Home Health Line Fact Sheet

Home Health PEPPER target areas

With the updated Home Health Program for Evaluating Payment Patterns Electronic Report (PEPPER), agencies are getting data on how their billing compares with other providers in 10 areas CMS is targeting for additional scrutiny. Here's a breakdown of each area, along with interventions recommended by CMS.

Low Comorbidity & High Comorbidity

Low Comorbidity looks at the percent of agency periods in a calendar year with a secondary diagnosis that qualifies as a low comorbidity adjustment.

High Comorbidity looks at the percent of agency periods in a calendar year with two secondary diagnoses that qualify as a high comorbidity adjustment.

Either of these could indicate a risk of potential over-coding of secondary diagnoses for high outliers, while it might suggest under-coding for low outliers.

Interventions: A review of medical records may be considered to determine if the coding of the diagnoses were substantiated by the medical record and appropriately captured.

Functional Impairment: Medium & High

Functional Impairment Medium looks at the percent of periods in a calendar year with a functional impairment level of medium.

Functional Impairment High looks at the percent of periods in a calendar year with a functional impairment level of high.

For high outliers, these could indicate over-representation of the functional impairment status on the OASIS, resulting in the assignment of elevated functional impairment. Low outliers could indicate under-representation.

Interventions: Review OASIS scoring of functional impairment to confirm the accuracy of the responses.

Average Case Mix & Outlier Payment

Average Case Mix looks at the total case mix weight for all periods paid to the agency in the calendar year compared to the total number of periods. This excludes periods with a low-utilization payment adjustment (LUPA) or a partial episode payment.

Outlier Payment looks at the total dollar amount of outlier payments in a calendar year compared to the total dollar amount of all payments.

These could indicate potential over-coding of beneficiaries' clinical, functional or comorbidity status.

Interventions: Determine whether beneficiaries' status as reported on the OASIS is supported and consistent with the medical record documentation.

Average Number of Periods

Average Number of Periods compares the number of periods paid in a calendar year to the number of unique beneficiaries served by the agency during the time frame.

This could indicate an agency is continuing treatment beyond the point where services are necessary.

Interventions: Review documentation for beneficiaries with a high number of periods to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition.

If the individualized assessment of the patient doesn't demonstrate the need for skilled care, such as instances where skilled care could safely and effectively be performed by the patient or unskilled caregivers, these services aren't covered under the home health benefit.

The agency should review plans of care for appropriateness and assess the appropriateness of discharge plans.

Periods With Low Visits & Non-LUPA Payments

Periods With Low Visits is the percent of periods in a calendar year with the number of visits equal to the LUPA threshold or one visit more than the LUPA threshold.

Non-LUPA Payments is the percent of periods that didn't have a LUPA payment during the calendar year.

These could indicate an agency is considering the minimum number of visits to obtain an HHRG payment instead of a LUPA payment when there are fewer visits than the LUPA visit threshold.

Interventions: Review documentation to ensure that it clearly substantiates that skilled services were reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition.

Similar to Average Number of Periods, you would also want to review the individualized assessment, plan of care and discharge plans for appropriateness.

Admission Source

Admission Source is the percent of periods in a calendar year where the admission source is institutional.

This target area is provided for informational purposes; admission source is determined by submission of claims.

Source: *Home Health Agency PEPPER User Guide, August 2026*