PEPPER for critical access hospitals, the Q4FY22 PEPPER that was released in early April of this year, 2023, I will share a sample PEPPER with you so you can see what PEPPER file looks like and what that data shows us. We will be reviewing some other resources, including the national and state level data and peer group bar charts. So, let's get started.

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. But if you're new to PEPPER, you might still have questions at the end of the session, and we have resources available to you to help if you do have questions. Those resources can be accessed through the PEPPER website in the critical access "Training & Resources" section. Of course, our website is [PEPPER.CBRPEPPER.ORG](http://PEPPER.CBRPEPPER.ORG).

Let's start at the very beginning. What is PEPPER? Well, PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Reports. A PEPPER is a comparative report that summarizes one facility'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 facility'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 all hospitals in the state. These comparisons are the first step in helping to identify

where your claims could be at a high risk for improper Medicare payments. In the PEPPER world, this means that your billing practices are different from most providers in the comparison group. I do want to stress that the PEPPER cannot identify improper payments. It's 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.

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 later for long term acute care hospitals. In 2010, TMF began distributing PEPPERS to all providers in the nation, and along the way, they developed PEPPERS for other provider types which you can see on this slide. Each of these PEPPERS is customized to the individual provider type with the target areas that are applicable to each setting. Then in 2018, CMS combined comparative billing report or CBR and the PEPPER programs into one contract, and the RELI Group and its partners TMF and CGS now produce CBRs and PEPPERS.

While the CBR program produces PEP-excuse me-reports that summarize Medicare Part B claims data, 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, why does CMS feel that 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 strategies to meet this goal such as data analysis activities, provider education, and early detection through medical review which might be conducted by the Medicare Administrative Contractor, a recovery auditor, or some other federal contractor. The provision of PEPPERS to providers supports these strategies. The PEPPER is considered an educational tool that can help providers identify where they could be at a higher risk for improper payments. The providers can proactively monitor and take preventive measures, if necessary. I should also mention that the Office of Inspector General or OIG requires that 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 a compliance program.

Now that we have a sense of the history of the PEPPER program and why it was created, let's talk specifically about the newest release of PEPPER, Q4FY22 the fiscal year 2022. Again, the PEPPER only summarizes Medicare fee for service Part A claims data and does not include any other payer types such as Medicare Advantage claims. Every time that a PEPPER is produced and released, the statistics are refreshed through the paid claims database. Therefore, if you're looking at a previous PEPPER release and comparing it to this release, you probably are going to see some slight changes in your numerator or denominator, your percentile, those types of things. That could be because there are late claims that are submitted or corrected claims, which would both be reflected in the updated statistics. Any time we produce a report, the oldest fiscal year rolls off as we add the new fiscal year.

Let's now talk about the improper payment risks that are pertinent to critical access hospitals. Critical access hospitals are reimbursed based on cost rather than DRGs. The primary risk we focus on in this PEPPER relates to unnecessary admissions. While coding errors do not impact critical access hospital reimbursement, it is always important to ensure that correct and compliant coding practices with followed in your facility. Those of you who have been working with PEPPER for a long time, know there have been changes over the years, and some significant since we first started producing the reports in 2003. The original target areas were identified primarily from information gained by the quality improvement organization, medical record reviews, and OIG studies. The target areas are evaluated

every year so that we can ensure that all target areas included in the report remain applicable and beneficial. As new risks are identified by recovery auditors or Medicare Administrative Contractors, or as policies change and are implemented, the target areas change to accommodate those risks. Because critical access hospital facilities treat many of the same type of patients as short-term acute care hospital facilities, most of the critical access hospital target areas mirror those of the ones in the short-term access excuse me *Short-Term Acute Care Hospital PEPPER*.

