Transcript for the Q4FY19 *Inpatient Rehabilitation Facility (IRF) Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

Welcome to this review of the PEPPER for inpatient rehabilitation facilities. My name is Kim Hrehor, and I work for the RELI Group, which is contracted with the Centers for Medicare and Medicaid Services, or CMS, to develop, produce, and disseminate the PEPPERs.

Today, I'm going to be reviewing the most recent release of the PEPPER for inpatient rehabilitation facilities. This is version Q4FY19. In this release, you will notice that there are two new target areas that have been added. So I will be discussing those in a little bit of greater detail. I will also be reviewing a sample PEPPER and other resources that are available on our website, which include the national and state level data, as well as the peer group bar charts.

Now, today's session is going to be a rather high-level overview of the PEPPER. So if you are new to PEPPER, or if after today's session you feel you need a little bit more information about PEPPER, do have recorded training sessions that are available on the "Training and Resources" page for inpatient rehabilitation facilities on our website pepper.cbrpepper.org. These are short chapters that have been recorded in segments that allow you to pick and choose the topics that you're interested in within the PEPPER, so I would encourage you to access these recordings at your leisure. They are available 24 hours a day, seven days a week.

So what is PEPPER? PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report. And essentially, the PEPPER is a comparative data report that summarizes one provider's Medicare claims data statistics for areas that could be at higher risk for improper Medicare payments, primarily in terms of whether the claim was correctly coded and billed and whether the treatment provided to the patient was necessary and in accordance with Medicare payment policy. In the PEPPER, we call these risk areas target areas.

Now, the PEPPER summarizes your hospital's Medicare claims data statistics in these areas, and then it compares your data with aggregate Medicare data in three different comparison groups — all providers in the nation, all providers in your Medicare Administrative Contractor, or MAC, jurisdiction, and all providers in the state. These comparisons are the first step in identifying where you could be at a higher risk for improper Medicare payments, which in terms of PEPPER simply means that your billing practices are different from the majority of other providers in the comparison group.

I do want to stress that the PEPPER cannot identify the presence of improper Medicare payments. But it can alert you if your statistics look unusual. Then you can determine if there's something that you want to take a closer look at.

PEPPER has been available for a number of years. It was originally developed in 2003 for short-term acute care hospitals and a few years later for long-term acute care hospitals. At that time the PEPPERs were made available through the state quality improvement organizations. In late 2008, CMS made some changes to the contracts for the QIOs, and starting in 2010, TMF Health Quality Institute began distributing PEPPERs to all providers in the nation. And along the next few years, they developed

PEPPERs for other provider types. You can see the PEPPER for inpatient rehabilitation facilities has been available since 2011.

Then, in 2018, the CMS again made some changes to the PEPPER program. They combined the PEPPER program along with the Comparative Billing Report Program into one contract. The comparative billing reports are focused similarly to PEPPER on areas of improper payments, but they are summarized Medicare Part B claims data, in the PEPPER summarizes primarily Medicare Part A claims data. So now, the RELI Group, along with its partners, TMF and CGS are producing CBRs PEPPERs for providers across the nation.

So why does CMS feel that the provision of PEPPERs to providers is supportive of their agency goals? Well, CMS is mandated by law to protect the Medicare Trust Fund from fraud, waste, and abuse, and they employ a number of strategies to meet this goal, such as provider education, data analysis activities, and early detection through medical review, which may be conducted by the Medicare administrative contractors, recovery auditors, or other federal contractors.

The provision of PEPPERs to providers supports the strategies. PEPPER is an educational tool that can help you identify where you might be at a higher risk for improper payments so then you can proactively monitor and take any preventive measures if necessary. I also should mention that the Office of Inspector General or OIG 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 component of a compliance program.

So let's focus now more closely on the newest release of the PEPPER for inpatient rehabilitation facilities. This is version Q4FY19, which means that it summarizes statistics for IRF discharges that occur in the most recent three federal fiscal years through the fourth quarter of fiscal year 2019. So this release will summarize statistics for the federal fiscal years 2017, 2018, and 2019. Remember the federal fiscal year starts October the 1st, and it runs through September the 30th of the following year.

