Hospice PEPPER Webinar

Questions and Answers

June 24, 2026

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1. PEPPER Access

The following subsections describe how to access PEPPER.

1.1 How do I identify my organization's Authorized Official (AO) or Access Manager (AM)?

The External User Services (EUS) Help Desk can assist you in identifying your organization's AO or AM and can answer questions about submitting a Staff End User role request with the PEPPER business function, if needed.

Note: You must have a pending role in the Identity & Access (I&A) Management System for the EUS Help Desk to provide the name of your AO or AM.

PECOS EUS Help Desk:

Phone: 1-866-484-8049

Email: EUS_Support@cms.hhs.gov

Hours of Operation: Monday - Friday, 7:00 a.m. - 7:00 p.m. ET

Website: https://eus.cms.gov

1.2 As a Staff End User, how do I access my facility's PEPPER?

Authorized Officials (AOs), Access Managers (AMs), and Staff End Users (SEUs) can access PEPPER through the PEPPER Portal. Taking these steps now will help ensure timely access when your facility's PEPPER is released.

How to Get Access as a Staff End User (SEU):

- Sign in to the CMS Identity & Access (I&A) System using your existing National Plan and Provider Enumeration System (NPPES) or Provider Enrollment, Chain, and Ownership (PECOS) credentials.
- Request the PEPPER business function for your organization. The Comparative Billing Report (CBR) business function is also available and can be requested at the same time.

Your AO or AM Must Approve Your Request

- Once approved, log in to the PEPPER Portal and download your organization's PEPPER.

Need Help Getting Started?

Step-by-step instructions for AOs and AMs are available in the I&A Quick Reference Guide and Frequently Asked Questions (FAQs).

2. Webinar Materials

The following subsection provides information on Webinar materials.

2.1 Will this presentation be recorded and available to view later?

Yes, the webinar recording, slides, transcript, and questions and answers will be available on the PEPPER website under the Training and Resources section.

3. PEPPER Release Schedule

The following subsection describes the PEPPER release schedule.

3.1 What is the release schedule of other PEPPER types?

CMS is relaunching PEPPER via ongoing releases through September 2026. See the schedule below for upcoming releases and currently available reports.

- March: Q4 FY 2025 Short-Term Acute Care Hospitals (STACH)
- May: Critical Access Hospitals (CAH)
- June: Hospice and Q1 FY 2026 STACH
- July: Long-Term Acute Care Hospitals (LTACH) and Inpatient Rehabilitation Facilities (IRF)
- August: Home Health Agencies (HHA) and Inpatient Psychiatric Facilities (IPF)
- September: Partial Hospitalization Program (PHP), Skilled Nursing Facilities (SNF), and Q2 FY 2026 STACH

4. Topic-Specific Questions

The following subsections provide answers to topic-specific questions.

4.1 Does "No Data" mean there were too few qualifying claims or episodes?

"No Data" means there were not enough qualifying claims or episodes for that target area and fiscal year. For example, if the Live Discharges tab shows "No Data," the hospice had fewer than 11 qualifying live discharge episodes for that year. If an episode continued beyond the end of FY 2025, it would not be included in the FY 2025 Hospice PEPPER.

4.2 What does the Live Discharges with Length of Stay (LOS) 61–179 Days target area measure, and are stays

over 180 days included?

The Live Discharges with LOS 61–179 Days target area looks at live discharge episodes where the patient's length of stay was between 61 and 179 days. Episodes longer than 180 days are not included in this target area; they may be captured in other length-of-stay measures, such as the Long Length of Stay target area, depending on the PEPPER definitions.

4.3 Can you explain how PEPPER groups claims into episodes?

The Hospice PEPPER combines claims for the same beneficiary at the same hospice into episodes for several of the PEPPER target area measures.

An episode starts with the first claim paid to the hospice for that beneficiary. It ends when the patient is discharged or when there is more than a 60 day gap before the next claim for that beneficiary.

If the next claim starts within 60 days after the previous claim ends, and the patient was not discharged, the claims are counted as part of the same episode

.The episode is assigned to the fiscal year in which the last claim in the episode ends.

4.4 Why does my PEPPER show 100% for No General Inpatient Care (GIP) or Continuous Home Care (CHC)?

A 100% target area percent for No General Inpatient Care (GIP) or Continuous Home Care (CHC) means that all episodes included in the denominator also met the numerator criteria for that target area.

4.5 How can a hospice validate its PEPPER data if it does not match internal records?

Hospices may notice that their PEPPER results do not exactly match their internal reports. This can happen for a few reasons.

PEPPER is based on the claims data available when the report is created. Because claims data can change over time, running the same PEPPER calculations on different days may produce different results.

PEPPER also uses specific claims fields and filters to calculate each target area. A hospice's internal reporting system may not include the same fields, filters, or data. If the internal data are different from the data used to create PEPPER, the results may not match exactly.

