Health Equity Confidential Feedback Reports Post-Acute Care Quality Report Programs (PAC QRPs)

Frequently Asked Questions

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Document Acronyms

Asian American/Native Hawaiian/Pacific Islander (AA and NHPI)
Calendar Year (CY)
Centers for Medicare & Medicaid Services (CMS)
Core-Based Statistical Area (CBSA)
CMS Certification Number (CCN)
Discharge to Community (DTC)
Division of Chronic and Post-Acute Care (DCPAC)
Frequently Asked Questions (FAQ)
Fee-for-Service (FFS)
Fiscal Year (FY)
Health Care Quality Information Systems (HCQIS)
HCQIS Access Roles and Profile (HARP)
Home Health (HH)
Inpatient Rehabilitation Facility (IRF)
Medicare Bayesian Improved Surname Geocoding (MBISG)
Medicare Enrollment Database (EDB)
Medicare Spending per Beneficiary (MSPB)
Long-Term Care Hospital (LTCH)
Post-Acute Care (PAC)
Provider of Services (POS)
Risk-Standardized DTC Rate (RSDTCR)
Skilled Nursing Facility (SNF)
Social Risk Factor (SRF)
Questions and Answers (Q&A)

1.0 Introduction

The Centers for Medicare & Medicaid Services (CMS) Division of Chronic and Post-Acute Care (DCPAC) developed new PAC Health Equity Confidential Feedback Reports that were made available to Post-Acute Care (PAC) providers in October, 2023. This Frequently Asked Questions document provides responses to key questions regarding the Health Equity Confidential Feedback Reports. This document is intended to be referenced in conjunction with the Health Equity Confidential Feedback Reports Fact Sheet, Education and Outreach webinar materials, and Questions and Answers (Q&A) session materials.[1]

2.0 Frequently Asked Questions and Answers

In this document, CMS has gathered frequently asked questions about PAC Health Equity Confidential Feedback Reports and summarized answers.

Section 2.1 responds to questions regarding report basics.
Section 2.2 responds to questions about accessing the reports.
Section 2.3 provides information regarding CMS's measurement of health equity.
Section 2.4 responds to questions regarding the report methodology.
Section 2.5 responds to questions regarding how providers can use their results.

2.1 Report Basics

In this section, CMS responds to questions regarding the basics of the PAC Health Equity Confidential Feedback Reports, such as the quality measures included in the reports and the anticipated frequency of report distribution

2.1.1 What are the PAC Health Equity Confidential Feedback Reports?

The PAC Health Equity Confidential Feedback Reports contain confidential information for provider's reference. Currently, CMS releases two separate reports that show provider performance on the Discharge to Community (DTC-PAC) and Medicare Spending per Beneficiary (MSPB-PAC) measures, stratified by beneficiaries' Medicare-Medicaid dual-enrollment status, and separately by beneficiaries' race/ethnicity. For information regarding how CMS uses results for these reports see Section 2.3.6.

2.1.2 Which PAC providers are able to access these reports?

The PAC Health Equity Confidential Feedback Reports will be available for the following provider types: Home Health Agencies (HHAs), Inpatient Rehabilitation Facilities (IRFs), Long-Term Care Hospitals (LTCHs), and Skilled Nursing Facilities (SNFs). Please note that different types of PAC providers are not compared to one another.

Additionally, individual provider access to the Health Equity Confidential Feedback Reports is subject to the reportability thresholds set by CMS. See Section 2.2.3 for more details.

2.1.3 Will CMS continue to produce these reports every year?

CMS plans to update the PAC Health Equity Confidential Feedback Reports **annually** after Fall 2023. Please refer to Section 2.4.2 for information on the years of data included in the reports for each PAC setting.

2.1.4 Will these reports be made publicly available?

The 2023 PAC Health Equity Confidential Feedback Reports are strictly confidential and released to providers for their reference. CMS's intention behind releasing these reports is for providers to use their results to develop strategies to reduce the negative impacts of social risk factors (SRFs) on measure

[1] Providers can access their Education & Outreach materials from the following provider training sites: HH, IRF, LTCH, SNF.

outcomes for their patients. Results from the 2023 PAC Health Equity Confidential Feedback Reports do not impact publicly reported quality program scores or provider reimbursement.

2.2 Accessing Your Results

This section explains how providers can access their reports, receive a 508 compliant copy of their report, and why they might not be eligible to receive a report.

2.2.1 How can I access my facility's/agency's report results?[2]

To locate your Health Equity Confidential Feedback Reports in iQIES, please follow the instructions listed below:

- Log into iQIES at https://iqies.cms.gov/ using your Health Care Quality Information Systems (HCQIS) Access Roles and Profile (HARP) user ID and password.
  - If you do not have a HARP account, you may register for a HARP ID.
- From the Reports menu, select My Reports.
- From the My Reports page, locate and select the *Health Equity Confidential Feedback Reports* folder link.
- Displayed for you is a list of reports available for download.
- Select the report name link to view the Health Equity Confidential Feedback Report data.

