

Medicare Post-Acute Care Utilization & Hospice Public Use File Frequently Asked Questions

Q: What is new in this year's PAC PUF?

A: We've redesigned the way users interact with the PAC PUF data to comply with the [2018 Evidence Act](#). All data for this product are now available via data.cms.gov as well as the [data.cms.gov API](#).

Users can access the PAC PUF datasets by visiting the [Medicare Post-Acute Care Utilization Main Landing Page](#). Each dataset contains relevant downloadable resources and an interactive "View Data" tool allowing users to interact with the data by year.

Q: What is included in the PAC PUF?

A: The PAC PUF contains information on demographic and clinical characteristics, as well as utilization and payment information for Medicare beneficiaries at the provider, state, and national levels for home health agencies (HHAs), hospices, skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs).

The PAC PUF also contains the following supplemental datasets:

- HHAs and IRFs by geography/provider and case-mix groupings for 2014-2023.
- SNFs by geography/provider and RUG type for 2014-2019.
- SNFs by geography/provider and case-mix grouping for 2020-2023.

Q: Does the PAC PUF report the calendar or fiscal year?

A: It differs by setting. The HHA benefit is reported on a calendar year basis (CY) while hospices, SNFs, IRFs, and LTCHs are reported on a fiscal year basis (FY).

Q: Where can I find information on the data sources used in the PAC PUF?

A: Information about data sources, including Medicare PAC payment systems, population, and aggregation can be found in the PAC PUF Methodology.

Q: What is the difference between charges and payments? Where can I find information about these, and other variables listed in the PAC PUF?

A: Charges are submitted to Medicare by the provider for reimbursement, whereas payments are what Medicare pays the provider for services. It is important to note there are several different payment variables in the PAC PUF to indicate different levels of payment (e.g., allowed amount, deductibles and coinsurance, standardized payment). We recommend that users review the Data Dictionary which describes the content, format, and structure of each variable listed in the PAC PUF.

A consolidated Master Data Dictionary and dataset specific data dictionaries are available as downloadable resources.

Q: Does the PAC PUF contain information for Medicare Advantage (MA) or Medicaid beneficiaries?

A: The PAC PUF includes one variable related to MA beneficiaries, *BENE_MA_PCT*. This variable is the proportion of Medicare beneficiaries enrolled in MA with at least one fee-for-service (FFS) paid claim while enrolled in an MA plan. This metric applies to MA Cost Plan beneficiaries who access HH, SNF, IRF, and LTCH services through FFS Medicare. In addition, all hospice care is provided under FFS Medicare when beneficiaries are under a hospice election. MA beneficiaries with zero FFS claims are not included in this variable. The PAC PUF also includes one variable, *BENE_DUAL_PCT*, which is the proportion of Medicare beneficiaries qualified to receive Medicare and Medicaid benefits and is also referred to as dual eligibility. Beneficiaries are classified as a dual if they receive full or partial Medicaid benefits in any month of the year.

Q: Is any data suppressed in the PAC PUF?

A: To protect the privacy of Medicare beneficiaries, we use cell suppression when appropriate and indicate instances of ten or fewer beneficiaries with an asterisk (*)

In addition, because of known data limitations in the reporting of dual-eligibles in Puerto Rico, values of *BENE_DUAL_PCT* are suppressed for records where STATE = 'PR' and replaced with a plus sign (+).

Q: How are missing data represented in the PAC PUF?

- A: (M) – The value is zero/missing because there were zero linked assessments. This applies only to variables that are derived from assessment data.
- (N/A) – IRF Therapy minutes prior to 2016 are labeled N/A because the requirement to record therapy data was effective for discharges on/after October 1, 2015.

We also use the symbols (*) and (+) to suppress data in certain instances. For further details, please see the frequently asked question “Is any data suppressed in the PAC PUF?”.

Q: How are averages calculated in the PAC PUF?

A: Averages are calculated using an arithmetic means. The numerator and denominator vary based on the specific variable being calculated. Please review the Data Dictionary for further information.

Q: Are beneficiaries counted more than once? Can the “Distinct Beneficiaries” be summed across providers?

A: The PAC PUF provides the number of distinct Medicare beneficiaries (i.e., a unique beneficiary) with at least one paid claim in the calendar or fiscal year. The PAC PUF aggregates the number of distinct beneficiaries based on the level of detail requested and applies cell suppression when necessary. A beneficiary is counted only once for each provider who had a paid claim, only once for each state in which they received care, and only once at the national level. Therefore, if a beneficiary received care from more than one provider in the same state, the PAC PUF would count the beneficiary twice at the provider level (i.e., once for each provider), but only once at the state level. If a beneficiary received care from two different providers in two

states, the beneficiary would be counted once for each provider, once for each state, and only once at the national level. Therefore, the counts in the detailed tables do not sum to the counts in the aggregate tables.

Q: Can a beneficiary be included in more than one chronic condition category per provider?

A: Yes. A beneficiary may have multiple chronic conditions and may be included in more than one chronic condition category.

Q: Can a beneficiary have more than one primary diagnosis category per provider?

A: Yes. The PAC PUF places a beneficiary into one of the primary diagnosis categories based on any claim per provider per CY for HHA claims and per FY for hospice, SNF, IRF, and LTCH claims. If a beneficiary has multiple claims for a given provider with primary diagnoses across categories, then the beneficiary will be included in each primary diagnosis category for that provider for which they have at least one claim. Please review the PAC PUF Methodology for further information.

Q: Why are the PAC PUF results different than other CMS products?

A: CMS publishes different data products for different purposes. Each data publication has their own respective methodology which may differ in the data sources and calculations. Caution should be used when comparing results across CMS data releases.

Q: If I publish findings from the PAC PUF in medical journals, do I need to obtain permission from CMS?

A: No. This data is public information, and users are free to use the data in publications.