Transcript for the Q4FY21 *Inpatient Rehabilitation Facilities (IRF) Program for Evaluating Payment Patterns Electronic Report (PEPPER)* Review

May 3, 2022

I would like to welcome you all today to this webinar where we will be discussing the Q4FY21 *Inpatient Rehabilitation Facility PEPPER*. My name is Annie Barnaby. I'm an employee of RELI Group, Inc. We are contracted with CMS to produce and distribute the PEPPER reports.

Our agenda today includes a review of the most recent release of the PEPPER for inpatient rehabilitation facilities, the Q4FY21 PEPPER that was released in early April of 2022. I will share a sample PEPPER with you so we can see what the PEPPER file looks like and what the data shows us. We will also be reviewing some other resources, including the national and state level data and peer group bar charts.

So let's get started. Today's presentation will be a high-level review of the PEPPER. If you're familiar with PEPPER this will be a nice refresher. 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. These resources can be accessed through the PEPPER website in the IRF training and resources section and our website is PEPPER.CBRPEPPER.org.

Let's start at the very beginning. What is PEPPER? PEPPER is an acronym that stands for Program for Evaluating Payment Patterns Electronic Report. A PEPPER is a comparative report that summarizes one facility's Medicare claim 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 policy. In PEPPER, these areas that might be at risk are called "target areas." The PEPPER summarizes your facility's claim statistics for these target areas and compares your statistics with aggregate Medicare data of other hospitals in three 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. In the PEPPER world this 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 you identify or alert you if your statistics look different than your peers but improper payments can only be confirmed through a review of the documentation in the medical record, along with the medical 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 the slide. 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 PEPPER programs into one contract and the RELI Group and 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 to areas that are prone to improper Medicare payments. So, why does CMS feel that these reports are valuable and support their agency goals? 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 might be conducted by the Medicare Administrative Contractor, a recovery auditor, or some other federal contractor. The provision of PEPPERs to providers supports all of 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 preventive measures if necessary. I should also mention that the Office of Inspector General, or OIG, requires that providers 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 that auditing and monitoring component of a compliance program.

Now that we have a sense of the history of the PEPPER program, and why it was created, let's talk specifically about the newest release of PEPPER, Q4FY21, the fiscal year 2021. Again, the PEPPER only summarizes Medicare fee-for-service Part A claims data and does not include any other provider types—or, excuse me—payer types, such as Medicare advantage claims.

Every time that a PEPPER is produced and released, the statistics are refreshed through the paid claims database. Therefore, if you're looking at a previous PEPPER release and comparing it to this release, you probably are going to see some slight changes in your numerator or denominator, your percentile, those types of things. That could be because there are late claims that are submitted, or corrected claims, which would both be reflected in the updated statistics. Any time we produce a report, the fiscal—the oldest fiscal year rolls off as we add the new fiscal year.

Let's now talk about the improper payment risks that are pertinent to inpatient rehabilitation facilities. IRFs are reimbursed through the IRF prospective payment system, or PPS. The primary risk that we focus on in this PEPPER relates to coding errors and unnecessary admissions. Those of you who have been working with PEPPER for a long time know that there have been changes in these target areas over the years, and some significant since we first started producing the reports in 2003. The original target areas were identified primarily from information gained through review of the IRF PPS, coordination with CMS IRF subject matter experts, and analysis of national claims data. The target areas are evaluated every year so that we can ensure that all target areas included in the report remain applicable and beneficial. As new risks are identified by recovery auditors or Medicare administrative contractors, or as policy changes are implemented, the Target areas change to accommodate those risks.

The target areas within the PEPPER pertain to a service or a type of care that's been identified as prone to improper Medicare payments. We construct these target areas as ratios, where the numerator is a count of discharges that could be problematic, and the denominator is a larger reference group that also

includes the same numerator discharges. This calculation allows us to calculate a target area percent; we'll talk about target area percents here in just a minute.

We have a list here of the target areas that are in this year's *IRF PEPPER*. Those last two target areas, *3-to-5-Day Readmissions* and *Short Stays* are relatively new. They were introduced in the previous release of this PEPPER.

So how do the percentiles work? This slide can help us to understand how the percentiles are calculated. The ladder image is a great representation of how we do just that. Next to 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 facility's percentile is to take all of these target area percents for a target area and a time period. We take the target area percents for all the facilities in the nation and we sort them from highest to lowest, and that is 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 facilities fall, and that point is identified as the 80th percentile. So, any facilities 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. A high outlier outcome could potentially mean over-coding, or it could just mean that your statistics look different for a justifiable reason.

