Home Health Agency
Program for Evaluating Payment Patterns Electronic Report User's Guide
Sixth Edition, effective with the Q4CY20 release

What's new in this edition?

In the sixth edition of the *Home Health Agency (HHA) Program for Evaluating Payment Patterns Electronic Report (PEPPER)*, the PEPPER Team made the following updates:

- Deleted the Top Diagnoses Report and Top Therapy Episodes Report and added the Top Clinical Groups Report
- Deleted the *High Therapy Utilization Episodes* target area and added three new target areas: *Low Comorbidity*, *High Comorbidity*, and *Admission Source*
- Updated the Using PEPPER section to include instructions for interpretations of low outliers

Introduction

The Government Accountability Office has designated Medicare as a program at high risk for fraud, waste, and abuse.[1] Medicare spending for home health care has increased dramatically in recent years,[2,3] and HHAs have been designated as providing Medicare services that have a high risk for fraud, waste, and abuse.[4] The Office of Inspector General (OIG) recommended that the Centers for Medicare & Medicaid Services (CMS) increase its monitoring of billing for home health services.[4] In 1999, the OIG encouraged health care providers to develop and implement a compliance program to protect their operations from fraud and abuse.[5] As part of their compliance programs, HHAs should conduct regular audits to ensure charges for Medicare services are correctly documented and billed. PEPPER can help guide a provider's auditing and monitoring activities with the goal of preventing improper Medicare payments.

What Is PEPPER?

PEPPER is a comparative data report that summarizes a single provider's Medicare claims data statistics in areas identified as at risk for improper Medicare payments. To develop the *HHA PEPPER*, Medicare claims data for all HHAs in the nation (obtained from the UB-04 claims submitted to the Medicare Administrative Contractor [MAC]) were analyzed to identify areas which could be at risk for improper Medicare payment. These areas are referred to as "target areas."

PEPPER does not identify the presence of improper payments, but it can be used as a guide for auditing and monitoring efforts. An HHA can use PEPPER to compare its claims data over time to identify areas of potential concern and to identify changes in billing practices.

Each HHA with sufficient data to generate a report receives a PEPPER, which summarizes statistics for these target areas regardless of whether the HHA's data are of concern. The report shows how an agency's data compares to national, jurisdiction, and state statistics. Data in PEPPER is presented in tabular form and in graphs that depict the HHA's target area percentages/rates over time. All of the data tables, graphs, and reports in PEPPER were designed to assist HHAs with identifying potentially improper payments. PEPPER is developed and distributed by the RELI Group, along with its partners TMF® Health Quality Institute and CGS, under contract with CMS.

---

[1] Government Accountability Office. "Medicare Fraud, Waste and Abuse: Challenges and Strategies for Preventing Improper Payments." June 15, 2010. Available at https://www.gao.gov/assets/gao-10-844t.pdf.

[2] Medicare Payment Advisory Commission. Medicare Payment Policy Report to Congress, Chapter 9, March 2015. Available at http://www.medpac.gov/docs/default-source/reports/mar2015_entirereport_revised.pdf

[3] Medicare and Medicaid Research Review 2013 Statistical Supplement. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2013_Section7.pdf#Table7.1

[4] Office of Inspector General. "Inappropriate and Questionable Billing by Medicare Home Health Agencies. 2012. Available at http://oig.hhs.gov/oei/reports/oei-04-11-00240.asp

[5] Department of Health and Human Services/Office of Inspector General. 1998. "Publication of the OIG Compliance Program, Guidance for Home Health Agencies," *Federal Register* 63, no. 152, August 7, 1998, 42410–42426. Available at: http://oig.hhs.gov/authorities/docs/cpghome.pdf

In 2015, PEPPER became available for HHAs. PEPPER is also available for short- and long-term acute care inpatient prospective payment system (IPPS) hospitals, critical access hospitals, inpatient psychiatric facilities (IPFs), inpatient rehabilitation facilities (IRFs), partial hospitalization programs, hospices, and skilled nursing facilities (SNFs) (the format of the reports and the target areas are customized for each setting). The *HHA PEPPER* is the version of PEPPER specifically developed for HHAs. The *HHA PEPPER* is available to the HHA's Chief Executive Officer, Administrator, President, Compliance Officer, or Quality Assurance/Performance Improvement Officer through the PEPPER Portal (accessible through PEPPER.CBRPEPPER.org).

