Using PEPPER to Strengthen Medicare Compliance Across Healthcare Settings: A Practical Roadmap for Providers

Executive Summary

The return of the Program for Evaluating Payment Patterns Electronic Report (PEPPER) is important. PEPPER is available for nine provider settings and provides each organization with provider-specific claims statistics for target areas associated with potential improper payments, including billing, coding, admission-necessity, utilization, and length-of-stay concerns. It does not determine whether a claim is wrong; it identifies patterns that differ from comparison groups and should be understood, tested, and documented (Centers for Medicare & Medicaid Services [CMS], 2026a; PEPPER Resources, 2026a). PEPPER is available for: Short-term acute care hospitals (STACHs), Critical access hospitals (CAHs), Hospices, Long-term acute care hospitals (LTACHs), Inpatient rehabilitation facilities (IRFs), Home health agencies (HHAs), Inpatient psychiatric facilities (IPFs), Partial hospitalization programs (PHPs), and Skilled nursing facilities (SNFs).

Used effectively, PEPPER can support the annual compliance risk assessment, focused record audits, coding and clinical documentation improvement, utilization review, denial prevention, quality and performance improvement, enterprise risk management, and board oversight. The most useful question is not simply, “Why are we an outlier?” Better questions are, “Can we explain the pattern? Does the record support it? and Have we responded appropriately?”

PEPPER as a Compliance Tool

PEPPER is a Microsoft Excel-based report that summarizes facility-specific Medicare fee-for-service data for target areas selected by the Centers for Medicare & Medicaid Services (CMS). Reports show trends over the most recent 12 available quarters and compare a provider with national, Medicare Administrative Contractor (MAC) jurisdiction, and state data. CMS describes PEPPER as a tool for identifying billing practices that may require improvement, areas that warrant auditing or monitoring, possible undercoding or overcoding, and trends such as increasing length of stay (CMS, 2026a; PEPPER Resources, 2026a).

An outlier is a signal, not a finding. PEPPER generally identifies high outliers at or above the 80th percentile and, for coding-focused target areas, low outliers at or below the 20th percentile. A provider may differ from peers for legitimate reasons, including specialized programs, referral patterns, case complexity, geography, population characteristics, or changes in services. The compliance obligation is to evaluate the difference rather than assume either wrongdoing or innocence (PEPPER Resources, 2026a).

PEPPER as a Compliance Tool cont.

PEPPER is facility specific and is available for provider settings listed below. PEPPER is not currently available for physician practices, laboratories, ambulatory surgery centers, clinics, or suppliers. Those organizations may have other comparative billing reports or data tools. Recognizing this distinction maintains accuracy while still demonstrating how broadly the report applies across the healthcare continuum.

PEPPER Provider Settings and 2026 Relaunch Schedule

CMS distributes PEPPER quarterly to short-term acute care hospitals and annually to the other eight provider settings. The 2026 relaunch proceeded in stages, with the remaining reports scheduled through September. As of August 2026, CMS had released reports for short-term acute care hospitals, critical access hospitals, hospices, long-term acute care hospitals, inpatient rehabilitation facilities, home health agencies, and inpatient psychiatric facilities; partial hospitalization programs and skilled nursing facilities. CMS scheduled the next PEPPER reports for release in September 2026. By the anticipated publication of this article in October 2026, the reports are expected to be available through the PEPPER Portal. (CMS, 2026b, 2026c; PEPPER Resources, 2026a).

PEPPER Updates as of August 2026

Provider Setting	Frequency	2026 Relaunch/Status
Short-term acute care hospitals (STACHs)	Quarterly	March, June, and September 2026 releases
Critical access hospitals (CAHs)	Annual	Released May 2026
Hospices	Annual	Released June 2026
Long-term acute care hospitals (LTACHs)	Annual	Released July 2026
Inpatient rehabilitation facilities (IRFs)	Annual	Released July 2026
Home health agencies (HHAs)	Annual	Released August 2026
Inpatient psychiatric facilities (IPFs)	Annual	Released August 2026
Partial hospitalization programs (PHPs)	Annual	Scheduled September 2026
Skilled nursing facilities (SNFs)	Annual	Scheduled September 2026

Note: *Release timing is based on CMS and PEPPER Resources. Organizations should confirm the current portal and training pages before relying on a scheduled date (CMS, 2026c; PEPPER Resources, 2026a).*

How PEPPER Can Be Used in Each Setting

Short-Term Acute Care and Critical Access Hospitals (CAH)

Hospital PEPPERs can help with compliance, coding, clinical documentation integrity, utilization management, case management, and finance teams prioritize reviews involving diagnosis-related group selection, complication and comorbidity capture, admission necessity, one- and two-day stays, transfers, readmissions, and length-of-stay patterns. Current hospital target areas include coding-focused measures and admission-necessity measures; therefore, an effective response should pair claims analysis with focused medical-record review rather than rely on percentile rankings alone (CMS, 2026d, 2026e).

