Transcript for Q4CY18 Home Health Agency PEPPER Review
July 18, 2019

Okay. I think we will go ahead and get started. I would like to welcome everyone to this review of the PEPPER for home health agencies. My name is Kim Hrehor, and I work for the RELI Group. RELI is contracted with the Centers for Medicare and Medicaid Services, or CMS, to develop and produce and disseminate the PEPPERs. For those interested in live captioning of today's event, you can access captioning by using the link that you will find in the first question in the Q&A panel. Today I will be focusing on the most recent release of the PEPPER for home health agencies. That is the version Q4, calendar year or CY18.

So today I am going to be focusing on the PEPPER for home health agencies, the newest release which is Q4CY18. In this release we have not implemented any revisions to the target areas so you will find this PEPPER to be the same as the PEPPER that was released last year. I know many of you are wondering how the PEPPER might be impacted by the new payment model, the patient driven grouping model or PDGM. I will talk about that later during the presentation. I am also planning to review other resources that you might find helpful, which include the national and state level data reports that are available on the website, as well as the peer group bar chart.

We will take a brief look at a sample PEPPER also during this presentation. If you are familiar with PEPPER, this is going to be primarily a review for you. If you are new to PEPPER though, you will find this a good introductory session for the PEPPER.

If after today's presentation, you still feel like you have some questions about the PEPPER and need a little bit more information, I would encourage you to visit our website, again, that is PEPPER.CBRPEPPER.org, and you can find in the home health training and resources section a number of recorded presentations. They are short chapters that address a variety of topics that are pertinent to the home health PEPPER. So feel free to access those recordings and listen to the ones that are of most interest to you. They are available 24 hours a day, seven days a week.

So what is the PEPPER? PEPPER is an acronym that stand for Program for Evaluating Payment Patterns Electronic Report. And the PEPPER is a comparative data report that summarizes one provider's Medicare claim data statistics in areas that might be a higher risk for improper Medicare payment, 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.

We refer to these areas as target areas in the PEPPER. The PEPPER summarizes your Medicare claims data statistics for these areas and then it compares them with aggregate Medicare data of other providers in three different groups; all providers in the nation, all providers in your

Medicare Administrative Contractor or MAC jurisdiction and then all providers in the state. These comparisons are the first step in identifying where you might be at a higher risk for improper Medicare payment, which really just means that your billing practices look different from the majority of other agencies in the comparison group. And I do want to stress that the PEPPER cannot identify the presence of improper Medicare payments. Those can only be confirmed through a review of the documentation in the medical record, along with the claim. But it can alert you if your statistics look unusual so then you can decide if there is something more that you need to be doing.

The PEPPER has been around for a number of years. It was originally developed in 2003 for short-term acute care hospitals and then a couple of years later a PEPPER for long-term acute care hospitals was developed. Back then it was provided by the quality improvement organization to the providers in their state.

In 2010, TMF began distributing the PEPPERs to all providers in the nation. They had a separate contract to do that and along the way, there were PEPPERs developed for other types of providers. You can see that the Home Health Agency PEPPER is the newest version. Those have been available since 2015.

Now, in 2018, CMS combined the Comparative Billing Report, or CBR, and the PEPPER program into one contract. The comparative billing reports are similar to PEPPER in that they focus on vulnerabilities to the Medicare trust fund but they focus on Medicare part B claims, whereas the PEPPER is more focused on Part A claims or claims for institutional providers. And so now the RELI Group along with its partners, TMF and CGS, are producing CBRs and PEPPERs. These reports focus on a wide range of topics and they do reach a wide audience of providers. Now, this change in the contract should be transparent to most of you in the provider community. You might notice some formatting changes to the PEPPER or the User's Guide or the website. But our team is continuing the production of the PEPPERs and the support that the provider community has become accustomed to.

So why does CMS feel that the provision of PEPPERs to providers is supportive of their own internal agency goals? Well, CMS is mandated by law to protect the Medicare trust fund from fraud, waste and abuse. And CMS employs a number of strategies to meet this goal such as provider education and early detection through medical review, which may be conducted by the Medicare Administrative Contractors, by recovery auditors or by any one of a number of other federal contractors. As well as data analysis activities. The provision of PEPPERs to providers supports these strategies. CMS considers the PEPPER to be an educational tool that can help providers identify where they might be at a higher risk for improper payments so then they can proactively monitor and take any preventive measures that they might find necessary.