Each time our team produces a new release of the PEPPER, we download all of the Medicare claims data from the paid claims database, and we reach refresh the statistics for all three fiscal years. What this means is that if you are looking at your PEPPER from last year, the FY18 release, and comparing it with the FY19 release, the new release, you may see some slight changes in numerator or denominator accounts.

This would be due to the fact that any late claims that have been submitted, any adjustments, resubmitted claims, those will all be reflected in the refreshed claims data. So it's possible that you may see some slight changes from one year to the next. And with each release of the PEPPER, the oldest year rolls off as the new one is added on.

Let's talk now about the improper payment risks that are pertinent to inpatient rehabilitation facilities. Inpatient rehabilitation facilities are reimbursed through the IRF Prospective Payment System, or PPS.

And just as in other inpatient settings of care, IRFs are at risk for unnecessary admissions, as well as incorrect coding, which can impact correct reimbursement.

The IRF target areas were developed through a review of the IRF PPF with a focus on areas that could be prone to improper Medicare payments. In addition, we coordinated closely with CMS to develop these target areas based on those that could be vulnerable to improper payments.

In addition, I'd like to mention that the Comprehensive Error Rate Testing contractor, the CERT contractor, they perform random reviews every year to estimate improper payments for CMS across all areas of care. And they produce an annual report, which is available on the CMS website. The report for 2019, the CERT report, the CERT Medicare Fee-For-Service Improper Payments Report showed that inpatient rehabilitation facilities had an error rate of 34.9% with a projected $2.5 billion in improper payment. Now, this is a decrease from the 2018 report, so that's a good thing for inpatient rehabilitation facilities. If you're interested in reviewing these reports more closely, you can find them on the CMS website at cms.hhs.gov/cert, that's C-E-R-T.

Now in the PEPPER, we provide these statistics for the target areas. And again, a target area is simply a clinical condition or a type of admission that has been identified as prone to either unnecessary admissions or incorrect coding or billing. In the PEPPER, the target areas are constructed as ratios, where the numerator is the count of discharges that may be problematic from either an admission necessity or a coding standpoint. And then, the denominator is the count of discharges of some larger reference group.

As we move into a quick we review of the target areas, you'll notice that each of our target areas has a numerator definition and a denominator definition that allows us to calculate a target area percent. And this will all be more clear to you as we move into a review of the sample PEPPER here in just a few minutes.

The PEPPER target areas for inpatient rehabilitation facilities have not changed really at all over the years since the first PEPPER was released back in 2011. We have had the same four target areas included in each release. And so it's exciting that this year we have a couple of new target areas that I'll be reviewing in just a moment.

Now, again, you can see here that these are the first two target areas that you'll find in your PEPPER. Each of these target areas has a numerator and a denominator definition. For the *Miscellaneous CMGs* target area, we're calculating that percentage of all Medicare discharges that are for the four miscellaneous Case Mix Groups, CMGs. And these include diagnoses such as stability, generalized weakness, and other miscellaneous conditions. We include all tier groups for these CMGs, and so keep that in mind as you're looking at your data.

In general, the *Miscellaneous CMGs* do not count towards the 60% compliance threshold, which stipulates that at least 60% of an IRF patient population must require treatment for one or more of 13 conditions. Comorbidities that meet certain criteria may determine this compliance threshold. For more information, go to the IRF PPF page on the CMS website.

CMGs at Risk for Unnecessary Admissions, this target area, calculates the percentage of discharges for eight CMGs as a proportion of all discharges. And these CMGs represent high-functioning patients with no tier group assignment. So we're looking at no comorbidities, the CMG prefix letter A. Again, these admissions may be at risk for unnecessary admissions.

