Transcript for the Q4CY21 *Home Health Agencies (HHA) Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

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I want to welcome you all today 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 & 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 in the very first question that is listed.

Before I move on to the content, let me review some housekeeping items. Because I am recording today's session, the phone lines will be muted the entire duration of the training. If you have questions, you may submit them at any time using the Q&A panel on your computer screen. I will answer questions verbally at the end of the session as time allows and a Q&A document will be developed and posted within two weeks of today's date.

Today, I will be focusing on the most recent release of the PEPPER for Home Health Agencies. That is the version fourth quarter, Q4, calendar year, CY21. In this release, there are some new target areas, and we'll review all target areas and how each is calculated. We will look at a sample PEPPER and we will review some other resources that you might find helpful, which include the national and state level data reports that are available on the website and the peer group bar charts.

Today's presentation will be a high-level review of the PEPPER. So, if you are familiar with PEPPER, this will be a nice refresher. But if you're new to PEPPER, you might still have questions at the end of the session. And we have resources available to you to help if you do have questions and these resources can be accessed through the PEPPER website in the Home Health Agency “Training & Resources” section. And, of course, our website is PEPPER.CBRPEPPER.org.

So, let's start at the very beginning. What is PEPPER? Well, PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report. A PEPPER is a comparative report that summarizes one hospital's Medicare claims data statistics for areas that might be at 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 policies.

In the PEPPER, these areas that might be at risk are called target areas. The PEPPER summarizes your hospital's Medicare claims data statistics for these target areas and compares your statistics with aggregate Medicare data of other hospitals in three different comparison groups. These comparison groups are all hospitals in the nation, all hospitals that are in your Medicare Administrative Contractor or MAC jurisdiction, and all hospitals that are in the state.

These comparisons are the first step in helping to identify where your claims could be at a higher risk for improper Medicare payments, which in the PEPPER world means that your billing practices are different

from most other providers in the comparison group.

I do want to stress that the PEPPER cannot identify improper payments. The PEPPER is a summary of your claims data and can help identify or alert you if your statistics look unusual as compared to your peers, but improper payments can only be confirmed through a review of the documentation in the medical record along with the claim form.

Taking a look at the history of the PEPPER, we can see that the program began back in 2003. TMF Health Quality Institute developed the program originally for short term acute care hospitals and later for long term acute care hospitals. In 2010, TMF began distributing PEPPERs to all providers in the nation and, along the way, they developed PEPPERs for other provider types, which you can see on this slide here.

Each of these PEPPERs is customized to the individual provider type with the target areas that are applicable to each setting.

Then in 2018, CMS combined the comparative billing report, or CBR, and the PEPPER programs into one contract and the RELI Group and its partners, TMF and CGS now produce CBRs and PEPPERs. While the CBR program produces reports that summarize Medicare part B claims data, the PEPPERs summarize Medicare part A claims data. These reports are produced for providers across the spectrum that help educate and alert providers for areas that are prone to improper Medicare payments.

So, why does CMS feel that these reports are valuable and support their agency goals? Well, CMS is mandated by law to protect the Medicare Trust Fund from fraud, waste and abuse. And they employ several 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 Contractor, a recovery auditor or some other federal contractor.

The provision of PEPPERs to providers supports these strategies. The PEPPER is considered an educational tool that can help providers identify where they could be at a higher risk for improper payments. The providers can proactively monitor and take measures if necessary.

I 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 billed and that those services are reasonable and necessary. PEPPER supports the auditing and monitoring component of a compliance program.

Let's focus now on the PEPPER for Home Health Agency. This newest release was made available in July of this year. This release summarized statistics for three calendar years. We are looking at calendar years 2019, 2020, and 2021. And the reason that we call this version Q4CY21 is because the report summarizes statistics through the fourth quarter of calendar year 2021.