I also should mention that the OIG, or the Office of Inspector General, encourages providers to

have a compliance program in place to help protect their operations from fraud and abuse. An important piece of 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. So the PEPPER supports the auditing and monitoring components of a compliance program.

Let me focus now more on the PEPPER for home health agencies. This newest release was made available July the eighth of this month, so just a couple of weeks now, nearly two weeks, it has been available. And it does summarize statistics for three calendar years. So we are looking at calendar years 2016, 2017, and 2018. And the reason that we call this version Q4CY 18 is because it does include the statistics through the fourth quarter of calendar year 2018.

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

Okay. I'm going to move on now to focus about the improper payment risks that are pertinent to the home health agencies at this point in time. Right now the home health agencies are reimbursed through the Home Health PPS or Prospective Payment System which pays higher rates to benes that — for services that for services to benes that have greater needs. And right now the home health agencies are paid on a 60 day episode payment. That is going to be changing under PGDM to a 30-day payment period. And a lot of the information is gathered from the patient assessment conducted by clinicians.

Now, as we all know the PPS, the Home Health PPS has been identified as at-risk for improper Medicare payments and in particular over the past few years, those of you who keep track of the improper payments report that is produced by the comprehensive error rate testing or CERT contractor, you know the most recent estimate for 2018 was that 17.6 percent of home health claims were found to be in error, resulting in a projected improper payment of over $3.2 billion. That is probably a big part of the reason, excuse me, that there is a transition to this new payment model.

Now, the existing target areas were developed based on a review of the home health PPS and with a focus on those areas that could be at a higher risk for improper Medicare payments. We reviewed studies that were related to improper Medicare payments and we also looked at

national level claims data. There was an OIG report that was released back in 2012 that identified six measures of questionable billing and that did guide our development quite a bit, as well as hand-in-hand coordination with CMS subject matter expert. I also want to mention that these target areas are evaluated on an annual basis and they may change over time as we continue to assess the home health improper payment risk and of course we do anticipate changes to the target areas in response to the new payment model.

I do want to spend a few minutes talking about the Patient Driven Grouping Model, PDGM which is replacing the current HHRG system which is effective January 1st. I know a lot of you are interested in what the PEPPER will look like after PDGM, and we are currently coordinating with CMS to get a feel for what would be of interest to CMS and what would be helpful to the providers in the PEPPER once the PDGM is in effect. I also want to remind people that there is a lag time with time periods that are included in the PEPPER. So the statistic for calendar year 2020, which is the first year of PDGM implementation, those are going to be released most likely in July of 2021. And that will be the first release that will reflect the PDGM statistics. And so there will be a bit of time before those are going to be out there.

I am certainly not an expert on PDGM. There is a link on the slide that I have included where you can obtain a lot of very helpful resources that CMS has made available regarding the new payment model. I can tell you that some of the potential changes that we are looking at will of course be high therapy utilization episodes target area. That one is going to be deleted. We are going to be ending that one after PDGM.

We are also looking at revising the episodes with five or six visits target area to something that might represent more closely when the home health does hit that minimum or the minimum plus one number of visits for the respective payment group. That is something that we are considering. We are thinking about looking also at comorbidities. There are going to be three comorbidity adjustments and a low — there is a low comorbidity, a low and a high. So we will be probably be taking a look at that to see if there is anything in there we can include in the PEPPER. Some of the top reports are definitely going to have changes. But at this point in time, nothing has been approved or formalized with CMS. I just want you all to know that of course we are interested in taking a look as well at how the target areas may change and as soon as we have something definitive, we will share that information with the provider community.

