Transcript for the Q4FY22 *Inpatient Rehabilitation Facility (IRF) Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

April 25, 2023

Annie: Good afternoon, everyone. Let's go ahead an get started. It's 3:00 Eastern Time. I want to welcome you all today. Thank you for joining the Q4FY22 inpatient rehabilitation facility PEPPER review. My name is Annie Barnaby, and I work for RELI Group, Inc., who is contracted with CMS, Centers for Medicare & Medicaid Services, to create and distribute PEPPER reports.

Before we move on to the content of today's webinar, let's review housekeeping items to ensure our 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 any questions, please submit them at any time using the Q&A panel on your computer screen. I will answer questions verbally at the end of the session as time allows. 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 submit your question through our Help Desk instead of addressing your question during this webinar. The Help Desk can answer specific questions and ensure that we are looking at the same report in your CBR to answer your question. You'll see the Q&A panel you can use if you have a question during the presentation. Be sure to submit your question to all panelists. You can also submit in full screen mode. Again, please remember to send the inquiry to all panelists.

Our agenda today includes a review of the most recent release of the PEPPER for inpatient rehabilitation facilities. The Q4FY22 PEPPER that was released in early April 2023. I will share a sample PEPPER with you so we can see what the PEPPER files looks like and what the data shows us. We'll also 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. These resources can be accessed through the PEPPER website in the IRF "Training & Resources" section. And our website is PEPPER.CBRPEPPER.ORG.

Let's start at the very beginning. What is PEPPER? PEPPER is an acronym that stands for Program For Evaluating Payment Patterns Electronic Report. 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 with other facilities in three different comparison groups. These comparison groups are all hospitals in the nation, all facilities that are in your Medicare Administrative Contractor or MAC jurisdiction, and all facilities that are in the state.

These comparisons are the first step in helping to identify where your claims could be at a higher risk for improper risk for Medicare payments. Which, in the PEPPER world, means your billing practices are different than others in the 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.

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 for originally 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 you can see on the slide here. Each of these PEPPERS is customized to the individual provider type with target areas applicable to each setting.

Then in 2018, CMS combined the 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 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 to alert providers to areas that are prone to improper Medicare payments. Why does CMS feel these reports are valuable and support their agency goals? CMS is mandated by law to protect the Medicare trust fund from fraud, waste, and abuse, and they employ several strategies to meet this goal such as data analysis activities, provider education, and early detection through medical review which might be conducted by the administrative contractor, recovery auditor or federal contractor. The provision of PEPPER 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 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 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 PEPPER 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 inpatient rehabilitation facilities. IRFs are reimbursed through the IRF payment system or PPS. The primary risk that we focus on in PEPPER relates to coding errors and unnecessary admissions. Those of you who have been working with PEPPER for a long time know there have been changes in these target areas 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 through a review of the IRF PPS, coordination with subject matter experts, and analysis of national claims data. 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 policy changes are implemented, the target areas change to accommodate those risks. 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 discharge 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 here in just a minute.

Here you can see a list of the *IRF PEPPER* target areas. There are no new target areas for this release of the *IRF PEPPER*.

When we get to the PEPPER, you're going to see percentiles listed. So, let's talk about how percentiles work. This slide can help us to understand how the percentiles are calculated. The 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 your facility's percentile is to take the target area for all the facilities in the nation and we sort them 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 facilities fall, and that point is identified as the 80th percentile. So, any facilities that have 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 a red bold font. A high outlier could potentially mean overcoding or it could just mean your statistics look different for a justifiable reason.

I'm going to go to our sample PEPPER now so we can see in an actual document how all of this data is presented. This is the sample PEPPER, and as you can see, it's released in Microsoft Excel format. This is available on the IRF “Training & Resources” page that you can get to from our PEPPER home page, PEPPER.CBRPEPPER.ORG. When we open the report, we first come to the purpose tab. Along the bottom, there are different tabs that we're going to go through and take a look. Most of those represent target area data. This first tab is kind of an introduction. It's an introductory tab with the purpose of the PEPPER. We have a list of our hospital, our facility. We have a reiteration of the version of the PEPPER that we're looking at, Q4FY2022. Then we have the jurisdiction listed as well so we can make sure that we are looking at the correct comparison data for our jurisdiction. Then, of course, above that, there is some information about the PEPPER overall you. I won't read that to you because it's a little bit dry. You can see it there. It's on the purpose tab of your PEPPER and then, of course, of the sample PEPPER.