Now, those of you who are familiar with PEPPER know that each time we produce a new report, we refresh the statistics for all time periods and all target areas. So, it is certainly possible 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 the numerator or denominator counts or maybe the national or state or jurisdiction percentile values. That would be expected because the refresh statistics are going to reflect any

corrected claims that might have been submitted, any late claims, those types of things.

So, there will probably be or there may be some slight differences in those numerator or denominator counts. Each time we produce a PEPPER, the oldest calendar year rolls off as we add that new one on.

Let's move on now to the focus on the improper payment risks that are pertinent to the Home Health Agencies. Prior to January 1st, 2021, Home Health Agencies were reimbursed through the home health PPS or perspective payment system, which paid higher rates for services to beneficiaries that have greater needs. Payments were based on a 60-day episode payment.

This reimbursement structure has changed under the patient driven grouping model, PDGM. The PDGM model has a 30-day payment period. The previous home health PPS had been identified at risk for improper Medicare payments. In particular, over the past few years, those of you who keep track of the improper payment reports that is produced by the comprehensive error rate testing, or CERT contractor, know the most recent estimate for 2019 was that 12.1% of home health claims were found to be in error, resulting in a projected improper payment of over $2.3 billion.

Now, this high level of projected improper payments probably played a part in the transition to this new payment model.

Prior 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. After reviewing studies that were related to improper Medicare payments, national level claims data and an OIG report from 2012 that identified six measures of a questionable billing, we worked in coordination with CMS subject matter experts to create the current target areas.

I also want to mention that all target areas are evaluated on an annual basis and can change over time as we continue to assess the home health improper payment risks.

The patient driven grouping model, PDGM, went into effect at the beginning of 2020 and again our team coordinated with CMS to adjust the PEPPER accordingly. This PEPPER version Q4CY21 does reflect the PDGM statistics and the modifications that were made to the PEPPER.

CMS has developed many resources for providers related to PDGM and you can find them on the CMS website through the link shown on this slide.

The target areas in the HHA PEPPER were created according to the potential risk for Medicare payments and 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.

In home health, we have two different types of results. Some target areas have a result that is a rate and these target areas are calculated with a calculation where the numerator and the denominator are different units of measure. Some of the target areas are reported as a percent. In this calculation, the numerator and the denominator are reported or measured using the same units and the numerator is a subset of that denominator.

Here we have a list of the target areas that are in the HHA PEPPER. You can see this is the beginning of

the list, actually. There are more coming. But you can see here these high morbidity and *High Comorbidity* and *Low Comorbidity* were new as of last year's release of the Q4CY20 release. But we have one, the *Functional Impairment — Medium* new as of this release, the Q4CY21 release.

And then the *Functional Impairment — High* is new as of this release. We have *Average Case Mix*, *Average Number of Periods*. *Periods with Low Visits* and that one was revised as of the last release. *Non-LUPA Payments*, *Outlier Payments*, *Admission Source*, again, relatively new, that one. Sorry. Went too far there.

We have these target areas listed for you here. And we do have the target area definition. But when we get to this sample PEPPER, we're going to be able to see these definitions in the PEPPER and these definitions are also available on the user's guide. And the user's guide is posted on the "Training & Resources" page for home health agencies on the PEPPER website, which is PEPPER.CBRPEPPER.org.

In the PEPPER, we are going to see percentiles and we're going to see data listed according to where the outcome falls in a percentile compared to, again, the nation, the jurisdiction and the state.

So, how do percentiles work? Let's take a look at that before we get to the PEPPER. This slide can help us to understand how the percentiles are calculated. The ladder image is a great representation of how we do that. Next in the ladder is a list of the target area percents sorted from highest to lowest. The first step our team takes when we calculate your hospital's percentile is to take all of these target area percents for a target area and a time period, the target area being the calendar year 2021 or 2020 or 2019. And the target area being one of the ten target areas that we just took a look at.

We take the target area percent outcomes for all the facilities in the nation and we sort them from highest to lowest. And that's what the ladder represents. You can see the percents listed from highest to lowest down the ladder.