If there are questions regarding accessing the Health Equity Confidential Feedback reports in iQIES, please contact the iQIES Service Center by email at iQIES@cms.hhs.gov or by phone at (800) 339-9313. For more information, please visit the Post-Acute Quality Initiatives Home Page.

2.2.2 How can I receive a 508 compliant copy of my report?

Providers can directly download their report using instructions from Section 2.2.1 above. However, if you would like to request a 508 compliant version of your PAC Health Equity Confidential Feedback Report, please email: HomeHealthQualityQuestions@cms.hhs.gov, IRF.questions@cms.hhs.gov, LTCHQualityQuestions@cms.hhs.gov, or SNFQualityQuestions@cms.hhs.gov

2.2.3 Why didn't my facility/agency receive a report, or a certain result in the report?

For each comparison method and stratification group included in the report for a given measure, a facility/agency has to meet specific reportability thresholds to receive certain results in their report. These requirements are described in detail in the Methodology Report.[3]

Additionally, a facility/agency must meet the across-provider comparison reportability threshold described in Section 2.4.4 for at least one race/ethnicity or dual-status population. This requirement ensures that all providers that receive the Health Equity Confidential Feedback Report have at least one comparison result populated in their report. If a provider does not meet this requirement, they do not receive a Health Equity Confidential Feedback Report.

2.3 Measuring Health Equity

This section answers questions about why CMS is measuring health equity. Providers can also learn about how CMS plans to use the reports and the reasoning behind the selected stratifiers.

2.3.1 Why is CMS measuring Health Equity?

The CMS Strategic Framework outlines strategic priorities identified by CMS. Among them is the need to

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[2] The terms "facility" and "agency" are used together to describe appropriate terminology for different PAC settings: IRF/LTCH/SNF (facility) and HH (agency), respectively.

[3] Providers can access their Education & Outreach materials from the following provider training sites: HH, IRF, LTCH, and SNF.

advance health equity across CMS programs. CMS's commitment to advancing health equity is further described in both the 2023 CMS Strategic Framework and the newly updated CMS Framework for Health Equity, which note the need to expand analysis of quality information to identify disparities.

2.3.2 Which measures did CMS choose to stratify in the Fall 2023 PAC Health Equity Confidential Feedback Reports, and why?

The DTC-PAC and MSPB-PAC measures are important, valid, and reliable cross-setting PAC QRP measures. They capture important patient[4] outcomes and efficiency of care. For more information on how these measure results are calculated for the Health Equity Confidential Feedback Reports, please see the Methodology Report.[5]

The Discharge-to-Community (DTC-PAC) measure represents the rate of successful discharge to the community, with successful discharge to the community including no unplanned rehospitalizations and no death in the 31 days following discharge from a PAC setting. In the reports, this is measured with a percentage rate called the Risk-Standardized DTC Rate (RSDTCR).

The Medicare Spending Per Beneficiary (MSPB-PAC) measure represents Medicare spending during a PAC treatment period and 30 days after. In the reports, this is measured in average dollar amounts called the average MSPB Amount.

2.3.3 Why did CMS choose Medicare-Medicaid dual enrollment status and race/ethnicity as the stratifiers?

Research suggests that certain social risk factors (SRFs), such as having a low-income background or being of a particular race/ethnicity, may be associated with an increased risk of poor health outcomes.[6] Dual enrollment status is used as a stratifier in the Health Equity Confidential Feedback Reports because research has shown that beneficiaries who are dually enrolled in Medicare and Medicaid tend to have more complex care needs compared to those who are eligible for only one program due to age, disability, or low-income status.[7] Additionally, CMS stratifies measure outcomes by race/ethnicity in the Health Equity Confidential Feedback Reports in order to better identify differences and variations in quality of care received by patients with different racial/ethnic backgrounds.

2.3.4 How is dual-enrollment status defined in the report?

Throughout the reports, the terms "dually enrolled" or "duals" indicate beneficiaries who were dually enrolled in both Medicare and Medicaid at any point during their stay. Similarly, the terms "non-dually enrolled" or "non-duals" indicate beneficiaries who were not dually enrolled in Medicare and Medicaid at any point during their stay.

2.3.5 What race/ethnicity groups are shown in the report?

The race/ethnicity categories shown in the reports are: Asian American/Native Hawaiian/Pacific Islander, Black, Hispanic, White, and Non-White. The "Non-White" group consists of American Indian/Alaska Native, Asian American/Native Hawaiian/Pacific Islander, Black, and Hispanic populations. Results for American Indian/Alaska Native patients are not shown separately because of limited sample size and accuracy concerns during testing.

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[4] Throughout this document CMS uses "patients" to refer to patients in the IRF, LTCH, and HH settings, and residents in the SNF setting.

[5] Providers can access their Education & Outreach materials from the following provider training sites: HH, IRF, LTCH, and SNF.

[6] See, for example, National Academies of Sciences, Engineering, and Medicine. Accounting for social risk factors in Medicare payment. Washington, DC: National Academies Press, 2017.