The target areas within the PEPPER pertain to a service or a type of care that's been identified as prone to improper Medicare payments. We construct these target areas as ratios where the numerator is a count of discharges that could be problematic, and the denominator is a larger reference group that also includes the same numerator discharges. This calculation allows us to calculate a target area percent, and we'll talk about target area percents in just a moment. First, we have a list of the *Critical Access Hospital PEPPER* target areas. You can see that we did we do not have any new target areas for this release, but we did remove a target area that is new as of this release, and that is the target area chronic obstructive pulmonary disease.

As an example of the target area calculation, you can see on this slide the calculation used to arrive at the outcome for the *Septicemia* target area. And this calculation is similar to the calculations for all the target areas, the data changing, of course, for the numerator and denominator for the specific target area. For the *Septicemia* target area, the numerator contains the count of discharges for DRGs 870, 871, and 872, and the denominator is the count of discharges for DRGs 193, 194, 195, 207 we have the whole list right there on the slide that you can see. This calculation will give us the target area outcome.

The PEPPER not only provides your outcome but also data of the percentile that you fall under as compared to other hospitals in the nation, in your jurisdiction, or in your state. We can use the percentile results to identify those providers who might be identified as high outliers or low outliers in each comparison for each target area.

This slide can help us to understand how those percentiles are listed that are listed in the PEPPER are calculated. This ladder image is a great representation of how we do that. Next to the ladder is a list of the target area percents sorted from highest to lowest. The first step our team takes when we calculate a percentile is to take all of those target area percents for a target area and a time period. We sort the target area percents from highest to lowest, and that's what the ladder represents. You can see the 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 is identified in the PEPPER target area tab data by red bold font, and a high outlier outcome could potentially mean overcoding, or it could just mean that your statistics look different for another justifiable reason. Now, on the flip side, we also identify the point below which 20% of the hospital's values fall which is the 20th percentile. That could mean that the facility may have some under-coding concerns. It is important to remember when we're talking about percentiles, that the PEPPER always identifies the top 20% as high outliers in the PEPPER and for the coding focus target areas, 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 the other facilities in the nation or in the jurisdiction or in the state. This context can help us identify about whether that difference is what we expect to see or if there's something that, perhaps, we should be concerned with.

Let's go now, before we head to this slide, let's go to our sample PEPPER and take a walk through and take a look at all the data that is held in the PEPPER.

This is a sample PEPPER for the critical access hospital Q4FY22 release. You can find this sample document on the "Training & Resources" page of the critical access hospital section of our home page, which, of course, is PEPPER.CBRPEPPER.ORG. When you open the PEPPER, of course, it is an Excel workbook, and we have tabs along the bottom that we'll look at here in just a moment, but we start with the purpose tab. This is an introductory tab really. It has information that we just went through actually about the *Critical Access Hospital PEPPER*. It lets you know where you can find the user's guide. I always encourage people to open that user's guide when you're looking at your PEPPER because there is a lot of information there that can be very, very helpful when you are going through your PEPPER and maybe have some questions about what you see. It lets us know this purpose tab lets us know our provider number and then our jurisdiction number, and there's a reminder version of the PEPPER that we're looking at. That's a nice reminder for us an introduction for us, I should say, on the purpose tab.

But moving on to the definitions tab, this is a very handy and very useful tab to use when you are going through your PEPPER. We're about to look into some target areas well, the target areas listed in the PEPPER, and we're going to see a lot of really dense dense data points, a lot of information, a lot of numbers, and this definitions tab is here for you to show you what each of those target areas count in their numerator and in their denominator. So, if you are looking at a target area tab, which we'll get to in just a second, and you're a little forgetful or a little mixed up as to what those numbers represent, this definitions tab is here for you, and all of the target areas are listed. Next to them is a detailed description or definition of the information that is included in the numerator or the denominator.

