# PEPPER

# Transcript for Q4CY19 *Home Health Agency (HHA) Program for Evaluating Payment Patterns Electronic Report (PEPPER) Review*

## September 1, 2020

Hello, everyone. I would like to welcome you all to this review of the PEPPER for Home Health Agencies. My name is Annie Barnaby and I work for RELI Group. RELI is contracted with the centers for Medicare and Medicaid Services or CMS, to develop produce and disseminate the PEPPERs.

For those of you who might be interested in live captioning of today's session you can access the captioning by clicking on the link that is in the Q&A panel, it is the very first question listed.

Today I will be focusing on the most recent release of the PEPPER for home health agencies. That is version Q4 calendar year or CY 19. In this release, we have not implemented any revisions to the target areas, so you will find target areas in the reports in the PEPPER to be the same as last year's PEPPER. I know that many of you are wondering how the PEPPER will be impacted by the new payment model, the patient driven grouping model or PDGM. We will review the planned changed later during the presentation. And also, we will review the new PEPPER format effective with the Q4CY19 reviews. We will also review other resources that you might find helpful, which includes the national and state level data reports that are available on the website, as well as the peer group bar chart and we will take a look, a brief look at a sample PEPPER also during this presentation.

Today's session will be a high-level overview, so 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 as 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, pepper.cbrpepper.org and you can find in the home health "Training & Resources" section a number of recorded presentations. They are short chapters that address a variety of topics that are pertinent to the whole 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 PEPPER? PEPPER is an acronym For Program for Evaluating Payment Patterns Electronic Report. It is a comparative data report that summarizes one provider's Medicare claims 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 policies. We refer to these targets — or 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 higher risk for improper Medicare payment, which really just means 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 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.

Looking at the history of the PEPPER, we can see that 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 organizations to the providers in their state. In 2010, TMF began distributing the PEPPERs to all hospitals in the nation and over the next several years there were PEPPERs developed for other types of providers. You can see that the *Home Health Agency PEPPER* is the newest version and that has been available since 2015. Then in 2018 CMS compared the Comparative Building Report, or CBR program and the PEPPER program into one contract. The comparative billing reports are similar to the PEPPER in that they focus on vulnerabilities to the Medicare trust fund but they focus on Medicare Part B claims, whereas the PEPPER is primarily focused on Part A claims or claims for institutional providers. And so now the RELI Group, along with its partners TMF and CGS, are providing these PEPPERs. These reports focus on a wide range of topics and they do reach a large number of providers.

Why are providers receiving PEPPERs and why does CMS feel 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 and an abuse and CMS has a number of strategies to meet this goal, such as data analysis activities, 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. The provision of PEPPERs to providers supports these strategies and 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 preventative measures that they might find necessary. I should also 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 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 the auditing and monitoring components of a compliance program.

Let's focus now on the PEPPER for home health agencies. This newest release was made available in August this year. The release was delayed by CMS due to the public health emergency related to the COVID pandemic. The release summarizes statistics for three calendar years. We are looking at calendar years 2017, 2018 and 2019. And the reason that we call this version Q4CY19 is because it summarizes statistics through the fourth quarter of calendar year 2019. Now, for those of you who are familiar with PEPPER, we 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 count or maybe the national or state jurisdiction percentile values. And that would be expected because the refresh statistics are going to reflect any corrective claims that might have been submitted, any late claims, those type of things. And so there probably will be or there may be some slight differences in those numerator and denominator counts. And each time we produce a

PEPPER, the oldest calendar year rolls off as we add the new one on.

Let's move on now to focus on the improper payment risks that are pertinent to the home health agencies. Prior to January 1st, 2020, home health agencies were reimbursed through the home health PPS or Prospect Payment System, which pays higher rates for services to beneficiaries that have greater needs. Payments were based on a 60-day episode payment. This has changed under the patient driven grouping model, PDGM to a 30 day payment period. The previous home health PPS had been identified as at risk for improper Medicare payments, in particular over the last few years for those of you who keep track of the improper payment report that is produced by the Comprehensive Error Testing Rate or CERT contractor, you know most recent estimate for 2019 was that 12.1 percent of home health claims were found to be in error, resulting in a projected improper payment of over $2.3 billion. That is probably a big part of the reason 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 of 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 released back in 2012 that identified six measures of questionable billing, and that guided our development as well as hand-in-hand coordination with CMS subject matter experts. I also want to mention these target areas are evaluated on an annual basis and may change over time as we continue to assess the home health improper payment risks. And of course, we do anticipate changes to the target areas in response to the new payment model.