[7] See, for example, Coughlin, Teresa A., Timothy A. Waidmann, and Lokendra Phadera. 2012 Health Affairs 31, no. 5

2.3.6 What are CMS's long-term plans for these reports?

CMS plans to release the PAC Health Equity Confidential Feedback Reports to providers on an annual basis. CMS is continuing to explore the potential of expanding this confidential feedback report approach to other measures and other SRFs and/or demographic variables for future reporting. Additionally, CMS is also exploring the use of PAC assessments data as a source for SRFs and demographic variables as such data become available.

2.4 Methodology

This section responds to questions regarding the PAC Health Equity Confidential Feedback Report methodology. Key concepts covered include stratification basics, the comparisons made in the report (across- and within- provider), and measure risk-adjustment. For more detailed methodological information, please see the Methodology Report.[8]

2.4.1 What is stratification and why is it important?

Stratification involves the calculation of certain outcomes separately for different populations. Stratified measure outcomes can provide valuable insight on how different patient populations perform on a given measure. This allows providers to see how the outcome of their care may differ between certain patient populations in a way that would not be apparent from an overall score (i.e., a score averaged over all beneficiaries).

2.4.2 What data did CMS use to calculate the results?

Data for a given year's report comes from the most recently completed payment determination year (PDY), based on the PAC setting.
Fall 2023 reports are based on data from:

- HH: Calendar Year (CY) 2021-2022
- IRF, LTCH, and SNF: Fiscal Year (FY) 2021-2022

Below is a list of data sources used to calculate results for the report:

- **Medicare Part A and B fee-for-service claims** are used to calculate DTC-PAC and MSPB-PAC measure outcomes and conduct risk-adjustment.

- **Medicare Enrollment Database (EDB)** data are used to determine beneficiaries' dual-enrollment status.

  Throughout the reports, the terms "dually enrolled" or "duals" indicate beneficiaries who were dually enrolled in both Medicare and Medicaid at any point during their stay. Similarly, the terms "non-dually enrolled" or "non-duals" indicate beneficiaries who were not dually enrolled in Medicare and Medicaid at any point during their stay.
- **Medicare Bayesian Improved Surname Geocoding (MBISG) Version 2.1.1** method is used to identify beneficiaries' race/ethnicity.

  The gold standard for measuring data on race and ethnicity is data that patients self-report. However, studies have shown that existing Medicare administrative race and ethnicity data which are based on self-reported data given a list of race and ethnicity options are often inaccurate. The original CMS administrative data on race and ethnicity are based on information reported to the Social Security Administration (SSA), using a form that required most patients enrolled in Medicare (those whose SSA information was provided prior to 1980) to choose "Black," "White," or "Other" as their race/ethnicity designation. For this reason, these data often misclassify Asian American and

[8] Providers can access their Education & Outreach materials from the following provider training sites: HH, IRF, LTCH, and SNF.

Native Hawaiian or other Pacific Islander, Native American, and Hispanic patients. In the absence of accurate self-reported race and ethnicity data on individuals, alternative approaches are often used, such as the method of indirect estimation.[9]

Therefore, for the PAC Health Equity Confidential Feedback Reports, CMS is using the Medicare Bayesian Improved Surname Geocoding Version 2.1.1 (MBISG 2.1.1), an imputation method designed for CMS by the RAND Corporation, to indirectly estimate racial and ethnic disparities. The race/ethnicity categories shown in the reports are: Asian American/Native Hawaiian/Pacific Islander, Black, Hispanic, White, and Non-White.[10] The "Non-White" group consists of American Indian/Alaska Native, Asian American/Native Hawaiian/Pacific Islander, Black, and Hispanic populations. Results for American Indian/Alaska Native patients are not shown separately because of limited sample size and accuracy concerns during testing.

2.4.3 Are the DTC-PAC and MSPB-PAC measure outcomes risk adjusted?

Yes, please see the Methodology Report for further information on the individual measure adjustments.[11]

2.4.4 What are the across- and within- comparisons presented in the report?

The PAC Health Equity Confidential Feedback Reports include two broad types of comparisons which provide a comprehensive summary of differences in care: Across- and Within- provider comparisons. The below sections provide detailed information about each comparison.

Across-Provider Comparison

The across-provider comparisons compare a given provider to all other providers *across* their same care setting (e.g., your LTCH compared to all LTCHs nationwide[12]). In the reports, CMS provides two *across*-provider comparisons: comparison to the national performance among all patients, and comparison to the national performance among the same populations. See below for more detail.

1. Comparison to the National Performance Among All Patients

The first across-provider comparison compares the measure outcome among a specific population at your facility (e.g., your LTCH's duals) to the national performance across all patients in your care setting (e.g., all LTCH patients nationwide). Please see the Methodology Report for further information.

Figure 1 depicts the concept of the across-provider comparison to the national performance across all patients.