Hospitals can also use PEPPER to test whether changes in documentation, physician query practices, observation management, transfer coding, or service-line growth are affecting billing patterns. A sharp change after a coding vendor transition, electronic health record implementation, or new specialty program may be explainable, but it still warrants validation. For rural hospitals and CAHs, the report can be particularly useful for examining short stays, readmissions, and discharge patterns in the context of limited local resources and transfer relationships.

Long-Term Acute Care Hospitals (LTACH)and Inpatient Rehabilitation Facilities (IRF)

LTACH and IRF PEPPERs extend the same risk-based approach to specialized post-acute hospital care. These organizations can use PEPPER to identify unusual payment classifications, coding patterns, admission and continued-stay concerns, length-of-stay changes, discharge trends, and patterns concentrated in a diagnosis, physician group, unit, or referral source. CMS released the FY 2025 LTACH and IRF reports in July 2026 and emphasized their use for finding billing patterns that may need improvement, identifying areas for closer monitoring, and recognizing potential undercoding or overcoding (CMS, 2026f, 2026g).

For these providers, PEPPER findings should be compared with preadmission screening, physician documentation, interdisciplinary plans of care, therapy intensity, coding support, discharge disposition, denials, and internal utilization data. A provider that can clearly connect its claims pattern to patient acuity and documented medical necessity is in a stronger position than one that simply notes the percentile and takes no further action.

Inpatient Psychiatric Facilities (IPF) and Partial Hospitalization Programs (PHP)

Behavioral health organizations can use IPF and PHP PEPPERs to assess whether admission, continued-stay, coding, utilization, and length-of-service patterns differ from peers. In psychiatric settings, the audit should focus on whether the record supports the level of care, active treatment, treatment-plan requirements, diagnosis coding, physician involvement, discharge planning, and the frequency and intensity of services billed. CMS reported that inpatient psychiatric facility reports were released in August 2026 and that PHP reports were scheduled for September (CMS, 2026c; PEPPER Resources, 2026a).

PEPPER can be particularly valuable when a behavioral health program has expanded rapidly, added intensive outpatient or partial hospitalization services, changed documentation templates, experienced high clinician turnover, or seen an increase in denials. Reviewing the data by program, location, clinician, diagnosis, and payer can help determine whether an outlier reflects a legitimate population difference or a systemic documentation, utilization, or billing concern.

Hospice

Hospice PEPPER focuses attention on claims and episodes that may present payment risk. The FY 2025 guide includes target areas involving live discharges, revocations, and length-of-stay patterns. A high percentile should lead to review of eligibility and recertification support, terminal prognosis documentation, face-to-face requirements when applicable, discharge rationale, level-of-care decisions, and whether services remained consistent with the plan of care (CMS, 2026h).

Hospices should avoid treating live discharge or long-stay data as proof of noncompliance. These patterns may be influenced by diagnosis mix, referral timing, patient choice, access barriers, or disease trajectory. The appropriate response is a targeted audit that tests whether the clinical record supports eligibility, continued hospice care, the reason for discharge, and the services billed.

Home Health Agencies

Home health agencies can use PEPPER to review patterns involving case mix, comorbidity adjustments, functional impairment, low-utilization periods, number of periods, and length of service. The report can help identify where Outcome and Assessment Information Set (OASIS) practices, diagnosis coding, care planning, visit utilization, or discharge decisions may be affecting payment. CMS released the 2025 HHA PEPPER in August 2026 and directed agencies to use it to identify billing patterns that may need review, areas for internal audit, possible undercoding or overcoding, and length-of-stay trends (CMS, 2026c; PEPPER Resources, 2026b).

An HHA response should connect the claims pattern to the clinical record and operational workflow. Useful comparisons include OASIS responses, diagnosis sequencing, physician or allowed-practitioner orders, plan-of-care updates, visit notes, missed visits, hospitalization and transfer data, low-utilization payment adjustments, and discharge practices. Agencies with multiple branches should compare locations to determine whether a pattern is local or systemwide.

Skilled Nursing Facilities

SNFs remain one PEPPER setting, but they should not dominate a cross-industry discussion. When the SNF report returns, facilities can use it to prioritize review of Medicare payment classifications, MDS and diagnosis coding, nursing and therapy documentation, physician certifications, utilization, length of stay, and related billing processes. The same principle applies as in every setting: the outlier identifies where to look; the record determines whether the claim is supported (PEPPER Resources, 2026a).

When PEPPER Should Be Used

PEPPER is most effective when it is incorporated into routine governance and operational cycles rather than reviewed once and filed. At a minimum, organizations should use it during the annual compliance risk assessment and audit-plan development. It is also useful before or after major operational changes, including a merger or acquisition, a new service line, a new referral arrangement, an electronic health record or billing-system conversion, a coding-vendor change, a staffing disruption, or a substantial shift in patient mix.