The target areas in PEPPER are calculated using a numerator and a denominator. In the numerator we are looking at the episodes or payments or whatever the value that might be potentially problematic and the denominator is a larger group. Now, in the home health we have two different types of results. There are two target areas where the result is a rate. And this is where the numerator and the denominator are different units of measure. Some of the target areas are also reported as a percent. And this is where the numerator and the

denominator are the same units. The numerator would be a subset of the denominator. We can take a quick review of these denominators, and you can see that each of them has a numerator and a denominator definition. And this is what we use to calculate either the rate or the percent. So, the average case mixed target area is looking at — is calculating the average case mixed for those episodes that end during the reporting period. We are comparing the sum of the case mix rate for all the episodes ending in that period, excluding the lupus and the PEP to the total number of episodes. This target area is currently focused on the risk of over coding on the OASIS which can result in higher payments for the home health agencies. This is one of those target areas that is reported as a rate. As is the second target area, average number of episodes where we are calculating the average number of episodes that each beneficiary received by dividing the total number of episodes by the total number of unique or individual beneficiaries that were served by that agency. And this target area is focused on the risk for continuing home health services beyond the point where they are necessary.

The episodes with five or six visits, this one is most likely going to be changing. To qualify for an HHRG, currently the beneficiary has to have five visits during the sixty-day period. If the beneficiary receives fewer than five visits then the Home Health Agency receives a LUPA, a Low Utilization Payment Adjustment Payment. And that LUPA payment is much less than the home health, the HHRG payment so there is an incentive to provide just enough visits to qualify for that full payment and that is what this target area is focused on. Now, similarly the non-LUPA payment target area is looking at that issue but from a different angle. Most home health agencies should have some number LUPA payments. The number of LUPA payments at a national level is 9 percent on average. So, if an agency has none or very few LUPA payments that could also be an indication of that incentive to receive that higher, full HHRG payment. High therapy utilization episodes, all of us know that the high therapy has been a focus of many auditors for the home health agencies for a while now. And the new payment model is not closely linked to therapy utilization. So, this target area will eventually be retired but currently it focuses on the number of episodes that had 20 or more therapy visits as compared to the total number of episodes. And of course this one is looking at the incentive to provide therapy to receive that higher reimbursement.

And then there is the outlier payments target area. This is a concern that had also been identified by the OIG in that 2012 report. A excessive amount of outlier payments could indicate improper Medicare payments again with the goal of enhancing reimbursement. So these are the target areas that are included in the PEPPER as it is today.

Now, you remember, each of these target areas has a numerator and denominator definition, and so the chances are that a lot of you can calculate these statistics for your agency on your own using your own claims data. The value in the PEPPER is that not only do we do these calculations for you but we also have these comparisons where we are showing you how you

compare to all of the home health agencies in the nation, in the jurisdiction, and the state. The percentiles are an important number in helping to give you some context so that you can understand how your target area percent or your rate might compare if you are relatively high as compared to everybody else, if you are relatively low, what might that mean. So, the percentiles are that handy number that allow to you do that.

When we calculate percentiles, we take all of the target area percents or the rate for all of the home health agencies in one of those comparison groups. Let's just say all home health agencies in the nation and here we are looking at the high utilization therapy episodes. So, we take all the target for the agencies in the nation, we sort them from highest to lowest and then we identify the points below by which 80 percent of those percents fall. And that point is identified as the 80th percentile. In the PEPPER, we use the 80th percentile as that boundary, that line in the sand to identify providers whose statistics look different from most of the other providers in that group.

Any Home Health Agency that has a target area percent that is at, equal to, or greater than the national 80th percentile, the value that is at the 80th percentile then the PEPPER is identified as an outlier. Now, noes that mean you are doing anything wrong? No, it sure doesn't. It just means you look different. But in the PEPPER we use these percentiles to help give you some context to understand where within that distribution your agency's value falls.

I want you to keep this in ladder image in your mind as we run through a sample PEPPER in just a few minutes because it will help, I think, reinforce again the percentile concept which some people find challenging.

I also have included this slide here on the comparison groups. It is primarily as a visual to remind you that we do have these three comparison groups: nation, jurisdiction and state. And many times the MAC jurisdiction comparison group is confusing to people and I am trying to simplify it by just letting you know that all of the providers that submit their claims to the same MAC that you do are in your MAC jurisdiction comparison group. So, it is a way of giving us a smaller group to compare with than nation. It may be a little bit more regional, although you can see that CGS does have some states there that are on the East Coast. And larger than the state. So, we have these national jurisdiction and state comparison groups. In the PEPPER we use the national percentiles when we are identifying outliers.