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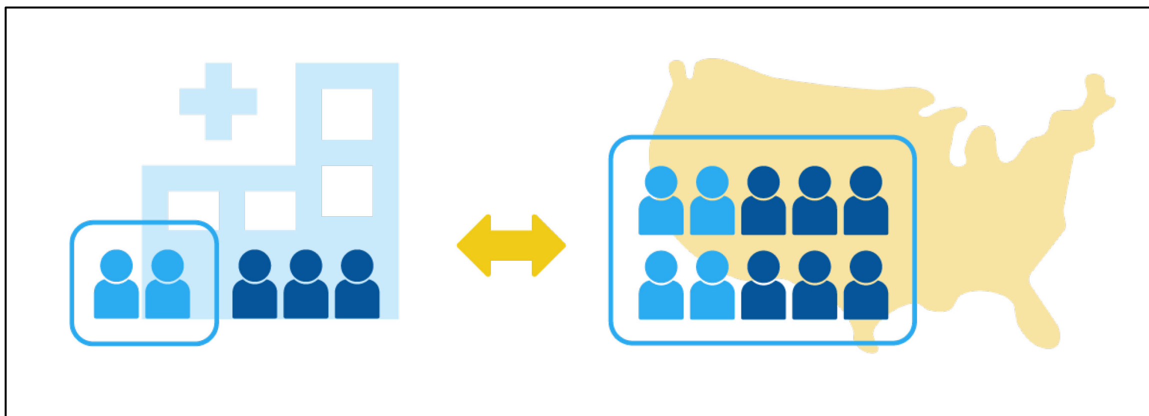
[9] See for example, Eicheldinger, C., & Bonito, A. More accurate racial and ethnic codes for Medicare administrative data. Health care financing review. 2008

[10] All groups other than Hispanic are defined as non-Hispanic.

[11] Providers can access their Education & Outreach materials from the following provider training sites: HH, IRF, LTCH, and SNF.

[12] Examples in this section use LTCHs to demonstrate how concepts apply for a given type of provider, but the same principals apply within the Health Equity Confidential Feedback Reports for HH, IRF, and SNF providers as well.

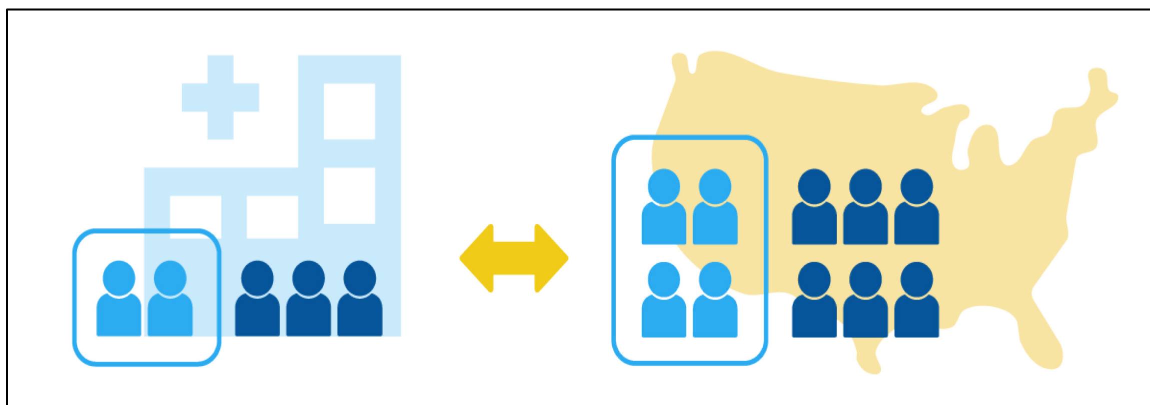
Figure 1. Across-Provider Comparison to the National Performance Across All Patients



2. Comparison to the National Performance Among the Same Population

The second across-provider comparison compares the measure outcome among a specific population at your facility (e.g., your LTCH's duals) to the national performance among the same population in your care setting (e.g., all duals in LTCHs nationwide). Please see the Methodology Report for further information. **Figure 2** depicts the concept of the across-provider comparison to the national performance among the same population.

Figure 2. Across-Provider Comparison to the National Performance Among the Same Population



Within-Provider Comparison

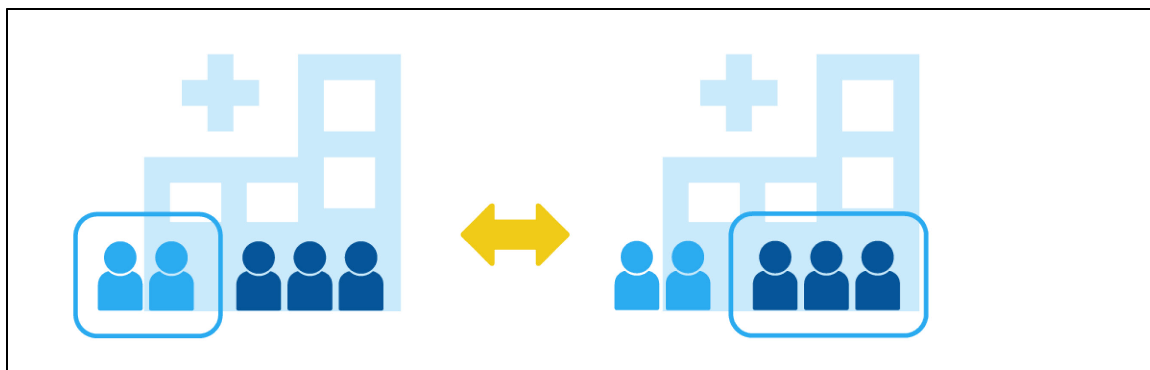
The within-provider comparison examines differences in the quality of care by comparing outcomes for stratified patient populations *within* the individual provider's care. Please see the Methodology Report for further information.