The next tab over is the definitions tab. This tab lists all of the target areas that are analyzed in the PEPPER report. They are listed here request the target area name and then the target area definition. This is a very handy tab to have when you're looking at the information in the PEPPER when you're looking at these tabs that we'll get to in a moment that have each of the target area calculations and data. If you get a little bit lost or you get a little bit overwhelmed as to what exactly is included in each of those target area numbers and data, you can easily click back to this definitions tab, and we have the information here for us. This information is also found in the user's guide, and we encourage everyone to use the user's guide when you are looking at your PEPPER. There is, of course, much more information in that user's guide. It's about 17 pages long. This is a great tab to have just to reference back when you're looking at the data that's listed in your PEPPER.

The compare tab is a list of the target areas listed here. We have the number of target discharges. So that's our target discharges. That's going to be the numerator for each of the target areas. We have those listed here for our reference. Now, next—in the next column, we have the percent, which, for this first *Miscellaneous CMGs* case mix group, we have 20.1% is our percent. So next to that ladder visual that we saw, we would be listed at 20.1%. This is in red bold font, meaning we are below the line on that ladder that represents-excuse me-above the line on that ladder that represents the 80th percentile. So that is our percent calculation. That is where we fall next to the ladder. The next column over, we see

the facility national percentile, the jurisdiction, and then the state. Each of these numbers represents the number-excuse me-the percentage of IRFs in each group, either nationally, your MAC jurisdiction or in the state that have a lower percent value than the IRF. When we look at it a little bit more closely, again, our percent calculation was 20.1%. That means on the ladder 83.6% of the IRFs in the nation have a lower percent value than us. They have a lower outcome than us. They're lower on the ladder than us. 84% of the IRFs in our jurisdiction have a lower percent value, and then 81.4% of the IRFs in the state have a lower percent value. This tab also gives us the sum of payments for this specific-for each specific target area. The target areas are all listed here, and we will see this information-the target discharges, the percent, and then the sum of payments. We will see that information again included in the more detailed target area information and data for each-on each one of these tabs when we get to them.

But this tab, the compare tab, is kind of an overview. It's not-it's not as detailed as the information that we're about to see in the target areas, but it does give us kind of, again, an introductory look at where we fall within each of these target areas.

We move to the next tab. We have our first target area tab information. It just so happens that our facility is a high outlier. It was a high outlier in 2021, and it remains a high outlier in 2022 for the first listed target area, miscellaneous case mix groups. If we have any questions about the totals that we're looking at, the denominator count, the target count, we can easily click back to the definitions tab.

Let's head back and look at this first table that is listed here. Again, we have our outlier status listed. We have been an outlier for the last two years. We'll see why as we move down in the table and in the data review. As we saw in the compare tab, at least for 2022, our target area percent-again, where we are in the ladder-in 2021 was 20% even. In 2022, it was 20.1%. Not a very large raise. We're still in the 80th percentile with both of those outcomes. The next row is target count, and as I mentioned before, this is going to be your numerator. Any of the discharges that are counted in the numerator contribute to the numbers that we see here for each of these fiscal years. Again, if we have any questions, we can go to the user's guide or we can click back to the definitions tab. That denominator count, same thing. It's going to be the number that is represented by, in this case, the count of all discharges. That's our numerator—excuse me. That's our denominator count. In fiscal year 2022 for us, it was 2,388. We also have some extra information. We have the average length of stay for those discharges that are counted in the target area. So that's in the numerator, as it says, 10. 10 days is our average length of stay.

The denominator, we have the same thing, average length of stay, 11.3. We have the average payment for the target count. Again, our numerator. In 2022, 17,259, that was our average payment for those discharges that are counted in the numerator of this target area. Then as we saw on the compare tab, that we have for all three of the years here, we have the target sum of payments. How much payment did we get overall for each of those fiscal years for those discharges that are counted in the numerator? It has grown for us as the sample provider over those three fiscal years quite a bit.