Let's review the patient model PDGM which replaced the HHRG system as of January 1st. I know a lot of you are interested in what the PEPPER will look like after PDGM. Over the past year, our team has coordinated with CMS to plan for PEPPER modifications. Because of the lag time in claims submissions, the current PEPPER still summarizes claims that were reimbursed under the HHRG payment model.

The PEPPER planned for release in 2021, version Q4CY20 will be the first which will reflect the PDGM statistics. CMS has developed many resources for providers related to the PDGM, and you can find them on the CMS website through the link shown on this slide. I can share the approved changes that will be included in next year's PEPPER. We have three new target areas planned which we will review in a few minutes and we will retire the *High Therapy Utilization Episodes* target area. We will revise the *Episodes with 5 or 6 Visits* target areas to evaluate payment periods when the home health does hit the minimum or the minimum plus one number of visits for the respective payment group. There will be changes to the supplemental reports and more details about these changes are included in the PEPPER User's Guide.

Let's move to a discussion about the HH PEPPER target areas. The target areas in the PEPPER are calculated using a numerator and a denominator. The numerator represents the episodes or payments or other measures 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 reported as a percent and this is where the numerator and the denominator are reported or measured using the same unit, units and the numerator is a subset of the denominator.

Let's quickly review the current target areas in the PEPPER. Notice that each target area has a numerator

and a denominator definition. And this is what we use to calculate either the rate or the percent. The *Average Case Mix* target area is calculating the average case mix for those episodes that end during the reported period. We are comparing the sum of the case mix rate for all of the episodes ending in that period, excluding the lupus and the PEPS to the number of episodes, excuse me. 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 receives 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. We can anticipate that both of these target areas will be — will continue to be included in the PEPPER.

The next target area is *Episodes with 5 or 6 Visits* and this one will be revised. To qualify for an HHRG under the previous payment model, the beneficiary had to receive five visits during the 60 day period. If the beneficiary receives fewer than five visits, then the home health agency received a LUPA, a Low Utilization Payment Adjustment payment and that LUPA payment is much less than the HHRG payment so there is an incentive to provide just enough visits qualify for the full payment, and that is what this target area is focused on. This target area will be revised to focus on the new visit threshold for the PDGM payment group. Similarly, the *Non-LUPA Payment* area is looking at that issue but from a different angle. Most home health agencies should have some number of LUPA payments. The number of LUPA payments at a national level is between eight and nine 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 the higher, full HHRG payment. We can expect to retain this target area as well.

The *High Therapy Utilization Episodes* target area, all of us know that the high therapy utilization was a focus of many auditors for the home health agencies in the prior payment model. The new PDGM is not closely linked to therapy utilization. So, this target area will likely be retired. It current focuses on the number of episodes that had 20 or more therapy visits as compared to the total number of visits. And of course, this one is looking the at the incentive to provide therapy to receive that higher reimbursement.

And then there is the *Outlier Payments* target area. An excess amount of outlier payments could indicate improper Medicare payments, again, with the goal of enhancing reimbursement.

These are the target areas that are included in the PEPPER as it is today.

Now let's review the future new *HHA PEPPER* target areas, those that we are planning to add to the CY20 report, planned for release in July 2021. To provide some background for these new target areas, some of the factors considered in the PDGM include the following. Comorbidity adjustments — the HHA receives a high comorbidity adjustment if there are two or more secondary guidelines used that are associated with higher resource use when both are reported together compared to if they reported separately. That is the two diagnoses may interact with one another, resulting in a higher resource use. The HHA receives a low comorbidity adjustment if there is one reported secondary diagnosis that is associated with higher resource use. The HHA receives no comorbidity adjustment if there are no reported secondary diagnoses that could be considered either a high or low comorbidity adjustment.