We have a target area that looks at outlier payments. Here, we're calculating the percentage of discharges that have an outlier approved amount of greater than zero dollars as compared to all discharges. IRFs that have a high percentage of patients with outlier payments might want to examine those cases to ensure that care was medically necessary and that the claim was correctly submitted. Might also want to think about looking at length of stay to ensure that continued care was necessary.

Short-term acute care hospital admissions following IRF discharge calculates the percentage of patients who are admitted to an acute care hospital within 30 days of discharge from an IRF. If we have a high target area percent here, this could possibly indicate that patients and/or their families are not prepared to handle patient care issues once they get home or that the discharge planning process was not started early enough in the patient's admission or that there could be post-discharge issues regarding medication compliance that perhaps could have been monitored or addressed in some proactive manner.

All right, now we get into these two new target areas — *Short Stays*. When a patient's pre-admissions screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, the IRF must immediately begin the process of discharging the patient to another setting of care, recognizing that it could take a day or more for the IRF to find placement for the patient. Instead of denying the entire claim, Medicare authorizes its Medicare administrative contractors to allow the claim to be paid at the appropriate case mix groups for that patient for stays of three days or less.

Now, when our team looked at claims data, we found that about 3% of IRF claims were for length of stay of 3 or fewer days. 2/3 of those short stay claims were transferred to a short-term acute care hospital, discharge status 02. But only 7% of the longer than 3 day stay claims were transferred to a short-term acute care hospital. So based on that information, CMS approved a new target area focused on short stays for addition to the *IRF PEPPER*.

The *3- to 5-Day Readmission* target area is designed to identify the potential for circumvention of the interrupted stay policy. For the interrupted stay policy, readmissions within three consecutive days from discharge, those are treated as a continuation of the initial admission for reimbursement purposes. If the patient is readmitted after the fourth consecutive day, then the IRF will receive two separate case mix groups payments.

And so you can see that there would be some financial incentive to readmit those patients after the short stay outlier — I'm sorry, after the interrupted stay period. So these are the two new target areas that you'll find in your PEPPER.

Now, with using those numerator and denominator definitions, it's likely that you will be able to calculate your target area percents for any of those target areas. The value in the PEPPER is that we calculate percentiles to help you understand how your target area percent compares to those of other IRFs in the nation, in the jurisdiction, and in the state. This can give you some context so you understand

whether your target area percent is high as compared to those other IRFs, low, somewhere in between. It can help also give you a heads up if your statistics look different.

Now, how do we calculate percentiles? When we calculate percentiles in the PEPPER, we take the target area percents for all of the IRFs for a target area for a time period, and then we sort them from highest to lowest. So this example here on the slide is a ladder that shows a target area percents sorted from highest to lowest. So this might be all of the IRFs in the nation for the *Outlier Payments* target area.

Once we have all of these target area percents sorted from highest to lowest, we identify the points below which 80% of those target area percents fall. And the target area percent that is at that point is identified as the 80th percentile. Any IRFs that have a target area percent at or above the national 80th percentile are identified as outliers in the PEPPER, and they will see their target area percent displayed in red, bold font.

Now, again, that doesn't necessarily mean that you're doing anything wrong. It just means that your target area percent is up here at the top of this scale, and your statistics look different from most of the other IRFs. 80% of those are below the 80th percentile.

Let's take a look at a sample PEPPER now to give you a better understanding of how the PEPPER is put together and how we use those percentiles, again, to identify outliers. And I want you to keep that latter example in the back of your mind as we go through this.

So you're seeing on your screen now the first page of the PEPPER. The PEPPER is a Microsoft Excel workbook, so it's distributed electronically. And when you first open the PEPPER, it opens to this page called the purpose page. You will navigate within the PEPPER by clicking on these worksheet tabs along the bottom of the screen.

Again, it opens to the purpose page. And what you'll see when you open your PEPPER is this image, the view. You'll see your six digit CMS certification number here on row 8, and then your hospital's name. Below that, it identifies that this report summarizes the discharges in the most recent three federal fiscal years through the fourth quarter of fiscal year 2019.