This is the point during the presentation where I like to share a sample PEPPER. What you are looking at now on your screen is the first page of the PEPPER. The PEPPER is distributed electronically. It is a Microsoft Excel workbook. You will navigate within the PEPPER by clicking on these worksheet tabs along the bottom of the screen. This first page is the purpose tab, here in this area on row eight you are going to see your six-digit CMS certification number. Or PTAN. Some of you call it a PTAN. Here you are going to see your provider's name. On the next row

you are going to see this is the report that summarizes the most recent three calendar years through the fourth quarter, calendar year 2018. The version, and here you will find your MAC jurisdiction name. So that way you will know which jurisdiction you are being included in.

The definitions tab is worksheet in the PEPPER that provides the complete numerator and denominator definitions for each of the target areas in the PEPPER. This might be helpful if you are examining your target area report and you are trying to figure out what does the numerator value include? What does the denominator value include? And so you can click on the definitions tab and find that information here.

The next report or tab is called the compare targets report. And I like to call this report the heart of the PEPPER. It is the only place in the PEPPER where you can see all of your agency's statistics all on one report. It only represents the most recent calendar year. So what we are looking at here reflects calendar year 2018. I am going to briefly walk through some of these numbers here. This first target area, average case mix, this is a brief description of the numerator and the denominator. This is the numerator count or value. When we compare the numerator to the denominator, this is the rate that we are calculating for this target area. Now, the denominator is not on this report, it is included on the individual target report. This Home Health Agency has an average case mix rate of 1.07. And when we compare our agency's rate to all of the other agencies in the nation, we can see that our national percentile is 63.7. So, I want you to think about that ladder and the distribution of all of those rates for all of the agencies in the nation and this agency is at the 63.7 national percentile. That means that 63.7 percent of all of the agencies in the nation have a lower rate than this agency does.

So, if we are thinking about that ladder distribution, they are approximately two thirds of the way from the bottom. Or one third from the top. Whichever your perspective is. So this gives us some context, helps us understand where in that distribution our agency falls.

Now, when we are comparing ourselves to all of the agencies in our jurisdiction, we are at the 64.0 jurisdiction percentile. And that means that 64 percent of the agencies in the jurisdiction have a lower target area percent — I am sorry, a lower rate than we do. And then compared to our state, you can see our percent value, our percentile is much lower. We are at the 40.8 state percentile. So, we are further towards the bottom on that ladder in that distribution of rate, 40.8 percent of the agencies have a lower rate than we do. We expect the variation in these percentile values because we are being compared to different set of providers for each of these calculations.

This last column here, the sum of payments, when we can calculate it, it is the total amount of Medicare reimbursement that the agency received for the numerator episode. So here the average number of episodes, these are the episodes during the period and this agency received $19.8 million for those—for all those episodes.

Now, let's take a look here at this episode with five or six visits. We can see our agency has a target area percent of 9.6 percent. That means 9.6 percent of their episodes have five or six visits. And again, thinking about that ladder in the distribution, where does our agency fall? When we are compared to all agencies in the nation, our national percentile is 80.8. So that means that 80.8 percent of all agencies in the nation have a lower target area percent than we do. So, we are at or above the national 80th percentile. Our target area percent is color coded in red, bold font as a visual cue. And so this is how we know that we are above the 80th percentile. If you are thinking about that ladder, remember we are pretty close to the top there. About 20 percent—we're in the top 20 percent there. And similarly, we have our jurisdiction percentiles and our state percentiles calculated here. This is the only place in the PEPPER where you are going to see your exact percentile on this compare targets report.

I do want to quickly go over the target area report. These are all structured in the same manner. There is one tab for each target area. The first thing you will notice when you click on the target area report is the graph up here, which is a visual representation of your agency's either rate or target area percent for these three time periods. So here we can see the average case mix for this agency. It doesn't look like it has changed much over time. Maybe increased just a smidge. We also can see how we are comparing to the 80th percentile for nation, which is the solid line. Jurisdiction is the dashed line. It is very hard to see. And the dotted line is the state 80th percentile. If our target area percent was at or above the national 80th percentile, then in the table below we would see our percent again indicated in red, bold font. Below the graph you are going to see the numbers that are behind the graph. These are the — this is the rate that is graphed in the graph. The numerator count or value. And the denominator value. And then the average length of stay for the denominator. We do put together average length of stay and reimbursement information for the numerator and/or denominator when we are able to do so.