Next, we identify the point below which 80% of those hospitals fall. That point is identified as the 80th percentile. So, any hospitals that have a target area percent that is at or above the national 80th percentile, will be identified in the PEPPER as a high outlier. A high outlier is identified in the PEPPER target area tab data by red bold font. And a high outlier outcome could mean potentially over-coding or it could just mean that your statistics look different for a justifiable reason - another justifiable reason.

Before we review a PEPPER, let's review the comparison groups again. On this slide, the visual reminds you that we do have three comparison groups; the nation, the jurisdiction, and the state. Sometimes the MAC jurisdiction comparison group is confusing to people. So, to simplify, think about it as being comprised by all of the providers that submit their claims to the same MAC. Those are the providers in the MAC jurisdiction comparison group. And that way, in that comparison is a way of giving us a smaller group to compare the nation and larger than the state. So, we have three really great beneficial comparison groups to show.

So, I'm going to go to our sample PEPPER now so we can see in an actual document how all of this data is presented for our use.

Okay. Here we have the Home Health Agency PEPPER, and it is distributed in an excel format, as you can see here. And along the bottom, you can see the different tabs that are available in the report. It is a

lengthy report. And it holds a lot of data, but all of the data that is housed here is extremely beneficial and can really help with compliance and with education within your facilities, so, we'll see how all that comes together on each of the tabs.

But this first tab is the purpose tab. I like to think of it as an introductory paragraph or an introduction to the PEPPER. It does let you know your provider number so that you can make sure you are looking at your PEPPER. It reminds us that this report is for the most recent three calendar years through Q4CY21. It summarizes a little bit of information about the PEPPER. And, again, lets us know this is the HHA PEPPER and the version that we're looking at. Then at the bottom here, it does list your jurisdiction.

So, when you are going through the data and you're looking at your comparisons, you can know you are in jurisdiction 15 and, of course, you can make sure that it is the correct jurisdiction that you would expect to see.

I mentioned before the definitions on the slides for each of the target areas. And I mentioned that they are available on in the user's guide. But the definitions tab, this next tab also houses all of that information for each of the target areas. You can see them listed here down the slide on the left and then the definition for each target area is written next to it.

So, we're about to be looking-- we're about to look at a lot of data and a lot of information for each target area. And this tab is a wonderful reference if you're looking at your PEPPER and you're thinking, okay, I'm looking at this target area. Which--what does this numerator mean? I forget. What does this denominator represent? I forget. You can click back to this definitions tab and all that information is here for you.

And we can just scroll down here. You can see all that information.

And if we look at just this *Average Number of Periods*, uh, the numerator is account of periods paid to the HHA during the time frame and then the denominator is a count of unique beneficiaries served by the HHA during the time frame and you can see the note here. It's reported as a rate, not a percent. That makes sense because of what we talked about earlier in the slides.

If a target area has a numerator that is a different unit from the denominator, in this case the numerator is a count of periods and the denominator is actually a count of beneficiaries. So those are two different items that we're looking at, two different things. And, so, the calculation is reported as a rate. But if we go up, let's take a look at the high comorbidity.

The numerator is a count of periods with two secondary diagnoses that qualify as a high comorbidity adjustment. And then the denominator is the count of periods paid to the Home Health Agency during the time frame. So, in the denominator, we're looking at the entire group of periods that were paid. And we're saying of that entire group of periods of that entire count of periods paid, what percentage of those periods had two secondary diagnoses that are high comorbidity adjustment? And we will see these, as well, when we go to each tab, but I just wanted to, again, call attention to the different ways that these target area calculated and why they are calculated in those ways, either as a percent or as a as a rate. Excuse me.

All right. Let's move on to the compare tab. Now, this compare tab is a little bit of an introductory data

set that we have. You can see the target areas are listed here. The report or the reportable data that is listed, excuse me, on the target area, or excuse me, on this compare tab represents any target area that has 11 or more target discharges. Excuse me, in the most recent time period. So, of course, we are working with a lot of home health agencies. We are working with a lot of data.

