Q2 FY 2026 Short Term PEPPER Webinar Transcript

October 15, 2026 – 1:00 p.m.

Harjinder Gill

Good afternoon. Thanks for joining today's webinar. My name is Jinder, and on behalf of the PEPPER project team and our CMS colleagues, we would like to thank you for joining today's PEPPER webinar on Short-Term Acute Care Hospitals, PEPPER Q2 FY 2026.

I want to go over a couple of housekeeping things before we get started.

Please note that we are recording this webinar, and all attendees will be placed on mute.

Please use the Q&A function to submit questions throughout the presentation. We will be answering the questions during the Q&A portion at the end.

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Additionally, if you have any questions you would like to ask after this session is complete, you can always email your questions to cms_cbrpepper@cms.hhs.gov.

Today's presentation will review PEPPER and how to use it, as well as looking at the website via the new portal, and then we will answer questions before closing.

To get started, I would like to introduce Hannah Klein, who will provide an overview of PEPPERs.

Hannah Klein

Thanks, Jinder. Hi and welcome. Thanks, everyone, for joining today. We'll start with a brief overview of what is a Program for Evaluating Payment Patterns Electronic Report, otherwise known as PEPPER. A PEPPER is an electronic report that displays statistics on Medicare payments for discharges and services that are considered vulnerable to improper payments. PEPPER displays data for the most recent federal fiscal quarters for the areas of vulnerability, which are called target areas.

The latest Short-Term Acute Care Hospital PEPPER, or Short-Term PEPPER, was released on September 30, 2026, and provides data for quarter 3 fiscal year 2023 through quarter 2 fiscal year 2026.

This Short-Term PEPPER was generated for hospitals with at least 11 claims for a given fiscal quarter for at least one of the target areas included in the report.

PEPPER is designed to encourage providers to review data about their billing practices so that they can improve the accuracy of the claims they submit to Medicare for reimbursement.

PEPPER enables hospitals to compare their claims data statistics against other hospitals or facilities, and their Medicare Administrative Contractor (MAC) jurisdiction, their state, and across the nation.

They are intended to be an educational resource for providers and can be helpful for strengthening compliance programs, preparing for or conducting internal audits of billing practices, or for improving documentation and patient care plans.

However, PEPPER does not identify improper Medicare payments. It is rather an educational tool for providers to help identify payment patterns that indicate areas of improper risk payments so that they may be reviewed further.

So, what data is included in the Short-Term Acute Care Hospital PEPPER? The data reflected in the Short-Term PEPPER is limited to claims for Short-Term Acute Care Hospitals, as identified by the CMS Certification Number (CCN) and the claim type code equaling 60, for services that were rendered between quarter 3 fiscal year 2023 and quarter 2 fiscal year 2026.

Additionally, the PEPPER only reflects results for claims that are listed as final action, with a valid medical record number, and that were paid by Medicare and those that indicate that the patient was discharged.

The Short-Term Acute Care Hospital PEPPER does not include claims from HMOs or Medicare Advantage, nor does it include data that is based on any claims that were cancelled by the MAC.

The target areas within the PEPPER display information about hospital payment patterns for specific areas that have been identified as potentially at risk for improper Medicare payments. These target areas were identified through reviews by the Quality Improvement Organization and studies by the Office of the Inspector General, and these may change over time as we learn more about new areas that are at risk for improper payments and make refinements to reflect changes in billing or coding requirements.

Generally, the target area numerator will capture the discharges identified as potentially problematic, while the denominator will capture the larger reference group.

Hospitals can use the target area percentages and their outlier status to pinpoint areas in need of further investigation or monitoring. They can also help your facility to understand how you perform compared to others in the nation, your MAC jurisdiction, or the state, and PEPPER data can help identify these areas to implement corrective action.

Within the PEPPER, each target area percent is displayed alongside an outlier status to indicate whether your hospital is an outlier when compared to all other hospitals in the nation. To determine the outlier status, the target area percent for each fiscal quarter is compared to the results of all hospitals nationwide. If the target area percentage is at or below the National 20th percentile, then the target area outlier status will be low outlier for that fiscal quarter. If the target area percentage is at or above the National 80th percentile, then the target area status will be high outlier for that fiscal quarter.

High outliers are calculated for all target areas; however, low outliers are only identified if the target area is focused on a coding focus target area.

If the target area percentage is between the National 20th and 80th percentiles, then the outlier status would be not an outlier.

On this slide, we have the example of the Stroke Intracranial Hemorrhage target area and you'll see that the National 20th percentile for that quarter was 77.3%, while the 80th percentile was

93.3%. So, if a hospital's percentage for this target area falls below that 77.3%, then they would be a low outlier. If the target area percentage falls between that 77.3% and 93.3%, then they would not be an outlier. If the target area percentage exceeds the 93.3% benchmark, then your hospital would be a high outlier for the Stroke Intracranial Hemorrhage target area for this specific fiscal quarter.