The within-provider comparison calculates two sets of measure performance differences between the following two combinations of patient populations:

- Patients who are dually enrolled and patients who are not dually enrolled; and
- Patients who are Non-White and patients who are White.

Figure 3 depicts the concept of the within-provider comparison. Here, CMS compares outcomes among a specific population at your facility (e.g., your LTCH's duals) to outcomes among a specific population at your facility (e.g., your LTCH's non-duals).

Figure 3. Within-Provider Comparison



2.4.5 How does CMS identify providers in similar geographic locations?

The Health Equity Confidential Feedback Reports provide information on patient outcomes among facilities/agencies in similar geographic locations, to give providers an idea of how providers located in similar areas performed. The geographic locations included in the reports are as follows: Rural or Urban location, Core-Based Statistical Area (CBSA), State, and Region. A facility/agency's rurality and CBSA information are obtained from the "Provider of Services (POS) File - Hospital & Non-Hospital Facilities" dataset, which is a publicly available source of provider certification, termination, accreditation, ownership, name, location, and other characteristics organized by CMS Certification Number (CCN).[13] State and Region data are determined from the facility/agency's CCN.

2.4.6 How does CMS identify providers with similar patient composition?

The Health Equity Confidential Feedback Reports provide information on patient outcomes among facilities/agencies with similar patient composition based on three characteristics: average clinical complexity, or "risk," of their patients; proportion of dual patients; and proportion of Non-White patients. The following sections provide further information on each characteristic.

How does CMS calculate risk brackets?

Patient risk brackets allow CMS to categorize providers based on average clinical complexity, or "risk," of patients within the facilities/agencies.
CMS calculates risk brackets using the following steps:

- CMS calculates a risk score for each DTC stay/MSPB episode that indicates the complexity of your patient.
    - For the DTC-PAC measure, it's calculated as the stay's expected DTC rate, as predicted through risk adjustment. A higher value indicates that the patient is more likely to have a successful discharge to community, based on the patient characteristics in the risk adjustment model.
    - For the MSPB-PAC measure, it's calculated as the stay's expected MSPB Amount, as predicted through risk adjustment. A lower value indicates that the patient is more likely to have a lower resource use during their stay, based on the patient characteristics in the risk adjustment model.
- CMS then calculates your average risk score. This is the average of the risk scores for all your DTC stays/MSPB episodes.

[13] More information on the POS dataset can be found here: https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-hospital-non-hospital-facilities

- Finally, CMS creates a distribution of the average risk score across all providers in your care setting with at least 25 (IRF/LTCH/SNF providers) or 20 (HH providers) stays for the DTC-PAC measure or at least 20 episodes for the MSPB-PAC measure.
    - CMS divides the distribution into deciles to create risk brackets with an equal number of providers in each bracket.
    - Risk bracket 10 includes providers with the highest average risk, while risk bracket 1 includes providers with the lowest average risk.

Your risk bracket includes providers who have a similar average risk score as you.

How does CMS calculate dual quintiles?

To determine facilities/agencies with similar proportions of dual patients, CMS groups each facility/agency into dual quintiles.

Dual-enrollment quintiles are calculated in the following steps:

- CMS calculates the proportion of your DTC stays/MSPB episodes that belong to beneficiaries identified as dually enrolled.
    - For the DTC-PAC measure report, CMS repeats the same calculation for each provider in your care setting with at least 25 (IRF/LTCH/SNF providers) or 20 (HH providers) stays for the measure.
    - For the MSPB-PAC measure report, CMS repeats the same calculation for each provider in your care setting with at least 20 episodes for the measure.
- Finally, CMS creates a distribution of the provider-level dual proportions. CMS divides the distribution into five quintiles with an equal number of providers in each quintile. Each quintile includes providers with a similar proportion of dual patient stays/episodes.
    - Quintile 5 includes providers with the highest proportion of duals, while quintile 1 includes providers with the lowest proportion of duals.

How does CMS calculate Non-White quintiles?

To determine the facilities/agencies with similar proportions of Non-White patients, CMS groups each facility/agency into Non-White quintiles.

Non-White quintiles are calculated in the following steps:

- CMS calculates the proportion of your DTC stays/MSPB episodes that belong to beneficiaries identified as Non-White.
    - For the DTC-PAC measure report, CMS repeats the same calculation for each provider in your care setting with at least 25 (IRF/LTCH/SNF providers) or 20 (HH providers) stays for the measure.
    - For the MSPB-PAC measure report, CMS repeats the same calculation for each provider in your care setting with at least 20 episodes for the measure.
- Finally, CMS creates a distribution of the provider-level Non-White proportions. CMS divides the distribution into five quintiles with an equal number of providers in each quintile. Each quintile includes providers with a similar proportion of Non-White patient stays/episodes.
    - Quintile 5 includes providers with the highest proportion of Non-White patients, while quintile 1 includes providers with the lowest proportion of Non-White patients.