Excuse me for one moment.

Sorry about that. Wet my whistle a little bit.

So, the threshold that we place, uh, within the PEPPER and within this compare tab specifically is 11 or more target discharges. So, if that numerator or that denominator is not 11, you're not going to see that target area listed on this tab down here on this list to the left.

So, if you get to this compare tab and you are hesitant or you don't see all of the target areas listed, that is okay. That does not mean necessarily there is something wrong. It doesn't mean that there's anything wrong. It just means that any missing target area fell below that threshold of 11 target discharges. I want to point that out because we will see it again within the PEPPER.

Okay. So, we see a lot of information here. We see the numerator counts or the amount. Amount comparing to referring to the *Outlier Payments*, of course. And then we have the percent or the rate.

Now, next to that for each co, excuse me, each target area, we're looking at low comorbidity. Let's look at that. We have the national percentile, the jurisdictional percentile and the state percentile. So, for example, looking at this sample PEPPER, of course, if this sample provider or, excuse me, this sample Home Health Agency is the national percentile is 59.9. That means that 59.9% of the home health agencies in the nation have a lower percent value than that, um, Home Health Agency.

From now on, I'm going to just talk about this PEPPER as if it is our PEPPER and we are looking at our statistics. As a group so I don't have to keep saying sample PEPPER provider, sample Home Health Agency provider.

So, we are looking at our Home Health Agency and we can see that our percent, or rate, percent, for this target area was 38.2%. That means with that outcome that means 59.9% of home health agencies had a lower percent value than us.

So, on that list next to the ladder, we are looking at we are at the line that has 38.2. We are at that level, wherever that may fall on the ladder. And 59.9% of the rest of the list is below us. And you can see here in the *High Comorbidity* and down at admissions source, we have some red bold font. We know from our slides that that means that this is a high outlier status. Let's look at those in detail when we get to each of those tabs. But let's start with the next tab, which is low comorbidity.

Now, after we get past the purpose and the definitions and the compare tab, which are kind of introductory tabs for you, we get into the deep dive of the data for each of the target areas. And, of course, first listed is the low comorbidity.

Each one of these target areas is going to be set up exactly like this. You're going to see the data listed exactly as you see here for each of these tabs as we move forward. You'll see. But I just want to go into detail looking at this one so that we can get used to the formatting and we can get used to how we're

looking at the information that was submitted.

We have the Home Health Agency information here, so this is our home health. These are the details and the outcomes that are for our Home Health Agency. We can see in calendar year of 2019 there is a no data listed. If you see this in your PEPPER, do not panic. There is not an issue. There is nothing wrong. And there wasn't a computer error or anything like that. But we are looking at a threshold of less than 11 for the numerator or the denominator.

So, in calendar year 2019, this Home Health Agency had less than 11 either in the numerator or the denominator or both for the specific target area. So, we're going to see zeros down that entire column calendar year for 2019. And that's okay.

Let's move on to calendar year 2020 and calendar year 2021. If we look at this top chart here, this top table we have our outlier status, and, again, we don't see any red bold font, so we are not an outlier for this target area. The target area percents is next and that is the calculation. That is your spot on the list down that ladder. And then, of course, we give you the final calculation, but we also give you the data that brought us to this calculation. In 2021, the target count for *Low Comorbidity* was 7,800, basically. And this 7,800 is in the numerator. Now, if we forget what the numerator is we can hop back to our definitions tab. And for low comorbidity, we have the numerator is the count of periods with a secondary diagnosis that qualifies as a low comorbidity adjustment paid to the Home Health Agency.

So, when we're looking at this data, again, if we get a little forgetful or tripped up about what exactly we're looking at and what these numbers represent, that compare tab is there for us. And I just want to say, again, that, um, 80th percentile, that is the line that is drawn across the list of outcomes for all the home health agencies and that is a line that is drawn at the point below which 80% of those home health agencies fall. So that is that 80th percentile line.