Moving on to the compare tab, this is, I feel, another type of introductory tab, into the PEPPER, we kind of dip our toes into the data we're about to see. This tab though gives us a sense of where we landed with the target areas and our target area percents for all the target areas all on one tab. So, let's take a look and see what I mean. As I said, the target areas are listed here on the left. We can see up here there is a note that says that this tab shows statistics for target areas that have reportable data. In parenthesis, it says 11 or more target discharges. As we go throughout the PEPPER and as you look at your PEPPER, if you ever see no data listed, that means that your numerator or your denominator did not have 11 or more data points to be included. So, the definition that we see here or if you see no data, that means that that was not 11 or more for the numerator or denominator. I'm not sure I don't think we'll see this on the sample PEPPER, but we'll take a look. If you see it on your PEPPER, please don't panic. It's not that anything's wrong. It's just that we have that threshold of 11, and the numbers did not meet that for that specific target area.

Let's look first at the *Respiratory Infections* target area. This compare tab gives us the information, the number of target discharges. If we ever see target number, that usually means, almost always, numerator. For our numerator, we could click back to the definitions tab, that numerator total for us was 24. Our percent so our number in that list next to the ladder was 51.1%. Moving on to these next columns, hospital and jurisdiction and state percentiles, we talked about the 80th percentile and we talked about the 20th percentile. This compare tab gives us great information about what percentile we land at when those lines are drawn across that list next to the ladder.

So, we know that our entry on this list next to the ladder is going to be 51.1% for *Respiratory Infections*. What this tab tells us is if we drew a line through our 51.1%, 28.5% of the hospitals would fall below us. So, it's like finding the 80th percentile, but we're finding what percentile we land on for each of these target areas in the nation, in the jurisdiction, and in the state. It also this also gives us the sum of payments. We'll see this information again on the target area tab, but as I said, this is a nice introductory to take a look at where we land. We do see some red bold font and we know from our slides that that does indicate that we are a high outlier in those specific target areas. We'll take a look then when we get there. But it's a great spot to start and see where we land and if we want to start digging in, when we

look at this compare tab, we can use the national percentiles, our jurisdiction percentiles, where we land for each of those target areas to see where we might want to start digging in and looking at some claims.

As we move on to the next tab, we're beginning to look at the tabs for each specific target area. So, we start with *Stroke Intracranial Hemorrhage*. This is not a fantastic tab to start with for the PEPPER review. So, I'm actually going to go I'm going to move on to *Respiratory Infections*, but welcome back to *Stroke Intracranial Hemorrhage* in just a moment. Let's start instead with *Respiratory Infections*. We have at the top of every target area tab, we have a table that has your hospital's and your facility's information for the fiscal years that are included in this report 2020, 2021, and 2022. We are not a high outlier for this target area in 2020 or 2022. We were in 2021. That is another great thing about the PEPPER and about the target area data because it does show you your trends over those three years, where you fell over all three years. And it shows you we'll get there in a minute the information about the national 80th and national 20th percentile over those three years. Things are always changing, and we like to be able to take a look at all that information on one tab.

We start with the outlier status. Next row down, we have the target area percent. As I mentioned before, if you see target area, then we are talking about the numerator. But this is our target area percent. So, this is our calculation for each of these fiscal years. We move down to the next row. We can see how we got there. We have the target count, the numerator, and we have the denominator count. That will let us know we don't want to just give you your target area percent outcome. We want to be able to show you what is included, what numbers we're seeing, what numbers came across when we did the data pull. That's what we give you in your hospital's table of data that is listed at the top of every target area tab.

For this target area, we also have the numerator average length of stay and the denominator average length of stay. Again, it's another way of looking at that data and lengthening our understanding of how our numbers play into everything, where we land on the ladder with our percent, the average length of stay of those patients. We give you all of that information on the PEPPER.

Next, we have the target it says numerator here average payment. Then the sum of payments. Now, it's always interesting to me to take a look at these average payments, really take a look at all the data. But if we look at the average payments for this sample hospital, they stayed steady over these fiscal years. The sum of payments fluctuated quite a bit. We can see that as well. This payment stayed steady. Again, there are so many data points for all of the target areas, and that's what makes the PEPPER so comprehensive, and it's what makes the PEPPER so valuable to so many departments and so many people within your organization. Everyone has an area that they are interested in the most, and they have data to that they can look at in the PEPPER regarding that area.