Admission source is also now a factor. If the beneficiary was treated in an institutional setting, for example, a short term acute care hospital, a long term acute care hospital, inpatient rehabilitation facility, or an IRF, inpatient psychiatric facility, an IPF, or a skilled nursing facility, SNF, within 14 days prior to the HHA admission, the HHA receives a higher adjustment than if the beneficiary was admitted to the HHA directly from the community setting. So, that represents a financial incentive.

CMS evaluated and improved — approved three new target areas designed to assess the potential for circumventing these new payment adjustments. High comorbidity, the numerator for this target area represents the count of periods with two or more secondary diagnoses that interact with one another and therefore qualify for a high comorbidity adjustment. And then the denominator is the count of all periods.

Low comorbidity-for that one, the numerator is the count of periods with one or more secondary diagnoses that are adjusted with higher resource use and therefore qualify for a low comorbidity adjustment, excluding periods that also qualify for a high comorbidity adjustment. And then in the denominator, again, we have the count of all periods.

The admission source target area the numerator for this target area is the count of periods with discharge from short term acute care hospitals, long term acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities or skilled nursing facilities in the 14 days prior to the home health admission. And the denominator, again, is the count of all periods.

The *HHA PEPPER* will include these new target areas after one year of PDGM claims are available for inclusion. Meaning that C4 — Q4CY20 release of this PEPPER, again, scheduled for distribution in July of 2021, will reflect these changes.

Now, you may remember each of these target areas has a numerator and denominator definition, as we just reviewed, so the chances are that a lot of you can calculate these statistics from your agency on your own using your own claims data.

The value in the PEPPER reporting is that not only do we prepare these calculations for you, but we also show you how you compare to all of the home health agencies those three groups of nation, jurisdiction and state, using percentile. The percentiles are an important number in helping to give you some context so that you can understand how your target area percent or rate might compare to others in those groups. You can determine if you are relatively high as compared to everyone else or if you are relatively low and what that might mean. The percentiles are the handy number that allow you to do that.

When we calculate percentiles we take all of the target area percents or the rates for all of the home health agencies for a target area and time period in one of those comparison groups. Let's say all of the home health agencies in the nation. Here we are looking at the *Episodes with 5 or 6 Visits*, target areas. So, we take all of the target percents or all of the agencies in the nation and we sort them from highest to lowest. Then, we identify the point below 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 the boundary, the 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 equal to or greater than the 80th

percentile, the value that is at that 80th percentile, then in their PEPPER they will be identified as an outlier.

Now, does that mean you are doing anything wrong? No, it definitely does not. It just means that you look different. In the PEPPER will use these percentiles to help give you some context as to where within that distribution your agency's values fall. I want you go keep this ladder image in your mind as we run through a sample PEPPER shortly, because it will help to reinforce, again, the percentile concept which some people do find challenging.

Before we review the PEPPER, let's review the comparison groups. On this slide, the visual reminds you that we do have those three comparison groups: nation, jurisdiction, and state. Sometimes the MAC jurisdiction comparison group is confusing to people so to simplify it, think about all of the providers that submit their claims to the same MAC. Those are the providers in the MAC jurisdiction conversion group; that is a way of giving us a smaller group to compare it with than the nation and then larger than our state.

So, at this point during the presentation, I would like to turn things over to Kim Hrehor who is going to share with us a sample PEPPER.

Thank you very much, Annie. I appreciate your covering all of that information for us today. All right. I am, as Annie mentioned, sharing a sample PEPPER for home health agencies. Those of you who have already accessed your PEPPER have noticed that we have made some formatting changes to the PEPPER. Most of these changes were made in order for the PEPPER file to be what is called Section 508 compliant. This allows people that might have hearing or sight disabilities, they have specialized software that enables them to utilize the information within the PEPPER. So, you will notice we have made some changes to the report, the font is larger throughout. We have removed a lot of the text boxes and replaced with text where that might be needed. There have been some other rearrangements made, but please rest assured that all of the information that you are used to seeing in your PEPPER is still there, it is just in a new package now.

So, the PEPPER is still distributed as a Microsoft Excel workbook and you are going to navigate within the PEPPER by clicking on these worksheet tabs along the bottom of the screen. When you open your PEPPER, it is going to open to the first page, which is called the purpose. You will see that now we have added the CMS logo to the PEPPER. The rest of the information is pretty much the same. You are still going to see your six digits CMS certification number or PTAN here, along with your provider name. On row 12 we are going to see the most recent calendar year of statistics that are summarized within the PEPPER. And you will also be able to see your jurisdiction, if you are not sure which jurisdiction comparison group is pertinent for you, you will see that identified here on row 26.

