PAC PUF FAQ’s for Website

Why were changes made to the previously released versions of the Home Health, Skilled Nursing Facility, and Hospice PUFs?

The Post-Acute Care and Hospice Utilization and Payment Public Use Files (PAC PUF) allows CMS to report data for home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals, better aligning CMS’ information products with the data standardization and cross-setting measures outlined in the 2014 Improving Medicare Post-Acute Transformation Act (IMPACT Act). While not included in the IMPACT Act, hospice provider information is included in the PAC PUF for ease of use.

What is the difference between “Total Charges” and “Total Payments”?

“Total Charges” refers to what the provider bills to Medicare. “Total Payments” refers to what Medicare actually pays to the provider.

Who pays the difference between what the provider charges and Medicare pays?

The provider has an agreement with Medicare to accept Medicare’s payment and the difference is not paid by Medicare or any other entity, including the beneficiary.

What is the difference between “Medicare Payment Amount” and “Medicare Standard Payment Amount”?

“Medicare Payment Amount” is the actual amount that Medicare pays. “Medicare Standard Payment Amount” is the amount that Medicare pays for episodes adjusted for geographic differences in payment rates.

How are averages calculated for the “Average Charge Amount”, “Average Allowed Amount”, “Average Payment Amount”, and “Average Standardized Payment Amount” variables?

The average payment and charge variables reflect the total payments or charges for a given provider code divided by the number of beneficiaries, episodes/stays, or days of service provided.

What are the definitions for the “Total Episodes/Stays” and “Distinct Users” variables?

“Total Episodes” reflects the total count of episodes provided by a specific home health agency in the calendar year. “Total Stays” reflects the total count of stays provided by a specific hospice, SNF, IRF or LTCH in the calendar year. “Distinct Users” reflects the number of distinct Medicare beneficiaries receiving at least one episode or stay in the calendar year. Beneficiaries may receive multiple episodes/stays per year but are only counted once in this field.

Can “Distinct Beneficiaries” be summed across providers for a total count of distinct users in the PAC PUF?

No, beneficiaries cannot be summed across providers for a total count of distinct users. Beneficiaries will only be counted once per provider, but a beneficiary may receive services from more than one provider in a year.

What are the "Total Days" variables in the PAC PUF? Can these variables be used to calculate beneficiary length of stay?
"Total days" reflects the total count of care days provided by a specific provider in the calendar year. Total days cannot be used to calculate length of stay because many home health, hospice and skilled nursing facility beneficiaries have stays that span multiple calendar years. The "Total days" variable in the PUF only includes the care days provided in a particular year.

Can a beneficiary be listed in more than one chronic condition indicator per row?
Yes, a beneficiary may have multiple chronic conditions and may be listed in more than one chronic condition indicator for a particular provider.

Can a beneficiary be listed in more than one primary diagnosis indicator per row?
No, a beneficiary cannot have multiple primary diagnoses and may not be listed in more than one primary diagnosis indicator for a particular provider.

How are therapy minutes defined in the PAC PUF?
Therapy minutes includes physical therapy, occupational therapy, and speech language pathology. All individual, half of concurrent, and one fourth of group minutes are included in this calculation.

What are the site of service variables? How was site of service determined in the PAC PUF?
The PAC PUF contains 6 variables containing the percent of hospice and home health days of care delivered at: 1) home; 2) assisted living facilities; 3) long-term care or unskilled nursing facilities; 4) skilled nursing facilities; 5) inpatient hospitals; and 6) inpatient hospice facilities. Note that starting in 2017, the methodology used for this measure is different than previously released versions of the hospice PUF, counting the proportion of days each provider delivered at each site of service, rather than the beneficiary count for which the beneficiary had the highest number of site of service days.

Does the PAC PUF contain information for beneficiaries in Medicare Advantage? What about Medicaid beneficiaries?
The PAC PUF contains limited information for certain beneficiaries enrolled in a Medicare Advantage plan, such as when MA beneficiaries receive out of network care that is paid under the Medicare fee-for-service program, as well as hospice claims for MA beneficiaries that elect hospice. Medicare Advantage encounter records are not included in the PAC PUF. The file also does not include claims from commercial payers or Medicaid.

Are any of the data suppressed in the PAC PUF data?
Data was suppressed if the provider delivered services to 10 or fewer beneficiaries in the calendar year.

If I publish findings from the PAC PUF in medical journals, do I need to obtain permission from CMS?
No, this data is public information and users are free to use the data in publications.