But let's get back to the *Low Comorbidity* target area for us. We are this Home Health Agency today. We had 7800 in our numerator and then our denominator was about 20,000 - 20,400. So again, we give you – excuse me, your target area, 28%, your outcome. That's the number on that ladder list and again, we give you the numbers we use to calculate that information. Not only do we give you the raw data that we use, but we also take it a step further and give you some more data relating to the numerator and the denominator.

We take a look at the average length of stay for all the items that are included in that numerator and all of the items included in that denominator. And then we take a look at focusing on the numerator here, the average payment of all 7,800 of these items. The average payment was about $2,000. The sum of payments for that numerator was $16 million - $16.1 million. 16.7 in the prior year.

This is a great PEPPER to take a look at because it does show there are shifts, there are changes in Home Health Agency data. You, uh, would not expect to see the same information. These calendar years are very close. Their data is very similar. There wasn't any huge leaps for this target area.

But if you do see a wide change in those areas or in the target count, the denominator count, that type of thing, you want to use that as a prompt to take a look at the items that are included in this target area calculation and, uh, see if the if that jump or that fall is expected, according to the care that you

provided through your Home Health Agency in those two calendar years.

This top table has all of our home health agency information. The second table listed is the comparative data, the good stuff, as I call it. The data that is going to compare us nationally, with our jurisdiction and with our state. Now, again, we have nothing in the calendar year 2019. But for calendar year 2021, again, let's leap over to that, the national 80th percentile was 42.4%. So, on that ladder in the list, that black line or let's think of it as a red, bold line was drawn across 42.4 because 80% of the providers fell below that mark.

Now in the home health agency we also look at the 20th percentile. This- for this calendar year, for this target area was 27.8. So, on the ladder, there's a green bold line drawn across through 27.8. Below that green line, 20% of the outcomes fall. So, we are not for this target area, in the national 80th percentile, so we are not above that red line and we're not below the green line. And we can use the data from the first table to kind of take a look at that and if it doesn't make sense we can have a look at it a different way using our Home Health Agency data in this top table. Let's look at the national 80th percentile. It's 42.4. Our target area percentile was 38.2. So, if you're thinking of a list of outcomes, highest to lowest, 38.2 is lower than 42.4. So, we are below that red, bold line.

Let's take a look at the lower end, the 20th percentile, that green line is 27.8% for the national comparison group. Again, our status- excuse me, our outcome was 38.2%. 38.2 is a bigger number that's 27.8. So, I just wanted to show you a different way of looking at the data and thinking about the data and taking a look at it so you can use your PEPPER in the best way possible.

If we scroll down, we can see there is a graph here. This graph represents this comparative data that is listed in this chart area. And it also represents the information that is listed for our Home Health Agency in this top table. And it does that by combining two types of charts, as you can see here. These blue bars, the bar charts, are our Home Health Agency's outcomes for this target area for either calendar year 2020 or calendar year 2021. Or calendar year 2019, if we had data for that time period, but we don't. So, we're starting at zero over there on the left.

Let's look at, again, let's look at calendar year 2021 since that is our most recent. If you hover over the bar, it will come up with the series value, 38.9. That sounds very familiar, doesn't it? 38.2. That is our target area percent. These bars represent these outcomes that we are seeing up in this top table.

Now, the line graph points, you can see there's red and then there's green. The red dot points for these line graphs, you can see a solid, a dash and then a dotted red line. And those represent the national 80th percentile. That is the solid red line with a diamond at each point. The state 80th percentile is the dashed red line with a triangle. And then the jurisdiction is the 80th for the 80th percentile, excuse me, is the dashed red line with it looks like a square. It will be a square with rounded edges.

So, you can see those plot points here.

Now, they are outside of these bar graphs. That is because we are not high outliers. We are not above the 80th percentile dot. And that is, again, another way of looking at it here. A lot of people are visual learners in terms of looking at the graph like this. A lot of people like to look at the raw data. So, we offer it all to you, so that you can see all the information that you want to see in the way that is best for

you to see it.