The next tab is the definition tab and here is where you can find complete numerator and denominator definitions for all of these target areas that are included in the PEPPER. This might be a handy reference if you are looking at some of the reports in your PEPPER and you are trying to determine what the numerator count or to the denominator count is representing, you can click on the definition tab and find that information here within your PEPPER.

Next, we have the compare targets report, and this report has been formatted, reformatted some to

again make it easier to read. I have always referred to this as the heart of the PEPPER. It is the only place within the PEPPER that you can see your agency's statistics for all of the target areas in one view. Now it does represent only statistics for the most recent calendar year and you will also notice that this particular PEPPER only lists four target areas on this report. The reason for that is that if your agency does not have sufficient data to calculate statistics for the most recent calendar year, then that target area for which there is not what we call reportable data is hot going to be listed here.

Now, you will notice that this report looks a lot shorter now. We have removed that description of the numerator and denominator for the target areas from this report. So, everything has been tightened up a lot. But the rest of the information is still included. So, for each of these tart areas, you are going to see your numerator count or amount for each of the target areas. When we compare the numerator to the denominator, which is not included on this report, but it is on the target area — target area tab, we can then calculate our target percent or rate.

Now, remember, we do have two of those target areas, these two, that are calculated as rates and so those will be displayed as a rate value. And then we are going to show you your national percentile, your jurisdiction percentile and your state percentile.

And so if we take, a look, for example at the *Average Case Mix* target area, our agency's rate is .94. Now, think about that ladder image that Annie covered just a couple of minutes ago. Remember, we take all of the agency's rates, all of them in the nation, and we sort them from highest to lowest. This agency's rate of .94 places them at the 35.7 national percentile. This means that 35.7 percent of the agencies in the nation have a lower rate than this one does. So it is kind of towards the bottom end of that ladder, about a third of the way from the bottom and that helps give us some context and helps us understand how our values compare to those of all of the agencies in the nation. When we are comparing ourselves to all of the other agencies in our jurisdiction comparison group, we can see that we are at the 35.1 jurisdiction percentile. So, still about a third of the agencies have a lower rate than we do, and then comparing ourselves to those agencies within our state, 42 percent have a lower rate than we do. Now, this last column will include the sum of Medicare reimbursement as appropriate for the target areas. This would represent the amount of Medicare reimbursement for the numerator episode.

Now, if your agency's percent or rate is at or above the national 80th percentile as Annie described then we are going to show your percent or your rate here in red bold font. That's the visual queue that your outcomes are placed as an outlier in the PEPPER. We can see here for the *Outlier Payments* target area, our percent or rate — I'm sorry, our percent of 9.9 percent places us at the 94.8 national percentile. So, thinking about that ladder, again, for this target area our value is pretty close to the top of the scale, with 94.8 percent of the agencies in the nation having a lower target area percent than we do.

Before I move on, I want to also mention that this is the only place within the PEPPER that you are going to see your agencies exact percentile. And we have that available only for the most recent calendar year.

Next, we will move on to look at the target area reports for each of these target areas. And so there will be a tab for each target area within your PEPPER. Here you are going to notice that, if you are familiar with the PEPPER, we have moved the graph that used to be at the top of the page to the bottom of the

page. The first thing that you will see here now is the data table. That's going to show you your statistics again for each of these calendar years, 2017, 2018, and 2019. There is a new row here that will tell you whether or not your provider, your agency is an outlier, so for this target area, we are not an outlier for any of these time periods. Here is the target area rate, calculated for this particular target area, which is average case mix. And then we have the numerator value, the denominator value, average length is not applicable for this particular target area, *Average Case Mix*. Which is basically the numerators, the case mixed weight.

We do have the denominator average length of stay, the denominator for this target area being the count of episodes during this time period. This is our average length of stay in days. If it were applicable we would have the average and total amount of Medicare reimbursement for numerator episodes, but of course this is looking at case mix. So it is not applicable.