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

We can see the PEPPER. It is pulled up on the screen. And this is the sample PEPPER that is posted on the PEPPER website in the training and resources section of the PEPPER website for IRFs. This first tab you can see on the bottom that the PEPPER is organized obviously as an Excel spread sheet and the different sections of the PEPPER are listed down here on these tabs.

Currently we're on the first tab, which is purpose tab. And this tab tells us the PEPPER version that we are looking at, so the most recent three federal fiscal years through the fourth quarter of the fiscal year of 2021. It gives us a little bit of information about the PEPPER, what the PEPPER's target goal is. Just make sure once again down here on row 25 that we're looking at the PEPPER that we do want to be looking at. And then the PEPPER also lists your jurisdiction. So this sample provider is in jurisdiction 14.

I do just want to confirm with everyone and ease everyone's mind. This is a sample provider. There is not—this is not actual data. We create a new sample PEPPER to use in these presentations so we're not looking at any one—any one facility's actual data.

If we move to this next tab, it is the definitions tab. We saw in our PowerPoint a list of the target areas that are included in this PEPPER. And the definitions tab breaks down each of those target areas and lets us know what information is in the numerator and what information is in the denominator for the calculation for each of the target areas. You can see this here. If we look at *Outlier Payments* that's the shortest one to take a look at here, the numerator is the count of discharges with an outlier approved amount greater than $0, and then the denominator would be the count of all discharges. So, when we were talking on the ladder slide about your percents and percentiles the percent would be the calculation of this calculation this numerator and denominator count. That is the percents that are lined up and down as we saw in that slide next to the ladder. So then as we said before, we find the 80th

percentile and then that is marked and those providers are sorted as such—or labeled as such on the PEPPER, I should say.

This tab is a great tab to have if you are looking through your PEPPER and wondering, wait a minute, what exactly am I looking at here? What do these numbers represent? It's easy to just go back to this definition's tab. This information is also housed in the user's guide for IRFs, so if you have that downloaded and handy, there is more information in the user's guide. But this definitions tab is a great reference, a great quick reference I should say when you're looking at your PEPPER.

Moving on to the compare tab, we can see here that the compare tab shows statistics for target areas that have what we call "reportable data." Reportable data is 11 or more target discharges in the most recent time period. Again, Q4FY21. The 11 plus is a threshold that we set when we're looking at the data, when we are sorting through all the PEPPER data and if you ever see no data or you see a blank box within your PEPPER, that just means that 11 target discharges that threshold was not met. So it's no need to panic.

On this tab we have the target areas listed here. You can see them right here in this chart. We have the number of target discharges for each of these target areas. We have the provider's percent, and we have the facility, national percentile, jurisdiction percentile, and state percentile and we also have the sum of payments, so, *Miscellaneous CMGs* for this provider the sum of all the payments for this data period is a little over $8 million. And we can see here this percent is highlighted in that red, bold font. We're going to see that a little bit more in detail when we look at the tabs for each individual target area. But you can see that it is indicated here as well.

So if you look at this information, I want to make sure everyone knows what this information represents. Let's take the *Miscellaneous CMGs* for an example again. The facility national percentile is listed here at 89.7 percent. That indicates that 89.7 percent of the IRFs in the nation had a lower percent value than this sample IRF provider. That same goes for the jurisdiction and the facility state percentile, those two columns and the same goes, of course the rest of the way down the chart for each of the other target areas. And it does mention up here the greater the percent value, particularly the national and jurisdiction, the greater the consideration should be given to that target area.

When we get to each target area tab, I'm going to show you some great information that we have about taking consideration of your target area percents and your percentiles and how everything falls into place.

Let's take a look at that first here. Sorry about that. Let's take a look at that first here with the *Miscellaneous CMGs* target area, the one we kind of just focused on in the last compare tab. This is the first listed target area. Let's break all of this down and see all the information that this PEPPER is giving us. This PEPPER represents three fiscal years-2019, 2020, 2021. For each of those three years, the PEPPER offers the outlier status, your outlier status. This was a high outlier for all three of those years. The target area percent for this provider, now, if we forget how we calculate that, we can hop back over to the definitions tab. But the target area percents are listed here. 19.9, 21.2, 21.3. I do just want to go through those because—I read them out loud to you because I want you to see that the target area percent doesn't have to remain static to be a high outlier. All of this data changes from year to year,

including the jurisdiction, the state, the national, and the sample provider or the providers' data. So all of that is changing as claims come in and as claims are being reviewed and analyzed. So we are going to see changes, of course, throughout the years, but I just wanted to point that out.