Now, the national and jurisdiction and state 20th percentile is also on the graph. Those are represented by the green, the solid green with a square is the national 20th percentile. The jurisdiction 20th percentile is the dashed line with a circle and then the state 20th percentile is the dots with a true square, it looks like. And, again, those plot points and those line graph points fall within our outcome. Because our outcome total is higher than this 20th percentile mark. So, this is what we would expect to see after reviewing the data that we had up top on those two tables.

If we keep scrolling down, not only do we give you all of this great data and all of this comparative data and information, but we also let you know some suggested interventions. A lot of people say, okay, I understand the data. Now what should I do with it? How can I apply this to my Home Health Agency? How can I apply this to my compliance program?

Well, you can see here we have the suggested interventions. If we were a high outlier for this target area, what should we do? What does that mean? Well, it indicates here it could be a risk of over-coding of those secondary diagnoses. And we suggest that you review medical records to make sure that the coding was substantiated in the medical record. If it wasn't documented, it wasn't done.

So, the same for the 20th percentile, we have suggested interventions here. This could mean potential under-coding. Again, review the records. Make sure all those secondary diagnoses, excuse me, were captured and submitted with the service.

Again, we give you all of this data and we want you to have all of the data and the comparison numbers, but we also want you to be able to apply the knowledge that you gained from this PEPPER and from each target area. We want you to be able to apply that to your everyday management of your Home Health Agency.

Let's take a quick look at--well, let's take a look at high comorbidity. I'm not going to go through all of the tabs in that great of a detail because I feel like that would be very dry and, again, they are all, excuse me, they all are formatted in the same way. And let's take a look at this *High Comorbidity* just to see how that is correct. So, we have our Home Health Agency information. We see some red, bold font. Okay. What does that mean?

Remember, we are a high outlier. What does that mean? That means that our outcome of 20.7% was higher than that red, bold line on the ladder. Our outcome was higher than 80% of the home health agencies' outcomes for this *High Comorbidity* target area. So, we are marked as a high outlier. Now, we'll talk about this when we get back to the slides, but this does not mean that you need to panic. It does not mean that a compliance issue absolutely exists or there is a problem, but it is a prompt for you to take a look at your records, see if there's anything that you might need to do. Of course, when we get down to that section of this tab, you can take a look at the suggested interventions. But let's look again at this table for our Home Health Agency. The target counts of the numerator for this target area for calendar year 2021 was about 4,200. The did denominator count, 20,000. Again, we give you the information in the data, take it one step further and let you know the numerator and denominator average length of stay.

Then we have the average payment and the sum of all payments and this Home Health Agency's bringing in about 9.6 million dollars for this target area. For the calendar year.

Moving down to the comparative data tab, let's look again. Let's concentrate calendar year 2021. That national 80th percentile, think of the ladder, outcomes listed down. That red, bold font line is drawn through 18.3. What was our target area percent? 20.7. So, obviously that is a higher number than 18.3. We are in the 80th percentile and we want to note that we are recognized as a high outlier for this target area.

The 20th percentile is 8.3, we are not identified as a low outlier here. It would be impossible to be both. But the low outliers would be anybody below 8.3 and of course we're up at 20.7.

Moving down, we have the graph. Again, the bar chart is going to represent our Home Health Agency's outcomes for this target area.

And then you can see the plot points for the line graph is a little different, it looks different for this target area because we are a high outlier. Our outcomes did fall over this national 80th percentile line. And that is just what we looked at up top with the table. So, this is, of course, what we would expect to see in this graph that kind of gives a visual of those data plot points. And then the green bold line with the square is the national 20th percentile, again we were not below that. Those are plot pointed within our outcome bar chart.

So, the suggested outcomes for this target area might be something that we take a closer look at because we are noted as a high outlier. Let's take a look. The suggested outcome, excuse me, the suggested intervention, again, this could be a risk of potential over-coding of your secondary diagnoses.