The next table down shows us the comparative data. So, we have the detail of our data and our numerator and denominator counts and all those calculations, where we fell, that extra information. The next table down shows us in number form the comparative data that we're going to see for each of those fiscal years. Let's stay concentrated on the fiscal year 2022 since it is that most recent fiscal year. The national 80th percentile as we learned from the slides is the indicator of what is going to make us a high outlier. We do calculate the jurisdiction and the state 80th percentile. However, the high outlier status is only indicated if you are above the national 80th percentile. In this case, fiscal year 2022, the national 80th percentile, that line next to the ladder or across the ladder is at 19.1. So, of course, our 20.1 was just a little bit higher, but we are in that 80th percentile. Let's move down to the graph. A lot of people look at data different ways. Some people like to look at the numbers. Some people like to look at the tables that we just reviewed. Some people, like me, like to look at the graph that is listed here. We

have all of this information for each of our target areas. So, every one of the tabs that we're going to click through, we won't go into quite as much detail as we do for this first one, but you're going to see the same type of information and the same datasets in two table forms and then this graph. So, let's look at the graph. We have a bar graph and then three line graphs. This bar graph, these blue bars, those represent our percents. If we hover over, the value is listed, 21.4. That matches our target area percent up here in the table. All of this information that we just reviewed in the table is shown in graph form for us.

Moving on to the line graphs, the national 80th percentile is this solid line with a diamond plot point for each of the fiscal years. The indicator for the national 80th percentile, that straight solid line, the plot points are within the blue bars for 2021 and 2022. That is because our outcome was higher than the 80th percentile's outcome. So, we would expect to see that after looking over this information in the tables. We would expect to see that plot point land within our bar graph information for our percent calculations. We do plot out the jurisdiction and the state. The jurisdiction is a dashed line with a square for those indicators, those plot point indicators. Then the state is a dotted line with a triangle.

We want to give you all this information. We want to show you all this data. We want to show you how we calculated it, and we do that in our tables up here and then in our graph. But we also want to give you some information on how to proceed if you are a high outlier. All of this data is no good to anyone in a vacuum. We need to know how to practically apply this when we are administrators or how we're related to the facilities. We have those listed for you here, suggested interventions for high outliers.

For this specific target area, we say, this could indicate if you're a high outlier. This could indicate there are unnecessary admissions for patients admitted in the miscellaneous case groups. A sample of medical records for those case mix groups should be reviewed. Again, we are letting you know how you can proceed if you are a high outlier or even if you just want best practices. That's what we are striving for, we're all striving for. We want to be creating best practices within all of our processes. These suggested interventions can help everyone, even if you're not a high outlier. This blurb here lets you know what types of records to review, how to review them, what you should be looking at, if you want to make sure that you have compliance across the board, and if you are a high outlier, how you might be able to avoid that in the future.

That was our first target area, miscellaneous case mix groups. Let's look briefly—I don't want to go into too much detail for each of the target areas because I don't want to bore everyone, but let's look at the rest of the target areas. This is case mix groups at risk for unnecessary admissions. We are not an outlier for this target area for any of those three fiscal years. Again, we have the target count. That's going to be those discharges that are included in the numerator of the calculation. Same with the denominator. Those discharges that are included in the denominator of this calculation. The average length of stay for those discharges in the numerator and the denominator, and then our average payment. This average payment and the sum of payments for this target area is much less than the one we just looked at, but, again, we listed them here because we want everyone to have the most information that they possibly can and the most beneficial information.

This graph and this comparative data table look a little bit different from the first target area because we're not an outlier in any of those three years. These are—these 80th percentiles are much lower. The percentile numbers are much lower than that first miscellaneous case mix group target area, but we are still below that 80th percentile, and that's reflected in the graph this solid line with the diamond. That solid line with the diamond, the dashed line with the square, the dotted line with the triangle, those line graph designs are not going to change from target area to target area. So, if we seek out the national 80th percentile and find these diamonds, they are above our blue bar graph data points because we are not above the 80th percentile. We're lower.

Again, we have some suggested interventions if you do find yourself as a high outlier for this target area.