And then below that is the comparative data table which shows us the rate that is at the 80th percentile for nation, jurisdiction and state. These are the values that are graphed as those red trend lines up here in the graph. And those are the values that are at the 80th percentile and that is where the line in the sand is so to speak in that distribution of values from highest to lowest. And all of our target area reports include at the very bottom what we call suggested interventions. These are general suggestions that you could think about to help you interpret what it might mean if you are a high outlier, what you might look at. And each of our target areas and reports includes this suggested intervention section. You will also find this information in the PEPPER user's guide.

Moving on, I will just quickly click through some of these. These are all put together in the same way. Here you can see there is a clear difference between the 80 percentile for jurisdiction, nation and state. A lot of times that reflects regional variation. We can see for this target area,

we have the average length of stay for the numerator. We also have the average and total amount of Medicare reimbursement for the numerator.

What is also nice about the graph is it allows to you visualize any changes overtime. Here we can see this agency has a small decrease every year in their episodes with five or six visits. So, if this is something that this agency has been working on, it looks like they are indeed moving in the right direction.

Non-LUPA payments. High therapy utilization episodes. This is another interesting graph. We can see that this provider's high therapy utilization episodes have increased over the past couple of years. Certainly they are well below the 80th percentile here. My question and probably the agency would notice this and would just think to themselves, has there been some change in our patient population? In the services that we offer? Those type of things. What would be driving this change in the high therapy utilization episodes? I always encourage people to think about their PEPPER statistics in that way, does it make sense that, does it reflect what they expect to see and if the answer to that question or those questions is no, then perhaps it would be wise to assemble a group of people within the agency to take a closer look.

And this is outlier payments. We do have a couple of reports in the Home Health PEPPER that are supplemental. They are informational only. They don't have any impact on outlier status. There is one that looks at the top diagnoses for the Home Health Agency reporting to the clinical classification software categories. We identify the total number of episodes for each of those categories. The percent of episodes. The number of visits. And the average number of visits.

And this is at the agency level. We also have a top therapy episode report. This one will most likely eventually be retired. Here we are looking at these different categories of therapies, early episodes, 0 to 13, early 14 to 19 therapy visits. Late 0 to 13 and late 14 to 19. And we are including the top five clinical classification system categories for each of those buckets. The number of episodes, the proportion of all episodes, the proportion within the episode group, and the total number and average number of visits. This is again at the agency level and then we have similar reports that summarize this information at the jurisdiction level for all of those agencies in the jurisdiction, we are putting all of that information together for you here.

I will go back to the presentation now. I know that was a quick review of the PEPPER but I have some other material and I am hoping I have enough time to get through it. Okay. So a lot of times people will ask me, what do I have to do? Do I have to use my PEPPER? Do I have to take any response due to the statistics or the findings in my PEPPER? The answer to that of course is no. You are not required to use the PEPPER. There is no mandatory response. There is nothing that you have to do. But I always like to remind people that there are other contractors that have access to the Medicare claims database and they are looking through the database to see

if they can identify providers that might benefit from perhaps some outreach or education. Maybe even a focused review. So the PEPPER is a way to give you a heads up if your statistics look different then you can at least be aware of that fact and if something looks unusual, that you don't expect, you can already be ahead of the game and look into whatever issues might be concerning.

I do encourage you to take advantage. This is a free report, provided by CMS. How do you get your PEPPER? All of the Home Health Agency PEPPERs are distributed through the PEPPER resources portal which is available through our website, this is our new website, PEPPER.CBRPEPPER.org. There is a PEPPER distribution, get your PEPPER link which will allow you to get some instructions on how you access your PEPPER. Each release of PEPPER is available for approximately two years from its original release date. So if you didn't access your PEPPER last year, which I think about 40 percent of home health agencies did last year, you can still access the PEPPER now. We cannot send the PEPPER through e mail.