Each HHA receives only its PEPPER. The PEPPER Team does not provide PEPPERs to other contractors, although it does provide a Microsoft Access database (the First-Look Analysis Tool for Hospital Outlier Monitoring [FATHOM]) to MACs and Recovery Auditors. FATHOM can be used to produce a PEPPER.

Each *HHA PEPPER* summarizes claims data statistics (obtained from paid home health Medicare UB-04 claims) for the most recent three calendar years (the calendar year begins on Jan. 1 and ends on Dec. 31). An HHA is compared to other HHAs in three comparison groups: the nation, MAC jurisdiction, and state. These comparisons enable HHAs to determine whether their billing statistics differ from other HHAs and whether they may be at higher risk for improper Medicare payments.

PEPPER identifies areas at risk for improper Medicare payments based on preset control limits. The upper control limit for all target areas is the national 80th percentile. Coding-focused target areas also have a lower control limit, which is the national 20th percentile.

In order to be eligible for inclusion in the *HHA PEPPER*, claims must meet the specifications shown below.

INCLUSION/EXCLUSION CRITERIA	DATA SPECIFICATIONS
Claim facility type equal to "3"	UB-04 Form Locator (FL) 04 Type of Bill, second digit (Type of Facility) = 3 (Home health agency)
Include claim service classification type of "Home health visits"	UB-04 FL 04 Type of Bill, third digit (Bill Classification) = 2 (Home health visits under Part B) or 3 (Home health visits Part A)
Services provided during the time periods included in the report	Claim "Through Date" falls within the three calendar years included in the report.
Exclude non-payment and interim claims	UB-04 FL 04 Type of Bill, fourth digit (Frequency) ≠ 0 (Non-payment/zero claim) or 2 (Interim – first claim)
Final action claim	A final action claim is a non-rejected claim for which a payment has been made. All disputes and adjustments have been resolved and details clarified.
Medicare claim payment amount greater than zero	The home health agency received a payment amount greater than zero on the claim (Note that Medicare Secondary Payer claims are included).
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Advantage (Health Maintenance Organization) plan
Exclude cancelled claims	Exclude claims cancelled by the MAC

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. After October

Using PEPPER

Compare Targets Report

HHAs can use the Compare Targets Report to help prioritize areas for auditing and monitoring. The Compare Targets Report lists all target areas with reportable data for the most recent year included in PEPPER. For each target area, the Compare Targets Report displays the HHA's numerator count, percent/rate, HHA's percentiles as compared to the nation, jurisdiction and state, and the "Sum of Payments" (where applicable).

Navigate through PEPPER by clicking on the worksheet tabs at the bottom of the screen. Each tab is labeled to identify the contents of each worksheet (e.g., Target Area Reports, Compare Targets Report).

The *HHA PEPPER* identifies providers whose data results (percentiles) suggest they are at risk for improper Medicare payments as compared to all HHAs in the nation. The HHA's risk status is indicated by the color of the target area percent/rate on the Compare Targets Report. When the HHA's percent/rate is at or above the national 80th percentile for a target area, the HHA's percent/rate is printed in **red bold**. When the HHA is a low outlier (for coding-focused target areas only), the HHA percent is printed in *green italics*. When the HHA is not an outlier, the HHA's percent/rate is printed in black.

The Compare Targets Report provides the HHA's percentile value for the nation, jurisdiction, and state for all target areas with reportable data in the most recent year. The percentile value allows an HHA to judge how its target area percent/rate compares to all HHAs in each respective comparison group.

The HHA's national percentile indicates the percentage of all other HHAs in the nation that have a target area percent/rate less than the HHA's target area percent/rate.

The HHA's jurisdiction percentile indicates the percentage of all other HHAs in the MAC jurisdiction that have a target area percent/rate less than the HHA's target area percent/rate. The HHA's jurisdiction percentile for a target area will be blank if there are fewer than 11 HHAs with reportable data for the target area in a jurisdiction.