Underneath your hospital's table data, we're always going to have the comparative data. We have the national jurisdiction and state 80th percentile and the national jurisdiction and state 20th percentile. When we're talking about the 80th percentile and 20th percentile indicating a high outlier status, we're only talking about the national 80th and 20th percentiles. We include the jurisdiction and the state percentile for each of those marks, but we want to make sure everyone understands that if you are a high outlier, that is because you were above the national 80th percentile or below the national 20th percentile.

Let's look at that national 80th percentile. It fluctuate quite a bit over these three years. Looking at fiscal year 2021, the national 80th percentile was 76.5. On the list next to the ladder, that red line indicating the national 80th percentile was drawn through 76.5%. Our outcome was above that, as we saw up

here, 77.6%. So, this table information can show us our outcome, our target area percent, but also where that 80th percentile line was drawn and where that 20th percentile line was drawn.

Looking a little bit further down on the tab, everyone looks at data differently. Everyone likes to have their data presented in different ways. Some people like the table data. Some people like to look at a graph. So, we provide both for you.

The information that we saw in the top two tables is all reflected in this graph that is posted a little bit further down on the tab. These blue bars are our facility's percent outcomes. Those are our outcomes listed with these blue bars. The 80th and 20th percentile are listed in line graph form with data points data plot points. The national 80th percentile is this red line that is a solid line with diamonds as their plot points. And then the jurisdiction national 20th percentile is a solid line with diamonds. It is in the green color instead.

Looking at our data, over the three years and looking down on the graph, we have our bar graph here in the middle for fiscal year 2021. Another great thing about this graph is that if you hover over the plot points or this bar graph information, it will show you your value. It says value 77.55%. Up above our target area percent is listed as 77.6. We round up. We were a high outlier in fiscal year 2021, and the plot point for the national 80th percentile is within our blue bar. We would expect to see that because that line was drawn through 76.5%, and our percent was higher than that. We were above that 80th percentile line. For fiscal years 2020 and 2022 we were not high outliers and those data points fall outside of our blue bar. We would expect to see that as well.

The jurisdiction and state 80th percentile are plotted on the graph as well. The jurisdiction is a dashed line, either red or green with a square as the data plot point. Sorry about that. And then the state line is a dotted line and their plot points with triangles. I always encourage everyone for each target area to take a look at your jurisdiction and your state 80th and 20th percentile. As I said before, the 80th percentile in the national realm is what we look at when looking at high outliers. It's important to see where you fall based on your comparison against all of your peers, not just the nation. So, the graph is a great way to do that. Of course, the tables up above as well. We give you all of this information in table form and then in graph form.

But we also include information for each target area about suggested interventions. We want to give you this data, but we also want you to be able to take this back to your facility and use it, and we let you know how you can use that when you read the suggested interventions for high or low outliers. Again, these are great points to read, even if you're not a high outlier or a low outlier. It gives you a great area to start to look at. It tells us what a high outlier or a low outlier may mean. Then how you can proceed to do a review or take action as you see fit to see why you may have been a high outlier. We like to have those suggested interventions, as I said. We want you to be able to utilize the data that you do see in the PEPPER. This is a great way to do that.

Let's go back to the *Stroke Intracranial Hemorrhage*. As I said, I didn't want to start with this tab because it has a few data points that are what you would not usually see, but we can see, with our hospital facility table data, we were not an outlier for this target area in 2020 or in 2021. In 2022, we see no data. As I said before, we're not going to let this panic us. We don't worry about that because that just means that the numerator or the denominator did not have more than 11. We can see the target area count and the denominator count for these are rather close to 11 for both of the prior years. It's not as much of a shock to see then that we have no data for 2022. I go back to show you this target area tab is set up in the same way. We have our hospital data. We have the comparative data. And then we have the graph, and as always, we have suggested interventions.