Down here on row 22, you will see your jurisdiction identified. The jurisdiction comparison group is comprised of all of the IRFs that submit their claims to the same Medicare administrative contractor as you do. So the jurisdiction comparison group is comprised of all of those IRFs in that MAC jurisdiction.

The next worksheet tab is called the Definitions tab. And here, you will find complete numerator and denominator definitions for each of the target areas in the PEPPER. This can be handy if you are looking at a target area report in your PEPPER and you're asking yourself, gosh, what is this numerator count summarizing? What does this denominator count represent? You can click over to the Definitions tab and see the complete numerator or denominator definition here.

The next report in the PEPPER is called the Compare Targets Report, and I like to call this the heart of the PEPPER. It's the only place in the PEPPER where you will be able to see your IRFs statistics for all of the target areas in the PEPPER. Now, it does only represent the most recent fiscal year. So the data that we're looking on, it's looking at in this Compare Targets Report is for fiscal year 2019.

And you'll also notice that we only see four target areas here. There are now six target areas in the *IRF PEPPER*. The Compare Targets report will only display the target areas for which your IRF has sufficient data to calculate statistics. If the numerator or denominator count is less than 11, we are not able to calculate statistics. And so those target areas, if they do not have reportable data for fiscal year 2019, are not included on this report.

Let's review what this exactly means. So for this first target area listed here, *Miscellaneous CMGs*, the cell has a brief description of the target area. Here we see that we have 61 target or numerator discharges. So we have 61 discharges for CMGs 2001, 2002, 2003, or 2004.

When we compare this numerator to all discharges, the denominator — and the denominator is not on this report, but it's on a different one in this PEPPER — we have a target area percent of 15.3%. But when we just look at this number, we really don't have any feeling for how we compare to the IRFs in the nation, in the jurisdiction, or in the state. And with the percentiles, again, thinking about that ladder, the percentiles will tell us. Well, they'll give us that context.

So here in this column, this is our national percentile. Our national percentile is 54.6%. This tells us that 54.6% percent of all IRFs in the nation have a lower target area percent than we do. So if we think about that ladder example, our target area percent of 15.3% has 54.6% of IRFs in the nation falling below it. So we're about at the middle, just slightly above the middle of that distribution in target area percent from highest to lowest. 54.6% of IRFs in the nation have a lower target area percent than we do.

When we compare ourselves to all IRFs in our jurisdiction, our jurisdiction percentile is 55.4%. So 55.4% of IRFs in the jurisdiction group have a lower target area percent than we do. And then, lastly, comparing ourselves to all IRFs in our state, then the state percentile is 50.0%. So exactly 50% of the IRFs have a lower target area percent than we do.

So for the *Miscellaneous CMGs* target area, you can see that we are approximately in the middle of that distribution, depending on which group we're comparing ourselves to. This is where that context comes in. We understand how our target area percent is comparing.

This last column here, the sum of payments, tells us the amount of Medicare reimbursement that our IRF received for these 61 numerator discharges. So almost $1.2 million in Medicare reimbursement for these 61 discharges.

Now, you can see here that none of our target area percents are color coded in red, bold font. That is because for none of our target areas are we at or above the national 80th percentile. As a matter of fact, for *Outlier Payments*, our national percentile is 7.9%. So that tells us that 7.9% of IRFs in the nation have a lower target area percent than we do.

So if we think about that ladder, we're pretty close to the bottom. Only about 8% of the IRFs have a lower target area percent. And similarly, these two target areas, we are again towards that lower end with about 20% of the IRFs having lower target area percents. Now, the Compare Targets Report is the only place in the PEPPER that you are going to see your exact percentile.

All right, let's start looking now at each of these Target Area Reports. This first one is for the *Miscellaneous CMGs* target area. You can see in the graph that our IRFs target area percent is displayed

by these blue bars for each of the three fiscal years. So we can see that our IRFs target area percent for *Miscellaneous CMGs* has decreased a little bit each year.