The HHA's state percentile indicates the percentage of all other HHAs in the state that have a target area percent/rate less than the HHA's target area percent/rate. The HHA's state percentile for a target area will be blank if there are fewer than 11 HHAs with reportable data for the target area in a state

To learn more about how percents differ from percentiles, see the "Training and Resources" page in the HHA section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

When interpreting the Compare Targets Report findings, HHAs should consider their target area percentile values for the nation, jurisdiction, and state. Percentile values at or above the 80th percentile (for all target areas) or at or below the 20th percentile (for coding-focused target areas) indicate that the HHA is an outlier. Providers should place the highest priority with their national percentile, as this percentile represents how the HHA compares to all HHAs in the nation.

Percentile values at or above the jurisdiction's 80th percentile or state's 80th percentile should be considered as well, though they should be given lower priority. The jurisdiction and state comparison groups are smaller; therefore, these percentiles may be less meaningful. In addition, regional differences in practice patterns may be reflected in jurisdiction and state percentiles.

The "Target Count/Amount" and "Sum of Payments" (available for target areas based on periods) can also be used to help prioritize areas for review. Areas in which a provider is at/above the 80th percentile that have a high sum of payment and/or numerator count may be given higher priority than target areas for which a provider is at/above the 80th percentile that have a lower sum of payments/numerator count.

Target Area Reports

PEPPER Target Area Reports display a variety of statistics for each target area summarized over three years. Each report includes a target area graph, a target area data table, comparative data, interpretive guidance, and suggested interventions.

Target Area Graph

Each report includes a target area graph, which provides a visual representation of the HHA's target area percent or rate over three years. The HHA's data is represented on the graph in bar format, and each bar represents a calendar year. HHAs can identify changes in the target area percent/rate from one time period to the next, which could be a result of changes in patient population, medical/therapy staff, or utilization review processes, for example. HHAs are encouraged to identify root causes of major changes to ensure that improper payments are prevented.

The graph includes red trend lines for the percents/rates that are at the 80th percentile (and the 20th percentile for coding-focused target areas) for the three comparison groups (i.e., nation, jurisdiction, and state), which the HHA can use to easily identify when it is an outlier as compared to any of these groups. A table of these values (i.e., "Comparative Data") is included under the HHA's data table. To learn more about how percents differ from percentiles, see the "Training and Resources" page in the HHA section on PEPPER.CBRPEPPER.org for a short slide presentation with visuals to assist in the understanding of these terms.

An HHA's data will not be displayed in the graph if the numerator count for the target area is less than 11 for any time period. This is due to data restrictions established by CMS. If there are fewer than 11 HHAs with reportable data for a target area in a state for any time period, there will not be a data point/trend line for the state comparison group in the graph. If there are fewer than 11 HHAs with reportable data for a target area in a jurisdiction for any time period, there will not be a data point/trend line for the jurisdiction comparison group in the graph.

Target Area HHA Data Table

PEPPER Target Area Reports also include an HHA data table. Statistics in each data table include the target (numerator) count for the target area, the denominator count, the proportion of the numerator and denominator (percent or rate), the average length of stay (ALOS) for the numerator and for the

denominator (where available), and the average and sum of Medicare payment data (available for period-based target areas).

For the *Average Case Mix* target area, the numerator ALOS, the average Medicare payments, and the sum of Medicare payments cannot be calculated for the numerator, which is the sum of case mix weights for periods paid to the HHA during the report period (excluding LUPAs and PEPs).

For the *Average Number of Periods* target area, the denominator ALOS cannot be calculated because the denominator is the count of unique beneficiaries served by the HHA during the report period.

For the *Outlier Payments* target area, the average and sum of Medicare payments are not reported to avoid duplication in reporting these measures. Instead, the average outlier payment amount for each calendar year is calculated and reported.

The HHA's percent/rate will be shown in **red bold print** if it is at or above the national 80th percentile (high outlier); for coding-focused target areas it will be shown in *green italics* if it is at or below the national 20th percentile (low outlier). For each time period, an HHA's data will not be displayed if the numerator count for the target area is less than 11.