2.4.7 Why did my facility/agency not receive a geographic location-related result within the report?

A given geographic location (e.g., Your CBSA, Your State, Your Region) result shows “N/A” values if your geographic location did not meet the reporting threshold (minimum ten facilities or agencies with reportable comparison results), or if no data were available on your facility’s geographic location. Further, the “Your CBSA” column is not populated with data if your facility is located in an area outside a Metropolitan

Statistical Area. Please see the Methodology Report for further information.[14]

2.5 Using Results

This section answers questions regarding how providers can interpret and understand their results. Additionally, providers can find more information on how to use their results, or find more resources to further understand the Health Equity Confidential Feedback Reports.

2.5.1 What results does CMS calculate for each comparison?

CMS produces three results for each of the comparison types, for both the DTC-PAC and MSPB-PAC reports:

- The Difference
- Confidence Interval of the Difference (i.e., “Confidence Interval”)
- Category of the Difference

This section describes these results in more detail.

Difference in Measure Performance

For each across- and within- provider comparison, CMS calculates a difference in measure performance between two groups. Each difference is calculated using the approach described in **Table 1** below.

Table 1: Health Equity Confidential Feedback Report Difference Calculation Methods

Comparison		Difference Calculation Method
Across-Provider Comparison	Comparison to the national performance among all patients	Your patients’ performance minus the national performance
	Comparison to the national performance among the same population	Your patients’ performance minus the national performance among same population
Within-Provider Comparison	Dual Status	Your patients’ performance for Duals minus your patients’ performance for Non-Duals.
	Race/Ethnicity	Your patients’ performance for Non-White patients minus your patients’ performance for White patients.

Confidence Interval of the Difference

The Confidence Interval shows the 95% confidence interval of the Difference; it includes the lower bound of the confidence interval, followed by the upper bound. We are 95% confident that the true outcome difference (e.g., within-facility difference between duals and non-duals at your facility) falls between the lower and upper bounds. To see an example walkthrough of a Health Equity Confidential Feedback Report table, including confidence intervals, please see the Health Equity Confidential Feedback Reports for Post-

[14] Providers can access their Education & Outreach materials from the following provider training sites: HH, IRF, LTCH, and SNF.

Acute Care Education and Outreach Webinar slides.[15]

Category of the Difference

For each across-provider and within-provider difference, each facility/agency receives a categorization to describe whether their facility/agency's patient populations are performing statistically significantly "Better than," "Worse than," or "No Different from," the comparison group. The values of the upper and lower bounds of the confidence interval determine whether the facility/agency's measure outcome for a particular population is statistically higher, lower, or no different than that of the comparison group. The below tables (Tables 3, 4, 5) describe the Category of Difference results for each comparison.

Table 2 describes how providers receive a given Category of the Difference designation for the across-provider comparisons to the national performance among all patients. To see an example walkthrough of a Health Equity Confidential Feedback Report table, including category of the difference interpretations, please see the Health Equity Confidential Feedback Reports for Post-Acute Care Education and Outreach Webinar slides.

Table 2: Category of The Difference Assignments for Across-Provider Comparisons to the National Performance Among All Patients

Category of the Difference	DTC-PAC measure	MSPB-PAC measure
Better than	If the lower bound of the confidence interval is greater than zero, then the category of the difference is "Better Outcome than National Rate," indicating that a facility/agency's Risk-Standardized DTC Rate (RSDTCR) for the patient population is statistically significantly higher than the national rate ($p<0.05$).	If the upper bound of the confidence interval is smaller than zero, then the category of the difference is "Better Outcome than National Average," indicating that a facility/agency's average MSPB-PAC Amount for the specific population is statistically significantly lower than the national average MSPB-PAC Amount ($p<0.05$).
Worse than	If the upper bound of the confidence interval is smaller than zero, then the category of the difference is "Worse Outcome than National Rate," indicating that your facility/agency's RSDTCR for the patient population is statistically significantly lower than the national rate ($p<0.05$).	If the lower bound of the confidence interval is greater than zero, then the category of the difference is "Worse Outcome than National Average," indicating that a facility/agency's average MSPB-PAC Amount for the specific population is statistically significantly higher than the national average MSPB-PAC Amount ($p<0.05$).
No Different from	If the confidence interval range contains zero between the lower and upper bounds, then the category of the difference is "Outcome is No Different than National Rate," indicating that a facility/agency's RSDTCR for the patient population is not statistically significantly different from the national rate.	If the confidence interval range between the lower and upper bounds contains zero, then the category of the difference is "Outcome is No Different than National Average," indicating that a facility/agency's average MSPB-PAC Amount for the specific population is not statistically significantly different from the national average MSPB-PAC Amount.

[15] Providers can access their Education & Outreach materials from the following provider training sites: HH, IRF, LTCH, and SNF.

Category of the Difference	DTC-PAC measure	MSPB-PAC measure
Not Applicable or "N/A"	If a facility/agency has an observed DTC rate of 0% or 100% for the patient population, indicating no variation in observed outcomes, confidence intervals and statistical significance are not calculated. Additionally, if a facility/agency does not meet the minimum required case count for the specific patient population, the confidence interval and the *Category of the Difference* are set to "N/A."	If a facility/agency does not meet the minimum required case count for the specific patient population, the confidence interval and the *Category of the Difference* are set to "N/A."