The next row down is your target count. That represents the numerator in our calculation for each of these target areas. The target area for this provider went up over these three years. If we want to talk about this PEPPER release, we're going to focus on column D over year, FY 2021. The target count was 432, denominator count was 2,031, which gives us our percent of 21.3.

Not only does the PEPPER give us all this raw data. We want you to be able to know how we calculated this information, where we got our data, how we got those calculations, but we also want you to know a little bit of extra information about this target area and about those target counts. To that end, we have on row 10 the target area—excuse me—the target average length of stay. So of those items that are in the numerator, what was the average length of stay for the sample provider 11.2? Then same for the denominator, 12 even. We also have the average payments for the numerator and then we have the sum of payments for the numerator. You might recognize this figure. We saw it on the compare tab for this provider for FY 2021. The sum of all these payments was, as we said before, a little over $8 million.

That first table that we see on the tab is the—your specific IRF's data but, the PEPPER is a comparative report, so of course we also offer you the comparative data. What data is being used to compare your IRF? How are we getting these high outliers? What terms are we using? What data are we using? That's listed for you under the comparative data.

Again, let's focus on fiscal year 2021. We can see the national 80 percentile was 80.6. Jurisdiction 15.7, and the state was 17.9. And again, we have this reminder that the state and/or the jurisdiction percentiles would be 0 if they were fewer than 11 providers. That threshold comes back into play here as well. Let's scroll down and look at the graph. As we're working through each of these target areas, as I said, the top that top table will be your specific facility's data. Second table will be the comparative data what we use to compare. Then this chart below mixes or melds, I should say, both of those data sets together so that you can see all the information on a graph. I think this is great because different people review data in different ways. Some people are visual learners—they like to look at the graph. Some people would rather look at the table and that makes more sense to them. We've provided both of these for you so that you can easily look at the data and see what's going on with your comparison groups.

We look at this table. We can see that these blue bars are the specific IRF's outcomes. Let's look at fiscal year 2021. So right here if we hover over it, it will say the value, 21.27. That's been rounded up, up here to the target area percent. This provider was a high outlier for all three years and you can see that listed here in the graph because the line graphs all fall within, or I should say below the facility outcome for this target area. So the national jurisdiction and state 80 percentile are listed here. And again, we can go up here and see for each year this dashed line is the jurisdiction, 15.7. This dotted line is the state again, look up top at the comparative data and you can see 17.7 and then the national is 18.58. These represent the 80 percentile. So if those bars are higher than any of these dot point, doesn't have to be all three. It is for this provider, for this target area, but it does not have to be all three. It can be in one of these data points for these line graphs. Those fall within the bar chart. Then that provider is higher than

the 80 percentile and therefore would be highlighted as a high outlier for that target area.

As I said before, there are some suggested interventions. The compare tab has mentioned the higher the percentile, the higher consideration you might want to place upon that target area. Here we have the considerations listed out for you. We let you know what can I do if I see this data, I'm not sure what to do with it, I don't know how to proceed, I want to make things better but don't know how we have that information here for you. We let you know what that high outlier could indicate and then how to move forward and how to perform a review that can help you to understand your data and how you might be able to change your processes, take a look at your patient population anything, you know, can affect these outcomes. It might be information that you expect to see, and that's perfectly fine as well. You might say, yes, I am a high outlier in this target area because of these factors, but if something doesn't look right and you don't see what you expect to see, then those suggested interventions are a great way to review and see what might be going on.

Let's move on to the CMG target are, the CMG is at risk for unnecessary admissions. This is a great area to review as well because we see the progression of these three years that are listed within this PEPPER. Up top at the your facility table, this is the information for this specific IRF. Let's look at fiscal year 2021 in just a minute, but first let's look at the outlier status. In 2019 there was no data. There were fewer than 11 providers with reportable data for the target area. Again, that threshold. FY 2021 the provider was not an outlier—excuse me—2020 and the same for FY 2021. We have the same information here. We have the target area percent, which is an outcome of the calculation of the two numbers, the target count which is always the numerator and the denominator count. We have information about the average length of stay for the numerator count. It went down, as you can see, from 2020 to 2021. Also, we have the denominator length of stay. It also went down not as drastically at the numerator. We have the average payments for the numerator and then we have total sum of payments for the numerator number. We do of course have a little bit more information about the numerator because those are the data at that are risk for improper payments. That's what we want to focus on. You can see the comparative data listed here, but I want to take a look at the graph. As we saw on the last target area tab, these blue bars were higher, or engulfed I guess you could say. The plot areas and the plot points for these line graphs-you don't see that here. That's because this provider is not an outlier for this target area in any of the three groups. And, again as I said, you can see those plot points are above—well above in this case but above the blue bar outcome for this provider. Again, we have those suggested interventions if you are listed as a high outlier and of course those suggested interventions change for each target area.