We can also see how our target area percent approximates to the 80th percentile for nation, which is the solid red line, jurisdiction, which is the dashed red line, and state, which is the dotted red line. We can see that in the oldest time period for fiscal year 2017, our target area percent was above the 80th percentile. Then we were below the 80th percentile for fiscal year 18, and even further below it for fiscal year 19.

The graph is a nice way to see how your target area percent changes over time. So if this IRF was making an effort to reduce their discharges for the *Miscellaneous CMGs*, they've done a good job. They can see that they've had some impact there.

Of course, changes in statistics can also be due to other factors. Maybe the patient population has changed. Maybe the referral sources or the external health care environment has changed. There could be staffing changes, changes in services offered.

A number of factors can affect the way your target area statistics look. So I usually encourage hospitals that if they see increases or decreases over time, just to think about what factors might be leading into that. And if there is anything that they should be concerned about, if there's something that doesn't look right, then take the next step. Coordinate internally with some other folks on your team. And maybe take a look at some medical records and claims.

Below the target area graph is a data table that shows us the numbers behind the statistics. So here we see our numerator count for the three fiscal years. This is where we find our denominator count. Numerator divided by denominator gives us the target area percent, which we can see for each of the three years. And this is the value that is graphed as the blue bars above.

If the target area percent is above the national percentile, we will see that displayed in red, bold font, as we do see that for the oldest time period here. We also include the average length of stay for the numerator discharges, the average length of stay for the denominator discharges, the average amount of Medicare reimbursement for the numerator discharges, and the total amount of Medicare reimbursement for the numerator discharges.

Below the hospital's data table is the comparative table data table, which identifies the target area percents that are at the 80th percentile for nation, jurisdiction, and state. If we think about that ladder example, these are the target area percents that are at that point below which 80% of the other percents fall. And these are the values that are graphed up here in the graph as these red trend lines.

At the very bottom of all of our target area reports, we do include suggested interventions for high outliers. If you were a high outlier for this target area, this is a very general sentence or two about what this might mean, and perhaps what records you might want to look at if you were to take a sample of claims, and what you might be focusing on. These suggested interventions are also included in the *IRF PEPPER* User's Guide.

Each of the target areas in the PEPPER has a report that is formatted in the same way. Now, this target area, CMGs At Risk for Unnecessary Admission, this IRF does not have sufficient data to calculate

statistics for any of the time periods for this target area. It means that they had less than 11 discharges for the CMGs that are at risk for unnecessary admission.

This doesn't mean that there's anything wrong with your PEPPER. It's actually not a bad thing if you don't have statistics calculated. You will notice that the graph will not contain any blue bars. And the data table for your IRF will not be populated. Everything is going to be empty with the exception of those 80th percentile data. And you can see here, state 80th percentile is 0. If there are not at least 11 IRFs in your state that have sufficient data to calculate statistics, then the percentiles will also not be calculated.

For *Outlier Payments*, here we can see that our IRF has a pretty low target area percent — short-term acute care hospitals following IRF discharge. The new target area, *3- to 5-Day Readmissions*, this IRF does not have sufficient data to report. In the *Short Stays* target area, below the 80th percentile.

We do include in the *IRF PEPPER* a couple of supplemental reports that are for your information only. They don't have any bearing on whether or not you are identified as an outlier in your PEPPER. This top CMGs report will show you, for the most recent fiscal year the top CMGs by total discharges for that CMG.

We list the CMG number and description, the total discharges here, and if there are fewer than 11, then the CMGs that have fewer than 11 discharges are not displayed here. We show you the proportion of discharges for each CMG to total, and then the facility's average length of stay for that CMG. The report will include up to 20 CMGs, again, as long as they have at least 11 discharges.

And then there is some summary information for the top CMGs and for all. We include the same type of information summarized at the jurisdiction level. This is formatted in very much the same way as the hospitals report. The difference is that in addition to the jurisdiction average length of stay for the CMG, we also include the national average length of stay for the CMG.