Now I'll turn it over to Teresa to walk through some examples of how to interpret your target area results.

Teresa Le

Thanks, Hannah.

Within the Short-Term PEPPER, there are 24 target areas. The coding-focused target areas seek to identify areas with potential over or undercoding problems. These are the first 10 target areas that appear in the report: Stroke Intracranial Hemorrhage, Respiratory Infections, Simple Pneumonia, Septicemia, Unrelated OR Procedure, Medical CC or MCC, Surgical CC or MCC, Single CC or MCC, Severe Malnutrition, and Ventilator Support.

The PEPPER identifies both high and low outliers for these target areas. Let's walk through a couple examples of how these target areas provide information for hospitals on their billing patterns.

The Stroke Intracranial Hemorrhage target area is a coding focus target area that measures the rate of discharges assigned a diagnosis related group, or DRG, for complex ischemic stroke or intracranial hemorrhage compared to all discharges for ischemic stroke or intracranial hemorrhage with or without a complication or comorbidity, including nonspecific cardiovascular accidents and transient ischemia without thrombolytic agent.

Hospitals that are high outliers for this target area may have billing errors related to the overcoding of DRGs 061, 062, 063, 064, 065, or 066.

Hospitals that are low outliers for this target area may have billing errors related to undercoding of these DRGs.

Hospitals with a low or high outlier status for this target area may benefit from a review of their medical records to confirm whether their outlier status is driven by coding errors.

Here we have some example claims to demonstrate how they contribute to the calculation of the stroke ICH target area.

In row one, the claim begins on October 4, 2024, and goes through October 10, 2024, when the patient was discharged. This claim has a DRG 062 assigned, so this would count towards both the numerator and denominator counts for the quarter one fiscal year 2025 time period.

In contrast, the claim in row 2, which began on November 1, 2024, and ended on November 11, 2024, counts only towards the denominator for the quarter one fiscal year 2025 calculation since the DRG for this claim is 069.

The claim in row 3 counts towards the numerator and denominator for the quarter one fiscal year 2025 target area percentage calculation since it concluded on December 30, 2024, and the DRG is 065, which is included in both the numerator and denominator definitions.

The claim in row 4 and 5 follow the same pattern.

The Septicemia target area is another coding-focused target area within the Short-Term PEPPER. This target area measures the proportion of hospital discharges with a DRG for septicemia or severe sepsis compared to all discharges for simple pneumonia and pleurisy,

respiratory system diagnosis with ventilator support, kidney and urinary tract infections or septicemia or severe sepsis.

Hospitals that are high outliers for this target area may have billing errors related to the overcoding of DRGs 870, 871, or 872.

Hospitals that are low outliers for this target area may have billing errors related to undercoding of these DRGs.

For hospitals with either low or high outlier status for this target area, we recommend reviewing the medical records for the relevant time period to understand whether there are any potential coding issues with these claims.

Here we have some example claims to demonstrate how they contribute to the calculation of the Septicemia target area.

In row one, the claim begins on October 4, 2025, and goes through October 10, 2025, when the patient was discharged. This claim has DRG 870 assigned, so this would count towards both the target numerator and denominator count for the quarter one fiscal year 2026 time period.

In contrast, the claim in row 2, which began on November 1, 2025, and ended on November 11, 2025, counts only towards the denominator for the quarter one fiscal year 2026 calculation since the DRG for this claim is 194.

The claim in row 3 counts towards the numerator and denominator for the quarter one fiscal year 2026 target area percentage calculation since it concluded on December 30, 2025, and the DRG is 872, which is included in both the numerator and denominator definitions.

The claim in row 4 and 5 follow the same pattern.

Now I'll turn it over to Dawn to walk through some admission-necessity target areas.

Dawn Strawser

You just heard Teresa covering the coding-focused target areas. I'm going to talk about the admission necessity-focused target areas.

You can see on your slide the admission necessity-focused target areas: Percutaneous Cardiovascular Procedures, Total Knee Replacement, Syncope, Other Circulatory System Diagnosis, Other Digestive System Diagnosis, the Medical Back, Spinal Fusion, the 3-Day Skilled Nursing Facility, the 30-Day Readmissions to the Same Hospital or Elsewhere, and the 30-Day Readmissions to the Same Hospital. We had the 2-Day Stay Medical and Surgical DRGs and the 1-Day Stay Medical and Surgical DRGs. Since these target areas are focused on admission necessity, the PEPPER only focuses on the high outliers for these target areas.

Here's an example of the 3-Day Skilled Nursing Facility target area. This assesses the rate of claims for the three-day inpatient stay before a transfer to a Skilled Nursing Facility ,and this is compared to all claims that are concluded with a transfer to a Skilled Nursing Facility. So that would be the denominator.