The *Outlier Payments* target area for this provider was no data listed. We can see here—what does that mean? It means the target did not—the target count, which is the numerator or the denominator count is less than 11.

We have short term acute care hospital admissions. Let's take a look at this. I'm not going to go through the last two in quite as much detail and I won't go through this one because I don't want to bore everyone. But let's just take a quick look at this target area. We have the outlier status. This provider was a high outlier for the past two years, 2021 and 2020. Very, very similar target area percents for all three years, actually. Same with the target area—excuse me—the target count and the denominator

count.

I wanted to show you this because I wanted to let everyone see that it doesn't need to be drastic changes in the data for the high outlier status to change. So if you see a high outlier status, if it's something that you expect to see, there's no cause for alarm. There's really no cause for alarm at all, but if there are very, very small shifts in this data you could be listed as a high outlier one year and a high outlier the next—excuse me—not a high outlier the next. Take a look at your data. Take a look at what's changed over the years and that will give you a great sense of what's going on as compared to the national jurisdiction and state data.

I also wanted to just take a look here. If you look at the graph, we have of course the blue bars for the provider's data. This provider had a target area of percent in 2020 of 15.4. That is the exact national percentile—excuse me—80th percentile. You can see that dot is just right on the tip of that blue bar. And then they had a target area percent outcome of 15.8 for 2021 and you can see 15.4 again for that national 80th percentile. It remains static but it just is peaking just below the top of that blue bar. And again, of course we have the suggested interventions.

The remaining target areas are—each have their own tab, the *3-to-5-Day Readmissions*, the *Short Stays*. And after the target areas, we have four more tabs here that provide even more data for you and your facility. We have the top CMGs for the most recent fiscal year. This tab is for the most recent fiscal year which is of course 2021. It has a list here of the top CMGs for this facility. You can see them listed here of course. The total discharges for each one, the proportion of the total—excuse me—the proportion of the discharge for each CMG to the total discharges. And then the average length of stay for each CMG. So this can let you know how your discharges are falling, what CMG has the larger percentage and the smaller percentage of those CMGs in regards to the total discharges. This is for your facility.

This next tab is the jurisdictions tab CMGs. You can use this information to compare to your top CMGs. The same information is listed here. Again, this is for the jurisdiction.

This next tab is for the CMG tier and discharge destination. Average length of stay, listed by CMG discharge destination—excuse me. You can see the tiers, the total, and the discharge destination. That's hard to say. The number of discharges, the proportion of all discharges for each of those as well.

This these two columns in this tab—these two columns, D and E, in this tab, I should say, have information about this IRF and then the jurisdiction. Then we have the jurisdiction again. This tab separates out the jurisdiction and the national average length of stay for these CMG tier and discharge destinations.

Again, the PEPPER has a wealth of knowledge on all of these tabs, and there is a lot of information to sort through. There's a lot of information to look at. I don't want anyone to get overwhelmed. However, you have all the time you need to review your PEPPER. We're going to talk about how to download it in just a second, but go through it because it really is incredibly valuable information, and take a look at your numbers. See if they're what you expect to see.

Talking about how PEPPER applies to providers? As I said before, the PEPPER can help a facility to identify areas where they may be outliers, and if that outlier status is something that should prompt an

internal review within these target areas. We often get the questions do I have to use my PEPPER, and do I need to take any action in response to my PEPPER? The answers to those questions are no. You're not required to use your PEPPER, though it's helpful information and we would encourage you to at least download it and take a look. You're not required to take any action.

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

As we saw, The PEPPERs are distributed in electronic format, in a Microsoft Excel workbook and are available for two years from the original release date. We cannot send PEPPER through email. Because of the sensitive data housed within the PEPPER, we have to be judicial in the way that 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 that you can have it in your files for your use.

You will need to enter some information to access your PEPPER through the portal. First, you'll be asked to enter your six-digit CMS Certification Number, which is also referred to as the provider number or Provider Transaction Access Number, the PTAN. This number is not your tax ID or an NPI number. For free standing IRFs, the third digit of this number will be a "3." And then, for short-term, the third digit will be a "0"; for critical access hospital IRFs, this will be a "1".

Now, for free-standing IRFs, if you are a free-standing IRF, your validation code will either be a patient control number or a medical record number for a traditional Part A patient who received services from July 1, 2021, through Sept. 30, 2021. Those are the "from" or "through" dates on a paid claim.