The other report is Average Length of Stay by Case Mix Group here and by Discharge Destination. Here, we have a couple of tables. And this is for the IRF discharges for the most recent fiscal year. We are showing you the number of discharges for each of these tier groups, the proportion of all discharges, the IRFs average length of stay, and then the jurisdiction average length of stay. These are the tier levels. And then we also look at discharge destination by number of discharges for each of those discharge destinations, the proportion of all discharges, the IRF average length of stay, and the jurisdiction average length of stay.

Below the table here, there is a description of what these categories for discharge destination include. And there are five categories. And again, the categories will display if there were at least 11 discharges in the most recent fiscal year. So that's at the IRFs level, and then we summarize that same type of information at the jurisdiction level. Again, for comparative purposes only, supplemental information that you might find helpful.

All right, we'll go back to our presentation now and move along. Sometimes, people will ask me if they have to use their PEPPER — if they have to take any action, take any next steps in response to their

PEPPER statistics. The answer to both of those questions is no. You're not required to use the PEPPER or to take any actions regarding your PEPPER statistics.

I always like to remind folks that there are other contractors that are sifting through the Medicare claims data looking for providers that could benefit from some educational interventions, perhaps a focused medical review. The value in the PEPPER is that it can help you determine or identify upfront when your statistics look different from the majority of other providers. And that way, you can have that heads up.

You can prepare by examining and thinking about whether the statistics in your PEPPER appear as you expect them to be, if you expect to look different from others. Or on the other hand, it could give you a heads up that perhaps there's something you might be concerned about. And you can take a closer look and just be ready if you might be contacted by any of these contractors. So the PEPPER is just really a roadmap, gives you that heads up. And I would encourage you to take use of this free data report that's made available by CMS.

How do you get your PEPPER? Again, the PEPPER is distributed electronically. And the PEPPER currently is distributed in two different ways based on whether or not you're a free-standing IRF or if you are a hospital-based IRF. Units of hospitals will receive their PEPPER through QualityNet distributed to the hospital QualityNet administrators. Many times these are the folks who are involved in submitting the hospital quality data.

We also distribute the PEPPERs to people who have basic user accounts in the PEPPER recipient role. The PEPPER will be available in the QualityNet account for 60 days from the date that it's uploaded. If you miss it, you can still download your PEPPER. But you will need to contact us through our Help Desk and ask us to upload it again.

The free-standing IRFs and the IRFs that are units of critical access hospitals will receive their PEPPER through our PEPPER Portal. That's accessed on the website or through the website. There are some instructions there that I would encourage you to review if you haven't utilized this process before. We do make the PEPPERs available for approximately two years from each release date.

You will need some information to access your PEPPER through the portal. You'll need your six digit CMS certification number, also referred to as a provider number or PTAN. And then, for verification purposes, you will need a patient control number or a medical record number from a claim for beneficiaries who received services between July 1 and September 30 of 2019.

These would be claims for traditional Medicare fee-for-service beneficiaries. And again, this is to ensure that we validate that you are someone with the hospital with an IRF who should have access to the PEPPER because the PEPPERs are not publicly available. We only make them available to each individual provider. Now, that validation code is updated for each release, though the validation code that you use last year will no longer be accepted this year. We do refresh that every year.

And if you're having trouble accessing your PEPPER, please do contact us through our Help Desk. We want you to be able to access your PEPPER. We don't want you to be frustrated. So if you're having some trouble, if you're struggling, contact us through our Help Desk, and we'll help you out.

Now, a heads up for the future distribution of PEPPER. The QualityNet system is being phased out by CMS in late 2020. And so we have been having some internal discussions with CMS. In the future, all of the PEPPERs may be distributed through the PEPPER portal.

We are also considering making some changes to the way the validation code is handled. We might be emailing the validation code to providers to the contact that is listed in the National Plan and Provider Enumeration System, or NPPES, or the Provider Enrollment Chain and Ownership System, PECOS. So this will be a good opportunity for all of you to make sure that the contact information listed in both of those systems is current. As more information becomes available, we will be committed communicating with the provider community, but it's always a good idea to make sure that that information is current in those systems.