Outlier Payments is our next target area. This target area is a great one to look at. If we look at this first table, we can see no data for 2020 and for 2022. I don't want anyone to panic if they see no data in one or more of your target areas. That simply means that the target or the denominator count is less than 11. We have that threshold of 11 that we use across the board really for all of the PEPPERs, all the facility type PEPPERs, and, again, that's just a threshold that we use. If any of those numbers are less than 11, we do not calculate the information for that facility for that target area. It's suppressed. That's why we see no data. In 2020 and 2022, we had our sample facility, us, had less than 11 in the target or the denominator.

The 2021 does have data. The target area percent was less than 1% for this facility. So, to reflect that, we have very tiny blue bar graph here, just in that middle row for 2021. Then the national 80th percentile was 37.3% for that year. So, of course, that data point is far above our bar graph down here that's less than 1%. As always, we have the suggested interventions.

The next target area is *Short-Term Acute Care Hospital Admissions Following an IRF Discharge*. We have data for all of these three fiscal years for this target area. Again, they are laid out exactly as we've seen them in the other target area tabs. We are not an outlier for this target area for any of those three fiscal years. That's reflected here. We have the same information that we've had in the last couple target area information. Our comparative data remains displayed in the same way in the comparative data table and then the graph below. As always, we have the suggested interventions for high outliers.

Our second to last target area is the *Three- to Five-Day Readmissions*. We are not an outlier for this target area. Even if you're not an outlier, let's take a closer look at this target area because as I was about to say, even if you are not a high outlier, you do want to take a look at the-your target area percent and then that national 80th percentile. Where on the ladder do you fall? That can help us—we can see that clearly on the graph as well. Am I close to being a high outlier? What do my statistics reflect? Our target area percent has gone down, this target area calculation, pretty steadily over the last three years, as we can see in the blue bar chart. We want you to take a look at all the information. We want you to think about why that might be. We want you to think about how close you are to being an outlier. What is the 80th percentile doing every year? Jurisdiction and state as well. How does that compare to what I'm doing every year?

There's a wealth of information, and we don't want everyone to just, you know, stop looking if you're not a high outlier. There is so much information that you can learn about your processes and about your internal compliance procedures that can help you, and we want you to utilize all this rich information and all this rich data. Of course, there are suggested outliers.

Okay. Our last target area is *Short Stays*. The *Three-to-Five-Day Readmissions* and the short stay target areas are new as of the Q4FY2019 release. They are relatively new, and those are the two newest target areas, these last two. Again, we have all the same information that we've seen in the other target area tabs.

We have four other tabs that are listed on the PEPPER report. This first one is the IRFs, the facility's top case for the fiscal year 2022. This is a list of the CMGs. We have the descriptions for all of those. We have your total discharges. We have the proportion of the discharges to total discharges and then the average length of stay for each of the CMGs. Again, this is so much information all on one tab, and it takes us from a different way of looking at our facility's information and at our facility's data instead of or in addition to, I should say, the target area information looking at specific target area groups and then target area discharges. We're looking at the CMGs overall now and how that relates to the total

discharges and the proportion and then the average length of stay. This is great information for all facilities, and, again, of course, we urge everyone to use this to your best practices.

The next tab over is our jurisdiction top CMGs. It's the same information except these are the top CMGs for the jurisdiction instead of for the facility. You can use this tab to compare to your top CMGs. How do we compare or where are our CMGs following? If we look at one CMG 0604, that's our top one as well. The proportion of this CMG to the total discharges was 6.4%. The jurisdiction was 8.3. So, we're a little bit lower. Again, for each of these CMG rows, we have all that information, and it's a great way to compare how your discharge information falls according to or compared to your jurisdiction.

All right. The next tab is the tier level for our most recent fiscal year. We have the tier levels listed here. Tier D, Tier A, Tier C, Tier D. They are listed according to number of discharges, the tier D, that low co morbidity had the most—or the highest number of discharges for the fiscal year 2022. As you can see, we have the proportion of all discharges, and this other information here so we can use this, again, to look at our discharges, how they are shaking out according to the CMG tiers. As we saw with the top CMGs, we also have this next tab, the jurisdiction tier level. We can use this to compare how these tier levels, again, fell for the jurisdiction as compared to ours and our facility.