As we flip through the PEPPER, we're going to see most of that same information. Excuse me. We're going to see the same formatting, different information, of course, for each of the target areas. We're looking here at the *Simple Pneumonia* target area tab. We were a high outlier for this target area in 2020 and in 2022. All this information we saw in the respiratory infection target area. We have the target area percent. Again, we give you the target count and the denominator count. We want you to be able to see the numbers that came to give you the result of your target area percent. We have your average length of stay, average payment, sum of payments. This is always interesting to me as well. If we look at fiscal year 2022, just for this one critical access hospital for this one target area, the sum of payments was \$600,000 over \$600,000. When we look at these numbers, especially with the dollar signs, we can see why CMS believes that these are valuable areas to look at for improper payments and why we all need to take all this very seriously because we want to play a part in the protection of the Trust Fund.

The *Simple Pneumonia* graphed information is here as it is with all the other target areas. The high outlier status plot points are within our blue bars, which is what we would expect to see based on the data that we see in our hospital's table information for fiscal years 2020 and 2022. Then, of course, we do have suggested interventions for the high and low outliers. I'm not going to go through every single one of the target areas because they are formatted all in the same way. Looking at *Septicemia* though, we were a high outlier for all three of those years. If I am this critical access hospital, this is definitely a target area that I might want to start with when I'm looking at my information, and I'm looking at areas that I might want to dig into and take a review of because we are high outliers for all three of those years.

Looking at the sum of payments, again, over \$2.5 million, over \$2 million for all three years. It's great to have this data and this information so that we can know where we need to look in our facility and if we need help as to where to go, we always have our suggested interventions.

Moving on to the *Medical DRGs with the CC or MCC*, again, this was a bit of a problem area, target area, for our sample critical access hospital. We were a high outlier all three years. This sum of payments is even bigger for this target area. \$7 million or over \$7 million for almost all the years. That's incredible.

Again, we have the graph, and we have the suggested interventions as we see for our results.

Let's stop here for just a moment at the *Surgical DRGs with CC or MCC*. We are low outlier. Our first low outlier status on the sample PEPPER. For fiscal year 2022, our target area percent so our listing, our entry in that list next to the ladder was 38.4%. Going down to look at the fiscal year 2022 national 20th percentile, it's 40%. So, this green line was drawn across that line on the ladder going through 40%, and our outcome was below that line at 38.4.

Instead of seeing the red diamond falling within our blue bar outcomes down here on the graph, we do see the green diamond instead. Of course, representing that we were a low outlier for just this one year, fiscal year, 2022. So, if I'm the simple critical access hospital, I'm going to go straight down and see what I can do, what could this mean. It could mean that there are coding or billing areas related to under-coding. So, I'm going to pull medical records. I'm going to make sure that there are no coding errors.

Instead of being a high outlier for all three of the years in this next target area, we're a low outlier for all three of those years. Again, we have our facility's information, the comparative information, the graph, and the high and low outliers, suggested interventions.

As I said, I'm not going to go through each one of these because they are all formatted in the same way. But we have 3-day skilled nursing facility qualifying admissions, *Swing Bed Transfers, 30-Day Readmissions to the Same Hospital or Elsewhere, 30-Day Readmissions to the Same Hospital, Two-Day*

*Stays for Medical DRGs, Two-Day Stays for Surgical DRGs, One-Day Stays for Medical DRGs, and One-Day Stays for Surgical DRGs.*

These last two tabs are not for target area information. Instead, they are a list of your hospital's top DRGs for the most recent fiscal year, of course, for this report that would be fiscal year 2022. We have a list of our most used DRGs, our top DRGs. We have 470, 871, and it gives us information for each of those DRGs as we go along and look at each row for these columns as well.