The report should also be revisited when denials, medical record requests, recoupments, or payer questions increase; when internal audits show recurring documentation or coding errors; when one facility or branch performs differently from others; or when leadership wants to test whether corrective action worked. In these situations, PEPPER provides a trend line and peer comparison that can be combined with internal data, denials, quality measures, hotline reports, and audit findings to form a more complete risk picture.

Organizations should not limit PEPPER to overpayment prevention. Low outliers in coding-focused measures can identify potential undercoding or lost reimbursement, while persistent trends may reveal training needs, inconsistent physician documentation, overly conservative coding, or a workflow that fails to capture supported services. The objective is accurate payment, not simply lower utilization or lower coding intensity.

From Compliance Report to Governance Responsibility

PEPPER review should be multidisciplinary. Depending on the setting, the team may include compliance, legal, coding, health information management, revenue cycle, finance, utilization management, clinical leadership, quality, therapy, nursing, medical staff, case management, and information technology. The team should understand how each target area is calculated, identify the claims represented in the numerator, select a defensible audit sample, and document the rationale for conclusions and corrective action.

OIG's General Compliance Program Guidance emphasizes risk assessment, auditing and monitoring, effective communication, accountability, and continuous improvement. DOJ's Evaluation of Corporate Compliance Programs similarly asks whether a program is designed around actual risks, appropriately resourced, informed by data, tested in practice, and improved through root-cause analysis and remediation. A documented response to PEPPER supports these expectations by showing that the organization used available information to identify, investigate, and address risk (Office of Inspector General [OIG], 2023; U.S. Department of Justice [DOJ], 2024).

Boards and executive leaders do not need to master every formula. They should know who obtains the report, which target areas are most significant, whether the organization completed focused audits, what the audits found, whether potential overpayments or underpayments were identified, what corrective actions were assigned, and how effectiveness will be measured. The governing question is whether the organization has a reasonable system for bringing meaningful billing and compliance risks to leadership and following them through resolution.

A Practical 90-Day Response

Timing	Primary Actions	Expected Output
Before Receipt	Confirm portal access; assign an owner; identify the review team; review prior PEPPER, denials, and unresolved audits; establish escalation criteria.	Access is ready, roles are assigned, and leadership understands the purpose and limits of PEPPER.
Within 30 Days	Review all target areas; prioritize national outliers, persistent trends, large payment exposure, and abrupt changes; validate the denominator and affected population; define audit samples.	A written risk-prioritization memo and focused audit plan.
Within 60 Days	Complete record audits; determine whether documentation supports coding, medical necessity, utilization, and payment; identify overpayments, underpayments, and root causes; expand the sample when indicated.	Audit findings, quantified exposure, and root-cause analysis.
Within 90 Days	Implement corrective action; revise policies, education, templates, supervision, software, or vendor controls; address repayment obligations when applicable; conduct follow-up testing and report material results.	A corrective-action plan with owners, deadlines, monitoring measures, and leadership reporting.

From Compliance Report to Governance Responsibility cont.

The organization should retain documentation of the report reviewed, target areas selected, records sampled, methodology used, conclusions reached, repayments or corrections made, and follow-up testing completed. This documentation helps demonstrate that leadership did not ignore a known risk and that the compliance program operated in practice rather than only on paper (OIG, 2023; DOJ, 2024).

Conclusion

PEPPER is a cross-setting Medicare compliance tool available to short-term acute care hospitals, critical access hospitals, long-term acute care hospitals, inpatient rehabilitation facilities, inpatient psychiatric facilities, home health agencies, hospices, partial hospitalization programs, and skilled nursing facilities. Each report is tailored to the risks of its setting, but the response framework is consistent: identify the pattern, understand the population, audit the underlying records, correct unsupported practices, monitor the result, and inform leadership.

The organizations best prepared for payer or government scrutiny will not necessarily be those with the fewest outliers. They will be those that can show they understood the information available, investigated the areas of greatest risk, acted when necessary, and confirmed that the response worked. PEPPER should therefore be treated not as a report card, but as a structured invitation to ask better questions and strengthen the compliance program before an external reviewer asks them first.

Turn Insights into Action

LW Consulting, Inc. (LWCI) can help organizations move from uncertainty around their data to informed action. Through a focused, one-day workshop, participants gain practical insights into their data and develop actionable plans to address identified opportunities and areas of concern.

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About LW Consulting, Inc.

LW Consulting, Inc. (LWCI) is a recognized leader in providing reimbursement, operational, compliance, and clinical consulting solutions across the healthcare continuum. For more than two decades, we have partnered with healthcare organizations to navigate complex regulatory requirements, strengthen compliance programs, mitigate risk, and improve organizational performance.

Our multidisciplinary team includes clinicians, compliance professionals, certified coders, auditors, reimbursement specialists, and operational experts with extensive experience across post-acute care, physician services, behavioral health, hospitals, and other healthcare settings. We assist organizations with compliance program assessments, coding and documentation audits, investigations, regulatory readiness, education and training, reimbursement support, and independent review services.

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