If a hospital is a high outlier for this target area, this could indicate an unnecessary admission used to qualify beneficiaries for their Skilled Nursing Facility admission.

On each target area tab, there are two tables displaying statistics for the target areas. We'll use the 3-Day SNF target area as an example of how to use the data in these tables.

That first table, Table 38 for the 3-Day SNF target area, displays the hospital statistics for the target area. In a separate row for each fiscal quarter, the table will display the outlier status, the

target area percent, the target area numerator and denominator counts, the average length of stay for the claims that meet the numerator and denominator criteria, and the average sum of Medicare payments for the claims that meet the numerator criteria.

Below the hospital statistics table is the Comparative Data table. Here is Table 39 for the 3-Day SNF target area. This table displays and provides the comparative data, including the National, Jurisdiction, and State 80th percentiles and the hospital's target area percent for each fiscal quarter, in that last column. If the target area would be a coding-focused target area, this would also display the National, Jurisdiction, and State 20th percentile benchmarks.

In this example, Table 38 shows that the hospital is not an outlier for the quarter 2 fiscal year 2026 time period. Their target area percent was 16.3% as they had 23 claims where the length of stay was 3 days and the patient discharge status indicated a transfer to a Skilled Nursing Facility out of the 141 claims where the patient discharge status indicated the patient was transferred to an SNF.

Table 39 shows that the National 80th percentile for quarter 2 fiscal year 2026 was 28.6%, which is higher than the hospital's target area percent of 16.3%, which is why they're not an outlier.

Now we'll look at the 30-Day Readmissions to Same or Elsewhere target area. This target area captures the rate of readmissions to the same hospital or to another Short-Term Acute Care Hospital within 30 days of the first or index admission.

If a hospital is a high outlier for this target area, this could be due to issues with that index admission or limited access to an alternative hospital.

Hospitals may want to review their high outliers for readmission to assess whether the admission, the discharge, the DRG assignment and quality of care or billing codes were appropriate for that admission.

Let's walk through a couple of examples of claims to demonstrate how the 30-Day Readmissions to Same or Elsewhere target area works.

In each row, the table displays information for that first index admission and the next admission for the same patient. Row one is the index admission to Hospital 1, which began on March 25, 2024, and lasted until the patient was discharged home on March 29, 2024. That same patient then was readmitted to the same hospital, Hospital 1, on April 15 of 2024 and remained in the hospital until April 17, 2024. Since that second admission began within 30 days of that index admission discharge date of March 29, that admission 2 is considered a readmission to Hospital 1 for the quarter 2 fiscal year 2024 30-Day Readmission target area rate.

In row 2, we see that admission 2 concluded with the patient discharge status code of 02, indicating that they were transferred to another Short-Term Acute Care Hospital for continued inpatient care at Hospital 2 on April 17, 2024. They remained at that hospital until April 20 of 2024, where they were discharged home.

Admission 3 does not count as a readmission to the index admission, which was for this one Admission 2, as the target area excludes cases where the patient discharge status code was 02 from the numerator.

Since the beneficiary did not have any further admissions after admission 3, there are no further readmissions for this beneficiary that count towards this 30-Day Readmission target area.

You can find this example and a few others in the Short-Term PEPPER User Guide.

The 2-Day Stay Medical DRG target area assesses the rate of medical stays with a 2 day length of stay compared to all the medical stays. Hospitals that are a high outlier for this target area may have admissions that did not meet the admission screening criteria or may be using inpatient stays, but an outpatient observation stay may be more appropriate.

Hospitals may review a sampling of admissions with a 2-day stay to determine whether the inpatient admission was appropriate or whether the care could have been provided on an outpatient basis.

On this slide, this screenshot is taken from the sample PEPPER on the tab for 1-Day Stay Medical DRGs. The sample PEPPER is available on the PEPPER website if you would like to follow along. Similar to the 2-Day Stay Medical DRG target area, the Short-Term PEPPER also displays information on 1-Day Stays for Medical and Surgical DRGs.

For the 1-Day Stay Medical and the 1-Day Stay Surgical DRG target areas, the target area tab also includes information about the top DRGs for the hospital and the hospital's MAC jurisdiction. The table displays the top 20 ranked DRGs for which there were at least 11 same day and 1-day stays for the respective DRG during the most recent 4 fiscal quarters. For each DRG, the table displays the count of discharges with a one-day or a same-day length of stay, the total number of discharges, the proportion of same and 1-day stays, and the average length of stay. Discharges are excluded if the discharge status code was 02, 07, 20, or 82 and if the claim occurrence code is 72. These are all explained in the user guide if you need discharge status code explanations.

The PEPPER displays this information for the hospital in Table 50, and then the hospital's jurisdiction data is in Table 51, which is displayed here.