Again, review those medical records, make sure that the coding of the diagnoses is correct. And that it is substantiated in the medical record.

Let's move on to the *Functional Impairment — Medium*. This is a new target area for this year. Let's take a look at the definition. For this target area in the numerator, we're going to have the count of periods with a functional impairment level of medium paid to the Home Health Agency during the time frame and then the denominator is the count of all of those periods. So, we will keep that in mind. As I said, I'm not going to go through this in great detail because all of these tabs are set up exactly the same way as those two first data points that we looked at or those first- those two target areas, I should say. But if we take a look, we do have a chart here that maps out all of our plot points and our bar chart. You'll see the state and the jurisdiction line graph plot points do fall underneath the Home Health Agency.

The higher outlier line and that status is only as compared to the national 80th percentile. We do give you, as you can see, of course, the jurisdiction and the state 80th percentile and 20th percentile, but to be marked as a high outlier, you have to be in that 20- or excuse me, 80th or the 20th percentile for- as compared to the national percentiles listed here. Then we have *Functional Impairment — High*. Again, this is new for this PEPPER.

Average Case Mix. This is one that is listed as a rate, not as a percent. And we talked about that earlier.

Average Number of Periods. We have periods with low visits. We have *Non-LUPA Payments*. *Outlier Payments*. And, of course, these are the same that we saw on the slides and on the definitions tab. And

then the admissions source. And this is a relatively new target area here.

You can see if we look at this chart, they just squeaked over the 80th percentile line, it's basically touching on the graph, but if you see here the national 80th percentile, that was drawn on the ladder across 35.3 and their target area is 35.5. So very, very close.

The last two tabs do not represent target areas. But instead, they represent a list of the top clinical groups for this most recent calendar year. So, of course for this PEPPER, that is going to be 2021. And we have the top clinical groups, the Home Health Agency top clinical groups that were used during this calendar year, 2021.

And then we have the jurisdiction top clinical groups for the most recent calendar year. So, this, again, we kind of have an introductory in the first couple of tabs and then we have a step back after all this dense and heavy data to take a look at the clinical groups that have been submitted over the year.

Let's get back to our slides.

So, we looked at the PEPPER. Let's talk about how the PEPPER applies to providers. The PEPPER, again, can help a facility identify areas where they might be outliers. If that outlier status is something that should prompt an internal review within the target areas. We often get questions; do I have to use my PEPPER? Do I have to take any action in response to my PEPPER? The answer to those questions is no. You're not required to use your PEPPER. Although it is helpful information, as we saw.

We encourage you to at least download it and take a look, but you're not required to take any action.

It is important, however, to remember that other federal contractors are also looking through the entire Medicare claims database. They might be looking for providers that can deliver some focused education or maybe even a record review. From your perspective, it would be nice to know if your statistics look different from others so that you can decide if there's something to be concerned about or if you need to take a closer look or if what you're looking at is what you expect to see in your PEPPER.

The PEPPERs are distributed in electronic format and, as we saw, in Microsoft Excel workbook and they available for two years from the original release date. We cannot send PEPPER through email. Because of the sensitive data that's housed within the PEPPER, we have to be judicial in the way we distribute the PEPPER, and it cannot be sent through unsecured Emails.

With this in mind, we do have a portal online that you can use to access your PEPPER and we encourage you to go to the portal and download your PEPPER so you can have it on file for your use.

There are specific people who are authorized to receive the PEPPER. We don't give access to just anyone. We only release a provider's PEPPER to that specific provider, which is why we have the portal and the specific validation code requirements so that not just anyone can come to the website and get your PEPPER. The PEPPERs are not available for public release, and we do not provide PEPPERs to other contractors.