Below that, we do show you the rate that is at the 80th percentile for the jurisdiction — I am sorry — for the nation, for the jurisdiction, and for the state, and so those are the values that you will see in the graph as the red line. It is a little hard to discern all three of them, but the solid line is nation, the 80th percentile for the nation. The dashed line is the 80th percentile for jurisdiction. Well, and the dotted line is the 80th percentile for the state. What is nice about the graph, here we are showing you your target area rate for these three years. What is nice about the graph is that it visually can help you identify when there might be changes from one year to the next whether those might be increases or decreases.

I always encourage providers if they do see an increase or a decrease in their target area statistics to think about the factors that could be leading into those increases or decreases. If there has been some sort of change in operation, in patient case mix, maybe your patients used to be really debilitated and for some reason there has been some change within your external healthcare environment, and now your patients are less complicated, perhaps that is vice-versa maybe you had new staff come on board that offered different types of services or have specialized skills, maybe you have made some changes in your coding or billing or other staff that have — could impact the way that the documentation is captured in the record. Clinical documentation improvement is also something to keep in mind if you have undergone some efforts for clinical documentation improvement. Sometimes we do see that affect statistics in the PEPPER.

But for this target area and for this hos — I am sorry, home health agency the numbers look fairly stable so that is not a change there. Below all of these graphs for each of the target areas, we do include some suggested interventions. What could this mean if you have a high outlier status for any of these target areas? This possibly could indicate the risk of potential overcoding of beneficiaries, clinical and functional status, and so the agency might think amount whether the functional and clinical status as reported on the oasis is supported and consistent with medical record documentation. Again, that is very generalized, I want to stress again there can be a lot of factors that could affect these statistics and so if you do see changes over time, please do come together with others within your organization and think about what are some of the potential impacts there.

Once you get used to looking at the target area reports for these target areas, you will notice that they are all put together, formatted the same way. For this target area, this is *Average Number of Episodes*. This provider is a high outlier for the oldest time period and not an outlier for the most recent two. Their

target area rate here of 2.71 was above the national 80th percentile. We can again see that red bold font here as a visual queue.

If we look at the graph, we can see that indeed this provider, their rate, their average number of episodes per bene, has decreased over the past couple of years, and so if this was a concerted effort that the agency was making to work on decreasing the average number of episodes per bene, then that is something they could see here and could be conceptualized or illustrated, rather, through the statistics within their PEPPER. And for this graph, it is really easy to see the distinction between national 80th percentile. This is the state 80th percentile and then the jurisdiction 80th percentile.

For *Episodes with 5 or 6 Visits*, this provider does not have reportable data for the most recent calendar year, so you see there is no data. These cells here are empty. Indeed, if we look at the numerator count for the past couple of years, they barely had reportable data for calendar year 2017. They had total episode count of 11 in the numerator, and 11 is the minimum that is required for the calculation of these statistics. So when that happens, when the numerator is less than 11, there is not going to be statistics calculated and we also will not see that blue bar for the percent on the graph.

*Non-LUPA Payment*, this one I think looks pretty stable.

Therapy utilization, that provider did not have sufficient data to calculate statistics for any of the time periods. So, they had none of those episodes there with 20 or more therapy visits.

For *Outlier Payments*, this agency has been a high outlier all three calendar years. It actually looks like their target area percent is increasing a little bit over time. So that might be something to look into, the dollar amount for those outlier payments.

Why that might be going up. There certainly could be legitimate reasons, but I also mentioned to you providers that if they look at their statistics in their PEPPER and what is reflected there is not what they expect to see, they don't quite feel right, then please get together with some other folks within your organization, post the medical records, review those records, along with the claim form and just make sure that you are adhering to the Medicare payment policy.

The PEPPER does include a couple of additional supplemental reports that don't have any bearing or impact on outlier status. This one shows us the top diagnoses or the clinical classification software diagnosis category for the most recent calendar year. We will lift up to 20, as long as there are at least 11 episodes within the calendar year. So, for each of these categories, then we would identify the total number of episodes, the proportion of episodes to the total number of episodes, the number of visits for that category, and the average number of visits. And again this is for your agency. I do expect that proper this category will be — I am sorry — this report will be retained.

