August 19, 2024

Dara Corrigan
Deputy Administrator and Director
Centers for Medicare & Medicaid Services
Center for Program Integrity
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Request for Information: CBRs & PEPPERs

Submitted via: CBRPEPPERInquiries@cms.hhs.gov

Dear Administrator Brooks-LaSure,

On behalf of our more than 5,400 nonprofit and mission-driven aging services providers from across the continuum of aging services, including home health, hospice, and skilled nursing facilities as well as our 36 state partners in 41 states, LeadingAge is pleased to offer the following information in response to the Centers for Medicare & Medicaid Services (CMS), Center for Program Integrity (CPI) Request for Information (RFI) on Program for Evaluating Payment Patterns Electronic Reports (PEPPERs).

We would like to start by noting, on the landing page for this RFI there was no sample report for home health, hospice, or skilled nursing facility. While some members were aware of the reports and some had downloaded previous reports, without examples we were unable to provide our members with visual support to review the questions.

Overall, our members utilize this report to help understand their hospice billing patterns in relation to their state, Medicare Administrative Contractor, and national cohorts. These are incredibly useful to improve their compliance and help inform clinical decision makers of potential issues with clinical and billing practices that could make the hospice an outlier in payment. While members use this tool to help with payment compliance, they rely on internal expertise to translate the data for clinical teams who may not be as familiar with billing practices and general statistical analysis. These internal experts, if provider is lucky enough to have them, are often required to translate the complex analytics into digestible and actionable steps for their clinical teams to improve compliance and prevent aberrant billing issues. When reports are issued, these experts often find themselves resetting with their teams on why and how to use these reports.

Our members who utilize this tool find it invaluable and LeadingAge strongly encourages CMS to continue to make these reports available to all provider types. The following is our response to CMS questions.

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Requested Demographic Information

Organization type: Association
Name of organization: LeadingAge
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Presentation

1. *Would you like to see PEPPERs improved in terms of their presentation? What, if any, formatting changes should CMS consider making to the PEPPERs? Are there any changes in graphics that would improve clarity?*

   Members strongly recommended CMS reevaluate the terminology used in the reports to align with conventional language used by providers. For example, many of the visuals and charts reference “targets” however, providers often conflate “targets” with “benchmarks” or “achievement” which are more positive. Providers must explain to staff that these are not “targets” they want achieve, rather these are targets for auditors to consider for review. The language used throughout these reports is geared towards audit contractors not providers attempting to improve their billing compliance.

   Members believe CMS should create more accessible charts for clinical teams. That is more plain language in the charts along with level setting charts, for example explaining percentile since sometimes outliers exist at both the top and bottom percentiles. Alternatively, having quick references on each chart of where the outlier percentiles fall allowing any staff to quickly reference the outlier percentile and then their individual percentile on the chart. CMS could provide a clear indication visually of when a provider is an outlier similar to the report’s charts that have red lettering a column indicating outlier status. On charts, color blocking could be used where an outlier would fall. Simple graphical additions like trend lines, data labels, clearer keys/legends would also improve clarity.

   Members felt the charts could be improved by adding clearer delineations between the different charted lines. Often lines overlap, allowing providers a way to manipulate the data by hiding a line to see the others would be beneficial. LeadingAge offers a free, members-only data tool to help members understand their quality achievements in relation to others in their service area, state, and nationally. In this tool, members can toggle on and off certain graphic elements by simply clicking on the data labels in the graph keys. This allows members to focus on just their organization compared to national trends or state trends or service area trends, or all three. Anything that would make comparisons based on location, size, and patient mix easier would be beneficial. LeadingAge’s hospice trend report is available here: https://data.leadingageny.org/index.cfm/r/?traction=r:hp.o&u=2FCFE9D6-278C-4E37-8B2D-D29003207AE6&w=t#

2. *Should CMS consider providing more visual aids to display data presented in the PEPPERs? If so, what types?*

   More visual aids are always useful to better understand the data however, again, our members expressed more concerns about how the data is displayed in those visual aids and language used in the graphics.

3. *Is the length of the PEPPER and the breadth of the information provided in the report appropriate? If not, is there information contained within the PEPPER that you suggest CMS consider eliminating or information you suggest adding to enhance the reports?*

   Members felt more data was always better but there was also interest in explanation from CMS on how it determines what data would be included in PEPPER and clarity on the reason for certain elements to be removed from reporting.

<u>Accessibility</u>

1. *How, if at all, is your facility currently utilizing the PEPPER?*

   Providers shared examples of working with clinical teams to better understand how practices of professionals are impacting billing. For example, some hospice agencies mentioned that recertification decisions were often made near the very end of the benefit period out of physician habit of tracking deadlines. This physician practice can cause the hospice to land near or in the outlier category for live discharges over after a certain number of days. By sharing the PEPPER report data on Live Discharges LOS 61-179 the compliance staff were able to help the clinical team understand how their clinical practice was making the agency an outlier when it came to billing compared to others. Clinical practices and policies were changed to use the time leading up to certification to monitor the patient and begin assessing whether or not another certification period was necessary.

2. *Has your facility historically experienced any issues downloading or accessing PEPPERs? If so, what changes should CMS consider making to this process, so it is easier for facilities to access their report(s)?*

   One of the biggest issues our providers flagged was the lack of handoff of PEPPER monitoring responsibilities during staff turnover. Many members shared that access information gets lost in staff transitions and the importance of reviewing the information, because it is not available as often as quality reports from iQIES for Care Compare, gets lost. PEPPER is not necessarily a common report used by smaller post-acute and hospice agencies, however, in order to increase the use and self-monitoring of the reports CMS should consider cross promoting PEPPER with other report releases or referencing it as an additional resource when new staff sign up for iQIES. Additionally, Medicare Administrative Contractors could remind new staff about signing up to access the reports.