As we saw when we were looking at the PEPPER, the PEPPER applies to providers in many, many ways. 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 each of those target areas. We often get the questions; do I have to use my PEPPER and do I have to take any action in response to my PEPPER? The answer to those questions are 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 are 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 can benefit from focused education or maybe even a record review. So, from your perspective, it would be 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 would expect to see in your PEPPER.

The PEPPERs are distributed in electronic format in a Microsoft Excel workbook and 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 this in mind, we do have a portal online that you can use to access your PEPPER, and we encourage you to go to the portal and download your PEPPER so that you can have it in your files for your use.

You will need information to access your PEPPER through the portal. First, you'll be asked to enter your 6-digit CMS certification number, which is also referred to as the provider number or provider transaction access number or PTAN. This number is not your tax ID or an NPI number. For the freestanding IRFs, the third digit will be 3. For short term, the third digit will be a 0. For critical access, 1. I'm not going to read this information off to you. Again, it is listed here on the slide. However, there is information here as to what to use for your validation code when you go to the portal to access your PEPPER. As we said, you're going to want to—you're going to need to enter your CMS PTAN number. For IRFs that are a unit of a short-term acute care hospital or critical access hospital, if you are the Health Care Quality Information Systems or the HARP security official, you will get an email that has the validation code. If you are not that person but you have contact with that person and you would like to access the PEPPER, you can discuss with them whether they can share that validation code with you.

If you do not know who this person is, you are not the person, you're still tasked with getting into the PEPPER, that's fine. You can enter either a patient control number or a medical record number for a patient who received services, again, this is for traditional Medicare Part A fee for service from July 1st, 2022, through September 30th, 2022. Then the contact from the provider enrollment chain, ownership system (PECOS) is also sent an email with a validation code. Those are three different ways really that you can use or get a validation code to access your PEPPER through the portal. The validation codes are updated for each PEPPER release, so if you're using a validation code from last year's PEPPER, you're not going to be able to gain access with that validation code. You're going to need to gain the one for this most recent release.

Now, once you receive your PEPPER, let's say you see a lot of red in there, what should you do? First thing that you should not do is panic. Remember, outlier status does not necessarily mean that compliance issues exist. By design, 20% of the providers are always going to be identified as an outlier for each of the PEPPER target areas. But if you are an outlier, I want you to think about why that might be. Again, do the statistics in your PEPPER reflect what you know given your operation, your patient population, referral sources, your external health care environment, any changes in services or staffing? If you have any concerns, sample some claims. Make sure the documentation in the medical records supports the services that were submitted. Review the claim and ensure it was coded and billed appropriately based upon the documentation in the medical record. The bottom line is to ensure that you're following the best practices even if you're not an outlier.

We have a number of resources that are publicly available on our website, PEPPER.CBRPEPPER.ORG. Some of those resources is aggregate information at both a national and a state level for the target area's top CMGs and average length of stay by CMG tier and discharge destination. This data is updated each time we have a PEPPER release. The national level data is available for freestanding IRFs and IRFs that are distinct part units.

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 would be applicable to what they would consider their peer group. So, these 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 discharges, location, which is either urban or rural, and owner ship type which is for profit, physical owned, nonprofit, or church owned, or government.

We do update the peer group bar charts annually. If you do not agree how we're representing your IRF'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. You'll need to contact them for that update. A number of other resources can be found on the PEPPER website. Of course, there's the user's guide, the PEPPER training sessions, a demonstration PEPPER, a spreadsheet in the Mac jurisdictions in total and by state, and testimonials on success stories. There are really nice success stories out there, one in particular from a Kentucky hospital that used their PEPPER to help them 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 website and click on the help/contact us button. Then click on the Help Desk button. Complete the online form and a member of our staff will respond promptly 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, using their 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 the provider. Be aware that not other organizations provide accurate information on the PEPPER.

This is a screenshot of our home page. We do have blocks of information and links for each of the facility types that we create PEPPERs for. I do want to thank everyone again for joining us today. Again, if you have any questions, feel free to visit the Help Desk at PEPPER.CBRPEPPER.ORG.