Table 3 describes how providers receive a given Category of the Difference designation for the across-provider comparisons to the national performance among patients of the same population.

Table 3: Category of the Difference Assignments for Across-Provider Comparisons to the National Performance Among Same Population

Category of the Difference	DTC-PAC measure	MSPB Measure
Better than	If the lower bound of the confidence interval is greater than zero, then the category of the difference is "Better Outcome than National Rate for the [Patient Population]," indicating that a facility/agency's RSDTCR for the specific patient population is statistically significantly higher than the national rate for the same population ($p<0.05$).	If the upper bound is smaller than zero, then the category of the difference is "Better Outcome than National Average for [Patient Population]," indicating that a facility/agency's average MSPB Amount for the specific population is statistically significantly lower than the national average for the same population ($p<0.05$).
Worse than	If the upper bound is smaller than zero, then the category of the difference is "Worse Outcome than National Rate for the [Patient Population]," indicating that a facility/agency's RSDTCR for the specific patient population is statistically significantly lower than the national rate for the same population ($p<0.05$).	If the lower bound of the confidence interval is greater than zero, then the category of the difference is "Worse Outcome than National Average for [Patient Population]," indicating that a facility/agency's average MSPB Amount for the specific population is statistically significantly higher than the national average for the same population ($p<0.05$).
No Different from	If the confidence interval range contains zero between the lower and upper bounds, then the category of the difference is "Outcome is no different than national rate for [Patient Population]," indicating that a facility/agency's RSDTCR for the specific population is not statistically significantly different from the national rate for the same population.	If the confidence interval range contains zero between the lower and upper bounds, then the category of the difference is "Outcome is No Different than National Average for [Patient Population]," indicating that a facility/agency's average MSPB Amount for the specific population is not statistically significantly different from the national average for the same population.

Category of the Difference	DTC-PAC measure	MSPB Measure
Not Applicable or "N/A"	If a facility/agency has an observed DTC rate of 0% or 100% for the patient population, indicating no variation in observed outcomes, confidence intervals and statistical significance are not calculated. Additionally, if a facility/agency does not meet the minimum required case count for the specific patient population, the confidence interval and the *Category of the Difference* are set to "N/A."	If a facility/agency does not meet the minimum required case count for the specific patient population, the confidence interval and the *Category of the Difference* are set to "N/A."

Table 4 describes how providers receive a given Category of the Difference designation for the within-provider comparisons.

Table 4: Category of the Difference Assignments for Within-Provider Comparisons

Category of the Difference	DTC-PAC measure	MSPB-PAC measure
Better than	If the lower bound of the confidence interval is greater than zero, then the category of the difference is "Better Outcome" than the comparison group, indicating that a facility/agency's RSDTCR for dual or Non-White patients is statistically significantly higher than the facility/agency's RSDTCR for the comparison population (non-dual or White patients, respectively) within the stratification ($p<0.05$).	If the upper bound is smaller than zero, then the category of the difference is "Better Outcome" than the comparison group, indicating that a facility/agency's average MSPB Amount for dual or Non-White patients is statistically significantly lower than the facility/agency's average MSPB Amount for the comparison group (non-dual or White patients, respectively) within the stratification ($p<0.05$).
Worse than	If the upper bound is smaller than zero, then the category of the difference is "Worse Outcome" than the comparison group, indicating that a facility/agency's RSDTCR for dual or Non-White patients is statistically significantly lower than the facility/agency's RSDTCR for the comparison group (non-dual or White patients) within the stratification ($p<0.05$).	If the lower bound of the confidence interval is greater than zero, then the category of the difference is "Worse Outcome" than the comparison group, indicating that a facility/agency's average MSPB Amount for dual or Non-White patients is statistically significantly higher than the facility/agency's average MSPB Amount for the comparison group (non-dual or White patients) within the stratification ($p<0.05$).

Category of the Difference	DTC-PAC measure	MSPB-PAC measure
No Different From	If the Confidence Interval range contains zero between the lower and upper bounds, then the category of the difference is "Outcome is No Different" than the comparison group, indicating that a facility/agency's RSDTCR for dual or Non-White patients is not statistically significantly different from the facility/agency's RSDTCR for the comparison group (non-dual or White patients) within the stratification.	If the confidence interval range contains zero between the lower and upper bounds, then the category of the difference is "Outcome is No Different" than the comparison group, indicating that a facility/agency's average MSPB Amount for dual or Non-White patients is not statistically significantly different from the facility/agency's average MSPB Amount for the comparison group (non-dual or White patients) within the stratification.
Not Applicable or N/A	If a facility/agency has an observed DTC rate of 0% or 100% for either the patient population or the comparison group, confidence intervals and statistical significance are not calculated. Additionally, if a facility/agency does not meet the minimum required case count for the patient population (dual or Non-White patients) or the comparison group (non-dual or White patients), the confidence interval and the *Category of the Difference* are set to "N/A."	If a facility/agency does not meet the minimum required case count for the patient population (dual or Non-White patients) or the comparison group (non-dual or White patients), the confidence interval and the *Category of the Difference* are set to "N/A."