When you go to the portal to get your PEPPER, you will need a couple of pieces of information. One is your six-digit CMS certification number and you will also need for verification purposes a patient control number or a medical record number from traditional fee-for-service Medicare beneficiary that received services at your agency the last three months of last year, that's the validation code. There is a validation code also that we can provide to you and some agencies have to use the validation code that is made available. The validation code will change, though, for each release. So, if you access your PEPPER say in March of this year, the validation code that you used at that time will no longer be accepted.

I would hope also that if you are having trouble getting your PEPPER through the portal, we don't want that. We don't want you to be frustrated. We don't want you to give up. We want you to get your PEPPER. So if you are trying to get your PEPPER and you are having trouble, contact us through the help desk before you're at your wits and our team will help you get your PEPPER. Once you get your PEPPER let's say you see a lot of red in there. I don't want you to panic. I want you to remember just because you are an outlier doesn't mean you are doing anything wrong. It doesn't mean that compliance issues exist. Remember, you are an outlier. It means you are in the top 20 percent as compared to all agencies in the nation. But I do ask that you think about why you are an outlier. Again, some of these things I mentioned do the statistics reflect your operation, what you know about the way your organization functions? If not, consider sampling some claims, reviewing documentation, reviewing the claims. Bottom line is just make sure that you are following those best practices, even if you are not an outlier.

Let me move on now to talk about the resources that are available on our website and again these are publicly available resources. The national level and state level data are available on the data page. There is information for the target areas. So you can see the numbers for those

target areas, the average in the nation, the average in the state, as well as information for the top diagnoses and the top therapy episodes reports that are included in your PEPPER. These resources are updated every year following the report release and they have been refreshed. They do reflect the calendar year 2018 information.

A few years ago we also began putting together peer group reports that will allow you the ability to compare your PEPPER statistics with the subgroup that you might consider to be your peers. Each of those target areas we identify the 20th, the 50th and the 80th national percentile for home health agencies in three categories. We are looking at size, location and ownership type. And these are made available again on the data page. Actually, these have not just been updated. I am expecting the calendar year '18 bar charts will be up there in the next day or two. There is a methodology document as well as a Home Health Agency by peer group file that will give you additional information. Sometimes the ownership type or the location is not congruent with what the Home Health Agency expected. We do obtain that information from the CMS provider of services file. So, you will need to work that out—that discrepancy out with CMS.

And this is just an example peer group bar chart that shows us. This is for outlier payments, how the 20th, 50th and 80th percentiles can differ based on size, which is the top blue graph, I know it is really small. We can see there is some difference there for smallest, medium, and largest agencies. Location is the middle graph there, the pink set of bars. We can see that urban agencies have much higher 80th and 50th percentile than the rural agencies do. And the bottom graph in green is looking at ownership type. And we can see a big difference there for the for-profit, the darker green bar. I do expect those are going to be updated within next day or two.

Other resources that you will find on the PEPPER website, PEPPER.CBRPEPPER.org website, include of course the User's Guide. There is a spreadsheet out there, a jurisdiction spreadsheet that will identify the total number of agencies in each jurisdiction in total, and by state. There are those recorded training sessions. We have a sample PEPPER out there. And some success stories. We worked with a number of home health agencies a year and a half, two years ago, who graciously worked with us to share their success story and how they use the PEPPER to help them with their internal operation. These are real, nice references. They are very nice testimonials. I would encourage you to take a little bit of time to look at them. They are not very long. And of course if you have a success story, we are always interested in sharing. So please consider that.

If you have questions or if you need help with your PEPPER, think about contacting us through our help desk. There is a form there, an online form you will complete. A member of our team will respond promptly to assist you. And just a reminder that we are the official source of

information and guidance on PEPPER, so please don't contact other organizations if you need help.

This is a screen shot of the homepage on the PEPPER website. The home health agencies resources, you can see that blue arrow pointing there on the right side of the slide. We can access the user's guide, the training and resources page, the PEPPER distribution page, and there is also a map of the PEPPER retrievals by state there that you can look at. There is a lot of information easily accessible from our homepage.