But we do prepare a Microsoft Access database which is called fathom and we do make that available to Medicare administrative contractors and to recovery auditors. And the fathom can be used to produce the PEPPER. While that might sound a little scary to some people, I want to point out that it is important

to remember that federal contractors have access to much more claims data information about providers than what is included in your PEPPER. They also have access to sophisticated data mining tools and other materials that may assist them with their efforts.

I should also point out that law enforcement, such as the Department of Justice or the Office of Inspector General may be able to obtain your PEPPER in an effort to support their internal activities. Again, now while that might sound alarming, remember, the benefit of the PEPPER is that you have an opportunity to have a heads up in the case that your billing patterns might look unusual. And then you can prepare if there should be any regulatory or law enforcement agencies that contact you.

You can access your PEPPER through the PEPPER portal. There are specific portal instructions listed at PEPPER.CBRPEPPER.org. You can go to the link that is the distribution center to get your PEPPER. And then also the validation codes are emailed to the contact that is listed for each Home Health Agency in the provider enrollment, chain and ownership system. So be sure to check your PECOS account and make sure that that information is as it should be so that only the correct person gets that login information.

If you get your PEPPER and you see a lot of red and green, as I said before, indicating that you're a higher or low outlier, don't panic. Remember, just because you're an outlier in your PEPPER, it doesn't mean that any compliance issues exist. And it doesn't mean that you're doing anything wrong. But again, we encourage home health agencies to think about why they might be an outlier and if those statistics in their PEPPER reflect what they would expect to see.

The something doesn't feel right, coordinate with others in your hospital, share the PEPPER information, put your heads together and think about factors. Pull some records and some claims and just evaluate to make sure that you're following best practices.

We do have a number of other resources that are available publicly on our website. PEPPER.CBRPEPPER.org. One of those resources is aggregate information for the target areas, both at a national and a state level.

Again, there is aggregate information regarding the top diagnoses, top therapy sessions and target areas. This information is updated each time we have a PEPPER release.

We also have peer group bar charts which are updated on an annual basis. Some time ago, we did have providers who asked us to make available a comparison that would be applicable to what they consider their peer group. So, these peer group bar charts enable providers to look at that type of information.

We have four different categories. We look at location. So that would be either urban or rural, ownership type, for-profit or physician owned, non-profit or church-owned or government, teaching status or surgical focused. And we do update those peer group bar charts annually. If you find you do not agree with how we are representing your hospital's ownership type or location, that information will need to be updated through CMS. We utilize the CMS provider of services file maintained by the CMS regional offices so you'll need to contact them for that update.

A number of other resources can be found on the PEPPER website. Of course, there's the user's guide, the PEPPER training sessions, a demonstration PEPPER, a spreadsheet that will identify the number of

home health agencies in each of those MAC jurisdictions in total and by state and some testimonials and success stories. There are some nice success stories out there, one in particular from a Kentucky hospital who got a different facilities type of PEPPER, a hospital PEPPER, but they use their PEPPER to help them identify under-coding.

As always, if you need assistance with PEPPER and you do not find the answer you need in the user's guide, please visit the PEPPER.CBRPEPPER.org website. Click on that help/contact us button and then complete the form. A member of our staff will respond to you promptly. Please do not contact any other organizations for assistance with PEPPER.

RELI Group is contracted with CMS to support providers with obtaining and using PEPPER. If you have questions, please contact us we are that official source. Please do not pay consultants to help you with PEPPER. We supply support at no cost and not all consultants are providing accurate information on PEPPER, unfortunately.

This is a screen shot of our website and you can see those resources are easily accessed from our home page. In addition, we have an electronic feedback link. Because our main goal is to provide information and reports that can be helpful in preventing these improper payments, we are interested in your feedback and suggestions for improvement. We strive to make these reports as easy to use and interpret as possible and so we welcome your input.

As we conclude, please take a minute to provide any feedback, especially in the exit survey. Let me know if this webinar was helpful to you. As I end, again, that survey will pop up. We appreciate any feedback that you can provide.

Thank you all so much for joining us today. I hope this was a beneficial webinar for you.