3. *Which format does your organization prefer for viewing your PEPPER (i.e., electronic via the PEPPER portal, hardcopy, or fax)?*

   All members we spoke to only accessed the electronic version of PEPPER via the portal. This access was preferred by all since it is much easier to take snap shots of the charts and add them to presentations and internal reports to educate staff.

4. *Would it be beneficial to receive PEPPERs more frequently than quarterly? If so, how often?*

   Our members felt that quarterly reports would be too frequent and not effective. Instead, LeadingAge members recommended an updated PEPPER every six months. Since Medicare claims data typically has a six month lag, if a report were issued in the fall and again at the standard date in April, it would provide agencies with clear actionable data for trending. This would be more than sufficient and provide a better chance to impact and avoid targets.

<u>Education, Training, and Other Resources</u>

1. *Is your facility familiar with the mission of the PEPPER program, which is to deliver facilities Medicare statistics for discharges and services vulnerable to improper payments, and to educate them by showing them how they compare to their peers and alert them of potential overutilization and potential payment errors.? If not, what information would be helpful for CMS to provide?*

   Our members are aware of the goal of the PEPPER program, however, again the language is oriented more to an auditor's point of view than a provider's. To provide clarity, LeadingAge recommends CMS change report terminology to better communicate when a provider is considered an outlier and at risk of audit for improper billing. Alternatively, more information on why CMS frames the data in this way may help providers get into the mind set of an audit entity with the responsibility to prevent inappropriate billing in the Medicare program.

2. *Has your facility historically utilized the supplemental PEPPER training materials provided on the PEPPER website (e.g., FAQs, user guides, webinar recordings)? If so, is this information helpful? Are there additional supplemental training materials or resources that CMS should consider providing?*

   Unfortunately, most of the supplemental materials were no longer accessible for our members to review and refresh themselves on the effectiveness of the training. LeadingAge as a national association has found the information in the user guide for hospice PEPPER, especially the measure details on the target areas, helpful to understand targeting of national audit programs.

   Members felt a basic training on how to read the reports would be helpful to orient their teams. Additionally, a teaching aid built with templates and simple examples of charts would be helpful. An access reference tool for staff to share during staff turnover and transitions would also be helpful.

3. *Has your facility historically found the PEPPER user guides that accompany the report(s) adequate for understanding the data provided in the report? If not, what changes to the user guides should CMS consider making?*

   While the user guides provide extensive detail on the actual targets used in the reports as well as interventions for preventing improper payments, it has little visual support to understand the different graphs and charts a provider will encounter in the reports. It would be very easy for CMS to add sample graphs and charts with explanations on how to read and interpret the data presented on each. CMS could also offer an example of a provider in the normal percentile of billing practices vs. a provider that is an outlier.

4. *Has your facility historically utilized other PEPPER resources like the help desk or mailbox? If so, are there any changes CMS should consider making to enhance the user experience when utilizing these resources?*

   None of our members mentioned using the help desk or mailbox for the PEPPER reports. LeadingAge does believe these resources should remain available. Like many of the current quality reporting programs do now, the help desk should issue a yearly, bi-yearly, or rolling (depending on actual volume) Q&A that could be available for each setting. This would answer common questions received by the help desk and provide a quick reference for providers before they reach out to the help desk.

5. *In your experience with PEPPERs, what aspects of the information provided do you find most beneficial? How could PEPPER reports better serve your organization to minimize Medicare improper payments due to billing, DRG coding, or admission necessity issues?*

   Our members felt the information on how close they were to becoming a billing outlier was invaluable and helped them identify when and where to implement interventions.

<u>Data Utilization</u>

1. *Are there other changes that CMS should consider making to the PEPPERs to make them more user friendly or to make the data presented easier to interpret?*

   Making these reports more accessible to the average healthcare staff member would be beneficial for all providers. The interventions in the user guides are written in a very accessible and actionable way. Applying this same user friendliness to the graphs and charts would help staff quickly identify where they have outlier billing or at risk of becoming an outlier and quickly identify interventions to correct the issues.

<u>Future Enhancements</u>

1. *What other suggestions would you have for CMS as it considers ways to improve the PEPPER program?*

Other information of interest to members for inclusion in the PEPPER reports included more claims information from quality sources, for example the Hospice Care Index which has many similar "targets" or metrics to the PEPPER. Our members also want to understand if and how clinical assessments such as MDS, OASIS, and the new HOPE tool connect with the PEPPER reports.

For hospice members there was an interest in more granular data on the length of stay data- e.g. average, median, average over lifetime. There was also interest in categorizing a PEPPER report for hospices serving less than 50 patients a year which constitutes a significant number of hospices but also includes hospices that may be attempting to stay below public reporting requirements.

Additionally, some members felt there might be reasons for their organization being near the "targets" for aberrant billing due to patient variation. CMS should consider these situations by the addition of population charts or cross reference the PEPPER with other CMS resources like the Health Equity Confidential Feedback Reports. In the same vein, LeadingAge recommends CMS include a matrix approach to the PEPPER indicators. While the individual indicators are helpful, having all risk indicators put together to see where a provider is compared to the risk indicators of others would be more beneficial. This could give a wholistic view of how that provider is performing on billing compliance. Right now, the data is incredibly diverse, and it is not clear which indicators are most critical or if there is a hierarchy of indicators where a provider should first focus their attention.

Finally, it is not clear which auditors use these reports and how. CMS should provide more information on which entities are looking at these reports so providers can be prepared for any additional documentation requests from those entities based on their PEPPER findings.

We appreciate your consideration of our comments and look forward to the future iteration of the PEPPER reports.

Sincerely,

Katy Barnett
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About LeadingAge: *We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home. For more information, visit leadingage.org.*