The next supplemental report, though, which shows the top therapy episodes will be retired for next year. This one is showing us for our agency the CCS diagnosis categories for these five different buckets of therapy visits. Early episodes, zero to 13 early, 14 to 19, late zero to 13, late 14 to 19, and early or late 20 plus. And so, since these are no longer applicable starting January 1st, 2020, this information is not helpful.

We also include within the PEPPER the same type of information summarized or aggregated at the

jurisdiction level, so the jurisdiction top diagnosis report is going to show us those top diagnosis categories for all of the agencies in our jurisdiction comparison group. That might be helpful information if you want to compare it or use it as some sort of, I don't know if I would call it a benchmark but just as a comparison. And then the same for the jurisdiction top therapy episodes report.

So, that was a quick look at a PEPPER and then I will go ahead and turn the presentation back over to Annie to take us through the rest of the slides that we have prepared for you today.

Thank you, Kim, so much for that review. Very, very helpful, so we all appreciate it.

So, let's continue on now to talk about how providers can use their PEPPERs. We get quite a few questions from providers, do I have to use my PEPPER? Do I have to take any response due to the findings in my PEPPER? The answer to those questions is, no, you are not required to use the PEPPER. You not required to respond or take any action related to your PEPPER statistics. But we always like to remind people 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 of this free report provided by CMS and it can really help to support your compliance efforts.

How do you get your PEPPER? Well, all of the *Home Health Agency PEPPERs* are distributed through the PEPPER portal, which is available through our website: pepper.cbrpepper.org. There is a PEPPER distribution, get your PEPPER linked where you can review instruction on how you can access your PEPPER in case that you are not familiar with the process.

Each release of the PEPPER is available for approximately two years from its original release date, so if you didn't access your PEPPER last year, you still have the opportunity to do so. And just a reminder that we cannot send the PEPPER via 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 during the last three months of last year. That is your validation code. There is another validation code we can provide to you. That validation code will change, though, for each release. So, if you access your PEPPER, say, earlier this year, the validation code that you used at that time will no longer be accepted. If you are having trouble getting your PEPPER through the portal, which some agencies do, 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, please contact us through our Help Desk and our team will help you get your PEPPER and help ease your frustration.

Once you have your PEPPER, let's say you see a lot of red in the report. We don't want you to panic. We want you to remember that 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, which simply means you are

in the top 20 percent as compared to all agencies in the nation. But we do ask that you think about why you are an outlier. Again, some of the things we mentioned earlier — 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. The bottom line is to make sure that you are following the best practices, even if you are not an outlier.

Let's 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. 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 in the top therapy episode 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 2019 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 you might consider to be your peers. For each of these target areas, we identified the 20th, the 50th and the 80th national percentile for home health agencies in those three categories. We are looking at size, which is based on the number of episodes per year, location, urban versus rural, and ownership type for profit, physician owned or nonprofit church owned, government, et cetera. And these are made available, again, on the data page and updated following each report release.

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 expects. Our team obtains that information from the CMS provider of services file which is maintained by the CMS regional offices. So please coordinate with your CMS regional office to make any updates or corrections that you feel are indicated.

This is an example peer group chart that shows us what those charts look like. This chart is for the *Outlier Payments*. We can see that urban agencies have a much higher 80th percentile and a somewhat higher 50th percentile than the rural agencies do.

Other resources that you will find on the PEPPER website, again, pepper.cbrpepper.org 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 and some PEPPER success stories. We worked with a number of home health agencies a few years ago who graciously shared with us their success stories and how they used PEPPER to support their agency. These are really nice references and testimonials so we encourage you to take a little bit of time to look at them, they're not very long. And of course if you have a success story related to PEPPER we are always interested in developing new success stories, so please consider sharing that with us.

If you have questions or need help with your PEPPER think about contacting us through our Help Desk. There is an online form you will complete, and 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 information if you need help.

This is a screen shot of the home page on the PEPPER website. The home health agency resources, you can see the blue arrow there pointing on the right side of the slide, we can access the User's Guide through that list there, the "Training & Resources" page, the PEPPER distribution page, and there is also a map of the PEPPER retrievals by state that you can access. There is a lot of information easily accessible from our home page.

So as we conclude, please take a minute to provide feedback and let us know if this webinar was helpful to you as we end the session the post event survey will display in the window and we do appreciate any feedback that you can provide.