Comparative Data Table

The comparative data table provides the target area percents/rates that are at the 80th and 20th percentiles (for coding-focused areas only) for the three comparison groups: nation, jurisdiction, and state. These are the values that are graphed as red trend lines on the target area graph. State percentiles are zero when there are fewer than 11 HHAs with reportable data for a target area in the state. Jurisdiction percentiles are zero when there are fewer than 11 HHAs with reportable data for a target area in the jurisdiction.

Suggested Interventions

Suggested interventions for providers, whose results suggest a risk for improper Medicare payments, are tailored to each target area and are included at the bottom of each report.

HHA Top Clinical Groups Report

The HHA Top Clinical Groups Report lists the top clinical groups for periods at the HHA that began in the most recent calendar year. For each clinical group listed, the report includes the total number of periods that have a principal diagnosis code mapping to that category, the proportion of periods for the clinical group to total periods, the number of visits, and the average number of visits. Please note that this report is limited to displaying the top clinical groups for which there were a total of at least 11 periods that began in the most recent calendar year.

Jurisdiction Wide Top Clinical Groups Report

The Jurisdiction Wide Top Clinical Groups Report lists the top clinical groups for periods in the MAC jurisdiction that began in the most recent calendar year. For each clinical group listed, the report includes the total number of periods that have a principal diagnosis code mapping to that category, the proportion of periods for the clinical group to total periods, the number of visits, and the average number of visits.

Note that this report is limited to displaying the top clinical groups for which there were a total of at least 11 periods that began in the most recent calendar year.

System Requirements, Customer Support, and Technical Assistance

PEPPER is a Microsoft Excel workbook that can be opened and saved to a personal computer (PC). It is not intended for use on a network, but it may be saved to as many PCs as necessary.

For help using PEPPER, please submit a request for assistance at PEPPER.CBRPEPPER.org by clicking on the "Help/Contact Us" tab. This website also provides many educational resources to assist HHAs with PEPPER in the HHA "Training and Resources" section.

Please do **not** contact your Medicare Quality Improvement Organization or any other association/organization for assistance with PEPPER, as these organizations are not involved in the production or distribution of PEPPER.

Acronyms and Abbreviations

Acronym/ Abbreviation	Acronym/Abbreviation Definition
ALOS	The average length of stay (ALOS) is calculated as an arithmetic average, or mean. It is computed by dividing the total number of days on claims ending during the report period at the HHA by the total number of claims submitted by the HHA during the time period.
CMS	The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for oversight of Medicare and Medicaid. CMS is a division of the U.S. Department of Health and Human Services.
FATHOM	First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) is a Microsoft Access application. It was designed to help MACs compare acute care PPS inpatient hospitals in areas at risk for improper payment using Medicare administrative claims data.
HIPPS	Health Insurance Prospective Payment System (HIPPS)
HHA	Home health agencies (HHAs)
HHRG	Home Health Resource Groups (HHRG)
HH PPS	Home Health Prospective Payment System (HH PPS)
IPF	Inpatient psychiatric facility (IPF)
IRF	Inpatient rehabilitation facility (IRF)
IPPS	Inpatient prospective payment system (IPPS)
LOS	The length of stay (LOS) is the total number of HHA days for the claim submitted by an HHA for a beneficiary's period. It is computed by subtracting the admission date ("From Date") on the claim from the discharge date ("Through Date") of the claim before then adding one.
LUPA	Low-utilization payment adjustment (LUPA)
MAC	The Medicare Administrative Contractor (MAC) is the contracting authority that replaced the fiscal intermediary and carrier in performing Medicare Fee-for-Service claims processing activities.
NCH	National Claims History (NCH)
OASIS	Outcome and Assessment Information Set (OASIS)
OIG	Office of Inspector General (OIG)
PEP	Partial period payment (PEP)
PEPPER	Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a data report that contains a single provider's claims data statistics for claims for service at risk for improper Medicare payments.
SNF	Skilled nursing facility (SNF)
UB-04	Standard uniform bill used by health care providers to submit claims for services. Claims for Medicare reimbursement are submitted to the provider's MAC.