If multiple DRGs share the same rank, all tied DRGs are going to be displayed on the report. If there are no DRGs with at least 11 of the same-day and 1-day stays during the most recent four fiscal quarters, then no data will display.

The bottom of each table displays the totals for the top DRGs as well as all DRGs, and this will be similar to the surgical DRGs tab, which is the next tab from the 1-day stay.

Now I'll look at the National Outlier Ranking tab. This outlier ranking tab includes the National High Outlier Ranking report, which displays a comparison of the hospital to all other Short-Term hospitals in terms of outlier status. The more target areas in which your hospital is an outlier, the higher the hospital's ranking will be. The goal of the National High Outlier Ranking Report is to help hospitals assess the risk for improper payments and trends across the target areas. For each fiscal quarter and each target area, the table would display a one if the hospital is a high outlier and a zero if the hospital is a low outlier or not an outlier. For quarters with fewer than 11 encounters that meet the numerator criteria, the table's going to display an n/a.

This is a quick look across all the quarters that are displayed in your PEPPER to see if for each quarter, the hospital has been a high outlier with multiple ones in a row or zeros. So, it's a quick look for you to see where the issues might be.

Now I'm going to pass it back over to Hannah to go over the PEPPER resources.

Hannah Klein

Thanks, Dawn.

So we're going to walk through how to navigate the PEPPER website and what the available resources and training are on the website.

You'll begin by visiting the CMS PEPPER web page. Here, in addition to accessing the PEPPER Portal, you can also find helpful resources such as FAQs and the latest User Guide, and information about how to contact our Help desk. In addition, a recording of today's presentation and a copy of the slides will be posted to the PEPPER Resources page.

To open the PEPPER Portal, you will click the blue button for PEPPER Portal, and to access the training and resources, you will click on Training and Resources from the navigation pane at the top. On the Training and Resources page, this is where you would find and access information for the specific PEPPER that you are interested in. You can also find information on how to register for upcoming webinars and sign up for PEPPER communications.

Now to go to each page, I'll just click on the hyperlink for the PEPPER that you are interested in. On the Short-Term Acute Care Hospital PEPPER specific page, once you click on that link, you would find the resources that are specific to the Short-Term Acute Care Hospital PEPPER. This includes the link to download the PEPPER User Guide, webinar materials, and the sample PEPPER.

As I noted, the transcript and recording from today's presentation will be available here.

We did want to highlight what you can find within the PEPPER User Guide. The Short-Term Acute Care Hospital PEPPER User Guide is a very valuable resource for understanding your PEPPER, and we encourage everyone to use this as a reference when reviewing your PEPPER. Within the User Guide, you'll find information on what has changed since the previous PEPPER release, an overview of the PEPPER, including detailed information and definitions for each of the target areas, definitions of key terms, and helpful examples of readmission cases.

Now, I'll turn it over to Dina.

Dena Gregory

Thank you, Hannah.

At this time, we don't have any questions. If you have any, please go ahead and put them in the Q&A box, and then we'll answer your question.

One popular question was already answered during the webinar. The materials for this webinar will be available on the website in the Training and Resources section. You'll be able to access the slides, which are there already, as well as the recording, the transcript, and the questions and answers, if we have any.

Would anybody else on the team like to offer any other answers to potential questions?

Harjinder Gill

I will just reiterate that we do have FAQs posted on the PEPPER website, so definitely take a look at that for reference. If you have anything in particular related to your PEPPER, please utilize the help desk or reach out to us. We can certainly discuss.

Dena Gregory

I see a question has come in through our chat function, but if you could please put your questions in the Q&A box so when we respond, it will go to everybody. I will read this out loud.

“Do you survey hospitals to see how many of them use the PEPPER reports or share what percent of hospitals download these reports?”

We do track the number of downloads of the reports and have that information on hand. But otherwise, we do not do any surveys of the hospitals to see how many are downloading, how many are using them, and how they are using them.

Is there anything that you would like to add to that?

Hannah Klein

I think if anyone has feedback on or would like to share how they use their PEPPER, you can always email our team. It's very helpful for us to understand how these reports are useful and any areas that might be more useful or worth adding in the future.

Harjinder Gill

OK, I don't see any other questions at this time. I think we can go ahead and close.

Harjinder Gill

Thanks, Dena. Thanks, Hannah, Teresa, and Dawn for giving us that overview.

Before we close, we do have three quick action items for you, a call to action.

First, please complete the webinar feedback survey.

Second, if you need access to your organization's PEPPER, register for the Staff End PEPPER business function in the I&A management system or work with your organization's Authorized Official or Authorized Manager.

Finally, once you do have access, we encourage you to download your PEPPER and use it to support your internal monitoring and review activities.

This does conclude today's webinar. We appreciate you joining us and all the important work you do.

Thank you so much, and have a great day.