4.6 Should a high outlier for single diagnosis be a concern?

Not necessarily. A high outlier means the hospice should review the related claims and medical records to confirm that all appropriate diagnosis codes were captured during billing. PEPPER is

informational and helps identify areas that may need further review, coding assessment, or staff education.

4.7 Is it negative if a hospice has many nursing homes or assisted living facility patients?

No. A high number of nursing homes or assisted living facility patients is not automatically negative. PEPPER helps hospices review the type of care those patients received, such as routine home care or continuous home care, and identify any patterns that may need further review.

4.8 What is the difference between a target percentage and a target rate?

A target percentage shows the share of relevant episodes that met the target area criteria.

For example: If a hospice had 100 total episodes and 25 met the criteria for Live Discharges Revocations, the target percentage would be 25%.

Some of the target areas are reported as rates instead of percentages because they are assessing a count of claims versus a count of episodes. For these target areas, a percentage is not appropriate as there could be many claims from a single episode that qualify for the target area criteria.

For example: If a hospice had 50 relevant episodes and 150 qualifying Part D claims, the target rate would be 3 Part D claims per episode.

4.9 Are PEPPER percentages and rates calculated for each fiscal year or for all 3 years combined?

Each target area is calculated separately for each fiscal year. FY 2023, FY 2024, and FY 2025 are not combined into one overall calculation. PEPPER looks at the claims or episodes that concluded within each fiscal year and calculates the target area percentage or rate for that fiscal year individually.

4.10 How should facilities use PEPPER information?

Facilities can use PEPPER data to identify where they may need to change billing practices, pinpoint areas in need of auditing and monitoring, identify potential Diagnosis Related Group (DRG) under- or over-coding problems, and identify target areas where length of stay is increasing. It does not identify fraud or improper payments.

4.11 How should I interpret the national, jurisdiction, and state values in the Compare section, such as 0.1, 0.4,

and 0.6?

On the Compare Targets report, these values show where your hospice falls compared with other hospices nationally, in your MAC jurisdiction, and in your state. For example, 0.5 means your hospice is at the 50th percentile for that target area. A 50th percentile means about half of hospices had a higher rate and about half had a lower rate for that target area. On the individual target area tabs, the comparative data table shows the 80th percentile, or 0.8, benchmark for the nation, jurisdiction, and state.

4.12 Which comparison determines high outlier status?

High outlier status is based on the national 80th percentile. Jurisdiction and state values are provided for context so hospices can compare their results with others in their area.

4.13 How can hospices better monitor non-hospice Part A and Part B spending for facility-based patients in real time, given limited visibility into facility billing and hospice responsibility for services related to the terminal illness?

Hospices generally do not have real-time visibility into all facility billing. To reduce risk, hospices should strengthen coordination with facilities at admission and throughout care, clearly communicate which services are related to the terminal illness and related conditions, and document that coordination. Hospices should also review available claims data, PEPPER findings, and other reports when available to identify patterns that may need follow-up with facility partners.

4.14 How can we get details on Part B claims?

PEPPER does not provide claim-level Part B detail. Hospices should use their own billing, compliance, or claims review processes to identify available Part B claim information and coordinate with facility partners when services may relate to the terminal illness or related conditions. If the hospice has questions about how Part B claims were included in a PEPPER target area, it should review the User Guide or contact the Help Desk.

4.15 Who has access to PEPPER data besides providers?

PEPPER reports are made available to providers through the PEPPER portal. CMS and its contractors may also use PEPPER data for education, monitoring, and program integrity activities. PEPPER is intended to help identify billing patterns that may warrant review; it does not identify fraud or improper payments.

4.16 Does the PEPPER report provide data on utilization of

respite care?

The FY 2025 Hospice PEPPER includes target areas, top terminal diagnosis reports, and live discharges by type reports; respite care utilization is not identified as a separate PEPPER measure in the available resources.

4.17 How should hospices with inpatient services interpret PEPPER comparisons?

PEPPER compares each hospice to all hospices nationally, in its MAC jurisdiction, and in its state; it does not create a separate comparison group for hospices with inpatient units. If your hospice has inpatient hospice services, use the national, jurisdiction, and state comparisons as context, then review the relevant target areas and your own service mix, documentation, and billing patterns when interpreting results. The Hospice PEPPER User Guide explains that PEPPER is intended to help hospices compare their data over time and against national, MAC jurisdiction, and state benchmarks, and to prioritize areas for auditing and monitoring.

4.18 Do high outliers affect reimbursement or payment?

No. A high outlier in PEPPER does not directly affect reimbursement or payment. PEPPER is an educational tool that helps providers review billing patterns, identify areas for audit or monitoring, and support accurate claims submission; it does not identify fraud or improper payments.

4.19 What percentage of hospices had no high outliers in the current PEPPER report?

Of the hospices that received the FY25 PEPPER, 7.8% had no high outliers.