So once you have your PEPPER, let's just say you see a lot of red in there, what should you do? The first thing you should not do is panic. I want you to remember that, by design, the PEPPER is going to identify the top 20% of the providers as outliers for those target areas. Just because you're an outlier, it doesn't necessarily mean that you're doing anything wrong or that compliance issues exist.

But if you are an outlier, again, think about why that might be. We talked about some of this during the earlier stages of the presentation. When you're looking at your PEPPER, do you expect to see those statistics as they are? Are there factors that could impact the way that your statistics look?

If you have any concerns, if there's any little uneasy feeling when you're looking at the data, and you're thinking this doesn't look right, I would encourage you, again, coordinate internally. Sample some claims. Review some documentation in the medical record. Make sure that everything is coded and billed correctly. The bottom line, really, is that you want to ensure that you're following best practices, even if you're not an outlier.

Moving on to the resources that are available on the PEPPER website. For each release, we put together national level and state level data available on the pepper.cbrpepper.org website on the data page. This is information for each of the target areas, as well as the top CMGs report and the average length of stay by CMG tier and discharge destination. So all of that's on the data page.

And we also filter it out looking at all IRFs in the nation, and then comparing freestanding IRFs to IRF units of hospitals. And again, all of that is updated annually following each report production.

Recognizing also that some folks might want to compare their statistics to a group that they consider to be more like them, their peer, we put together a peer group bar charts that identify for each of the target areas the 20th, the 50th, and the 80th national percentile for IRFs in three different categories. We look at size, which is based on number of discharges. We look at location, which is either urban or rural, and then ownership type — for profit or physician-owned versus non-profit or church owned versus government.

These peer group our charts are also updated annually. There are a couple of documents there that can give you more information as to how we put these together. That's the methodology. And then the IRF by Peer Group file will identify for you which of those subcategories or each of the topics that your IRF was categorized in.

If you disagree with your ownership type or location, you will need to work with your CMS regional office to make that change. Our team utilizes the CMS Provider of Services file to make the ownership type and location determinations, and that information is maintained by the CMS regional offices. So if there's something there that you're not agreeing with, you'll need to work with your CMS regional offensive coordinator.

This is an example of what the peer group bar charts look like right now. For each target area, this example is the *CMGs at Risk for Unnecessary Admissions*. We have three bar charts. The top one is looking at discharges, so that's size. Middle one, pink, is location, urban or rural.

And then the bottom one is ownership type, for profit or church, government, or for profit. And here we can see how the 80th, 50th, and 20th percentiles are different for each of those subcategories in these different care groups. So if you wanted to compare your target area percent with the peer group that you feel is most like you, this is a handy reference for you. I'll also mention that right now our team is working on making some changes to these reports, and so the format may appear different as what's in the slide today.

You'll also find on our website on the "Training and Resources" page a number of other resources we maintain a PEPPER User's Guide that you may find as a handy reference. There is also a spreadsheet there that identifies the total number of IRFs in each jurisdiction in total and also by state. We have those recorded PEPPER training sessions. And there is also a sample *IRF PEPPER* that you can review.

If you need assistance with PEPPER, if you have questions about the statistics, if you're curious about how you might use this information, if you need assistance accessing your report, contact us through the Help Desk. Again, that's on our website. There is a form that you will complete, and a member of our team will respond promptly to assist you. Just a reminder to not contact any other organizations or associations for assistance. We are the official source for guidance and information related to the PEPPER.

This is screenshot of the home page of the PEPPER website. You can see the blue arrow there pointing on the right to the Inpatient Rehabilitation Facilities box. You can easily access the User's Guide, the "Training and Resources" page, and the PEPPER distribution page right from the home page there. So all of that information is easily accessible.

The Help/ Contact Us tab, it's a little bit hard to read, but it's up there towards the top-right of the screen, and that's where you'll request assistance. So if you do have questions, please visit the Help Desk at pepper.cbrpepper.org. We'll be glad to help you. Thank you so much for joining me today.