Now, next to this tab, we have the jurisdiction's top DRGs. These two tabs show, of course, the DRG usage for us and then for our jurisdiction. So, this is a comparison tab that if we click back and forth, we can see how our DRGs compared to those DRGs used in our jurisdiction.

So how does PEPPER apply to providers? Well, the PEPPER can help a facility to identify areas where they may be outliers, and if that outlier status is something that should prompt an internal review within that target area.

We often get the questions, do I have to use my PEPPER, and do I need to 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's helpful information and we would encourage you to at least download it and take a look. 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 for providers that could benefit from some focused education or maybe even a medical review. So, from your perspective, it would be nice to know in your statistics are different from others so you can decide if there's something to be concerned about and if you need to take a closer look and what you expect to see in your PEPPER.

As we saw, the PEPPERS are distributed in electronic format in a Microsoft Excel workbook. They are available for two years from the original release date. We cannot send PEPPER through email because of the sensitive data housed within the PEPPER. We have to be judicial in the way that we distribute the PEPPER, and it cannot be sent through unsecured emails. With that in mind, we 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 for your use.

Let's look in detail about how to access your PEPPER. When you're accessing your PEPPER, you will be asked to enter data and information. In preparation to go to the portal to get your PEPPER, you will need to first have your six-digit CMS certification number. The third digit of this number will be a one. This is also referred to sometimes as the provider number or PTAN, and this is not the same as your tax ID or your NPI number.

The validation code for your PEPPER also has been e mailed to the HARP administrator on file for your facility. A new validation code will be required each time a PEPPER is released. The validation code that you used to successfully access your PEPPER the previous year or for an earlier release will no longer be valid or accepted for every new release. Again, your validation code has been e mailed to the HARP security administrator on file for your facility.

If you get your PEPPER and you see a lot of red and green indicating you as a high outlier or low outlier, don't panic. Remember that just because you're an outlier in your PEPPER, it doesn't mean that compliance issues exist, and it doesn't mean that you're doing anything wrong. But, again, we encourage hospitals to think about why they might be an outlier and if those statistics in their PEPPER reflect what they would expect to see.



If something doesn't feel quite right, please coordinate and share the PEPPER information. Put your heads together and think about different factors. Pull some records along with some claims and just evaluate to make sure that you're following those best practices.

We have a number of other resources that are available publicly on our website, [PEPPER.CBRPEPPER.ORG](http://PEPPER.CBRPEPPER.ORG). One of those is aggregate information at a national and state level. There is aggregate information regarding the target areas and the top DRGs. We do update this information each time we have a PEPPER release.

We also have peer group bar charts which are updated on an annual basis. Some time ago, we did have providers who asked us to make available a comparison that will be applicable to what they would consider their peer group. And so, those peer group bar charts enable providers to look at that type of information. We have three different categories. We look at size dictated by the number of episodes, location, which is either urban or rural, and ownership type, for-profit or physician-owned, nonprofit or church owned or government. We do update those peer group bar charts annually. If you find that you do not agree with how we are representing your 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 that update.

A number of other resources can be found on the PEPPER website, of course. There is the user's guide, the PEPPER training sessions, a demonstration PEPPER, a spreadsheet that will identify the number of hospitals in each of those MAC jurisdictions in total and by state, and some testimonials and success stories. There are nice success stories out there, one in particular from a Kentucky hospital that used their PEPPER to help them any other identify under-coding.

As always, if you need assistance with PEPPER and you do not find the answer you need in the user's guide, please visit the [PEPPER.CBRPEPPER.ORG](http://PEPPER.CBRPEPPER.ORG) website and submit a Help Desk ticket. We will contact you very promptly to assist you, and please do not contact any other organization 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 a consultant 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 home page. You can see the critical access hospital section is in the middle on this top row.

I want to thank you all again for joining us today, and I hope you found this webinar to be beneficial. Again, if you have any questions, you can visit the Help Desk at [PEPPER.CBRPEPPER.ORG](http://PEPPER.CBRPEPPER.ORG).