IRFs that are distinct part units of a short-term acute care hospital or critical access hospital will use the validation codes provided to the HARP Security Administrator. You will you that validation code to access your PEPPER from the PEPPER portal

You can see this detailed information that we just went over. And this information is housed on our website in the Distribution Schedule, and when we go to the website to take a look at the peer group bar charts, I'll point out that area.

Please note that these validation codes are updated for each release, so you won't be able to use a validation code that you received for a previous PEPPER release.

If you receive your PEPPER, and you see a lot of that red bold font indicating that you are a high outlier, please don't panic. Remember that 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 you to think about why you might be an outlier. And if those statistics in your PEPPER reflect what you would expect to see. If something doesn't feel quite right, please coordinate with others in your hospital share the PEPPER information, put your heads together, and think about those outside

factors. Pull some records along with some claims, and just evaluate to make sure that you're following best practices.

We have a number of other resources that are available publicly on our website, again, PEPPER.CBRPEPPER.org. Some of those resources is aggregate information at both at a national and a state level for the target areas, top CMGs, and average length of stay by CMG tier and discharge destination. This information is updated each time we have a PEPPER release. At the national level, data is available for free-standing IRFs, and for IRFs that are distinct part units. And again, this data is updated annually.

We also have peer group bar charts, which are also updated on an annual basis. Some time ago, we did have providers who had asked us to make available a comparison that would be applicable to what they would consider their peer group. And so, these peer group bar charts enable providers to look at that type of information. We have three different categories. We look at size, dictated by the number of discharges, location, which is either urban or rural, and ownership type, for-profit or physician owned, nonprofit or church owned or government.

We do update the peer group bar charts annually. If you find that you do not agree with how we are representing your IRF's ownership type or location, that information will need to be updated through CMS. We utilize the CMS provider of services file, and that's maintained by the CMS regional offices, so you'll need to contact them for that update.

Let's go to the PEPPER home page so I can show you the peer group bar chart area and also that distribution schedule. This is our home page. There is a link to the portal, front and center here. If you want to download your PEPPER. It's easy to do so. Just go straight to that link. There are also other links to the PEPPER portal. We want to make sure that, at every turn if you're looking for the portal you have the link easily available. What I was talking about before with the information that you will need to download your PEPPER is in this distribution schedule. As you can see we have the information here for all of the provider types that we have for our PEPPER releases. If we look at the IRFs, we have the distribution date. That was April 5th. Again, we have a link to the portal. We have a direct link to the training and resources, and then right here is the portal access instructions. So if you're having a little bit of trouble, we do have the information listed out here for you.

I'm sorry. I forgot to show the peer group bar charts. Back to the home page. When you are on CBR—or, excuse me—PEPPER.CBRPEPPER.org, if you're looking for the peer group bar charts you're going to go to the data page, and you can see a drop down for all the types of facilities. We're select Inpatient Rehab Facilities and here are those other data resources that we were talking about. They do download as an Excel spreadsheet.

Let me stop sharing this and start sharing the IRF, peer group bar chart. That's better. Here we have these peer group bar charts. As you can see here this demographic group on the first tab is rural versus urban. So we can see 20th percentile, 50th percentile, 80th percentile. That information as we talked about on the slide is housed within these tabs. You can take a look at this information and see how your facility stacks up against these 20th, 50th, and 80th percentiles for each of these peer groups. It's drilled down data that you can take a look at.

As you saw we do have a number of other resources that can be found on the PEPPER website. Of course, we have the user's guide, there are PEPPER training sessions, the sample PEPPER that we reviewed, a spreadsheet that will identify the number of facilities in each of those MAC jurisdictions in total and by state. And some testimonials and success stories. There are some really nice success stories out there. One in particular from a Kentucky hospital that used their PEPPER to help them identify under-coding.

As always, if you need assistance with PEPPER and do not find the answer you need in the users guide, please visit the PEPPER.CBRPEPPER.org website and click on the help/contact us button. You can click on the Help Desk button, fill out the form and a member of your staff will respond to assist you. Please do not contact any other organizations for assistance with PEPPER. RELI Group is contacted with CMS to support PEPPER—excuse me—support providers in obtaining and using their PEPPER. If you have any questions, please contact us. We are the official source of information on PEPPER. Please don't pay consultants. We provide support at no cost to you. And there are some other organizations that might not provide accurate information on PEPPER. If you're working with us you can be sure that all the information you get is correct and accurate

Here's a screenshot of our home page. We saw that as we were looking around to find our peer group bar charts and the portal access.

I want to thank you all for joining us today. I hope that you found this webinar to be beneficial, and if you have any questions at all you can feel free to visit the Help Desk, again, at PEPPER.CBRPEPPER.org.