Amid pressure to ratchet down Medicare overpayments for home health services, home health agencies will soon be able to address their compliance issues using the Program for Evaluating Payment Patterns Electronic Report (PEPPER).

TMF Health Quality Institute, which generates PEPPERs for CMS, is planning the first release in July, says Project Director Kim Hrehor. TMF has been working with CMS home health subject matter experts to develop risk areas for the PEPPERs, which are free reports on billing rates in certain risk areas. PEPPERs are designed to help hospitals, hospices and other providers tailor their compliance monitoring to outliers unique to their facilities. They allow providers to compare their billing rates to those of their peers in the nation, in Medicare administrative contractor (MAC) jurisdictions and in states in the target areas. It’s a red flag when a provider’s billing in a target area is at or above the national 80th percentile, which means it bills a higher percentage for that target area than 80% of all providers nationally. That doesn’t necessarily mean there was an error, but it’s up to the providers to determine whether they have a compliance issue or some reasonable explanation.

A ‘Big New’ PEPPER Release

The home health PEPPERs “will be a big new release,” Hrehor says, because there are more than 12,000 home health agencies in the nation. Another reason is the intense focus on home health billing and documentation errors by Medicare watchdogs. The HHS Agency Financial Report says the fiscal year 2014 improper payment rate for home health claims jumped to 51.4% from 17.3% the year before. For the first time, a home health provider in February settled a false claims case over allegations it violated the Medicare face-to-face encounter requirement (RMC 2/16/15, p. 1).

“The continued increase in improper Medicare payments makes this new setting ripe for external focus and thus for these comparative reports,” she says. “Home health agencies would be wise to seek out their report once it is released to see how their claims data statistics compare, and consider whether they might be at higher risk for improper Medicare payments.”

Here are the six target areas that will be in the home health PEPPERs, Hrehor says:

1. **Outlier payments**: Medicare pays home health agencies extra for beneficiaries who incur unusually high costs. Outlier payments could be triggered when they provide too many therapy services during visits or too many visits overall, Hrehor says. In a 2009 report, for example, OIG said that “Miami-Dade County accounted for 52 percent of the approximately $1 billion Medicare paid nationally in home health outlier payments, while only 2 percent of all Medicare beneficiaries receiving home health services resided there.” CMS has tried to get a handle on outlier abuse by capping the percent each agency can collect at 10% of its total home health payments, OIG said in a 2012 report.

2. **Average number of episodes per beneficiary**: A home health episode is a 60-day span of care, and home health agencies submit a Medicare claim for each episode, Hrehor says. There is potential for abuse because there is no limit on the number of episodes that home health agencies can bill for or the length of time a patient can receive care, she says. Therefore, they have a financial incentive to continue to provide services, she says. While some beneficiaries may require longer care with an HHA, it might be questionable if most of an agency’s beneficiaries were in that category, Hrehor says. The PEPPER data will allow home health agencies to hold up a mirror to themselves.

3. **Average case mix**: Hrehor says CMS suggested this risk area, which gets at the identification of beneficiaries with unusually high case mixes. “There’s a concern about potential overcoding with this risk area,” Hrehor says. In other words, HHAs perhaps exaggerate beneficiaries’ illnesses and/or their functional impairments on the Outcome and Assessment Information Set (OASIS), which home health agencies are required to submit to Medicare as a condition for payment.
(4) Episodes with five or six visits: HHAs receive the home health resource group (HHRG), which is the prospective payment, for beneficiaries who have at least five visits during the 60-day episode. Otherwise, Medicare pays HHAs a low utilization payment adjustment (LUPA), which is a per-visit payment and tends to be lower than the HHRG, Hrehor says. “We are looking at the percentage of episodes where home health agencies met the minimum amount of visits necessary to get the higher reimbursement” in the absence of medical necessity for the five or six visits, she says.

(5) Non-LUPA payments: In a reverse engineering of the above risk area, the PEPPER identifies HHAs that are outside the norm for payments that are not LUPAs. The national average of claims for LUPA payments is 8%, and HHAs that have very few or none might have a problem, Hrehor says. “It’s unrealistic for home health agencies to never have any LUPA payments,” she says.

(6) High therapy utilization episodes: HHAs generate higher reimbursement by providing more speech, physical or occupational therapy. “We are looking at the percentage of episodes that had 20 or more therapy visits,” Hrehor says. “The more therapy, the higher the HHRG payment,” she says. This has been a problem for skilled nursing facilities and is a risk area in the SNF PEPPERS (RMC 9/2/13, p. 1).

For more information, contact Hrehor at Kimberly.Hrehor@area-b.hcqis.org.