2.5.2 How should I interpret my across-provider comparison results?

Tables 6 and 7 below provide information on how to interpret the across-provider comparison results.

Across-Provider Comparison to National Performance Among All Patients

Table 5 summarizes how to interpret the *Difference* and *Category of the Difference* results from the Across-Provider Comparison to National Performance Among All Patients.

Table 5. DTC-PAC and MSPB-PAC measure Report Result Interpretations for Across-Provider Comparison to National Performance Among All Patients

Discharge to Community	Medicare Spending per Beneficiary
A **positive** DTC Rate Difference signifies that the specific patient population at your facility/agency has a higher DTC rate (i.e., better outcome) than patients nationwide in the care setting.	A **positive** Average MSPB Amount Difference signifies that the specific patient population at your facility/agency has a higher average MSPB amount (i.e., worse outcome) than patients nationwide in the care setting.
A **negative** DTC Rate Difference signifies that the specific patient population at your facility/agency has a lower DTC rate (i.e., worse outcome) than patients nationwide in the care setting.	A **negative** Average MSPB Amount signifies that the specific patient population at your facility/agency has a lower average MSPB amount (i.e., better outcome) than patients nationwide in the care setting.

Across-Provider Comparison to National Performance Among the Same Population

Table 6 summarizes how to interpret the *Difference* and *Category of the Difference* results from the across-provider comparison to national performance among the same population.

Table 6. DTC-PAC and MSPB-PAC measure Report Result Interpretations for Across-Provider Comparison to National Performance Among the Same Population

Discharge to Community	Medicare Spending per Beneficiary
A **positive** DTC Rate Difference signifies that the specific patient population at your facility/agency has a higher DTC rate (i.e., better outcome) than patients of the same specific population nationwide in the care setting.	A **positive** Average MSPB Amount Difference signifies that the specific patient population at your facility/agency has a higher average MSPB amount (i.e., worse outcome) than patients of the same specific population nationwide in the care setting.
A **negative** DTC Rate Difference signifies that the specific patient population at your facility/agency has a lower DTC rate (i.e., worse outcome) than patients of the same specific population nationwide in the care setting.	A **negative** Average MSPB Amount Difference signifies that the specific patient population at your facility/agency has a lower average MSPB amount (i.e., better outcome) than patients of the same specific population nationwide in the care setting.

2.5.3 How should I interpret my within-provider comparison results?

Table 7 summarizes how to interpret the *Difference* and *Category of the Difference* results from the within-provider comparisons.

Table 7. DTC-PAC and MSPB-PAC measure Report Result Interpretations for Within-Provider Comparison

Discharge to Community	Medicare Spending per Beneficiary
A **positive** DTC Rate Difference signifies that: • Duals at your facility/agency have a higher DTC rate (i.e., better outcome) than non-duals at your facility/agency, or • Non-White patients at your facility/agency have a higher DTC rate (i.e., better outcome) than White patients at your facility/agency.	A **positive** Average MSPB Amount Difference signifies that: • Duals at your facility/agency have a higher average MSPB amount (i.e., worse outcome) than non-duals at your facility, or • Non-White patients at your facility/agency have a higher average MSPB amount (i.e., worse outcome) than White patients at your facility.
A **negative** DTC Rate Difference signifies that: • Duals at your facility/agency have a lower DTC rate (i.e., worse outcome) than non-duals at your facility, or • Non-White patients at your facility/agency have a lower DTC rate (i.e., worse outcome) than White patients at your facility.	A **negative** Average MSPB Amount Difference signifies that: • Duals at your facility/agency have a lower average MSPB amount (i.e., better outcome) than non-duals at your facility, or • Non-White patients at your facility/agency have a lower average MSPB amount (i.e., better outcome) than White patients at your facility.

2.5.4 How can PAC providers use the Health Equity Confidential Feedback Reports?

The Health Equity Confidential Feedback Reports provide data on whether differences in measure outcomes for patients with SRFs are occurring at your facility/agency. Providers can use these results to develop strategies to reduce the impacts of SRFs for their patients.

2.5.5 If I would like more information on the PAC Health Equity Confidential Feedback Reports, where should I go?

For further information regarding the 2023 PAC Health Equity Confidential Feedback Reports, please refer to:

- Health Equity Confidential Feedback Reports Fact Sheet.
- Health Equity Confidential Feedback Reports for Post-Acute Care Education and Outreach Webinar.

- Health Equity Confidential Feedback Reports for Post-Acute Care Questions and Answers Webinar.
- Methodology Report.

Providers can access these Education & Outreach materials from the following provider training sites: HH, IRF, LTCH, and SNF.

2.5.6 Where can I share feedback with CMS on the usefulness of the PAC Health Equity Confidential Feedback Reports?

If you would like to submit feedback to CMS on the PAC Health Equity Confidential Feedback Reports, please submit it to your provider-specific helpdesk email.

- HH: HomeHealthQualityQuestions@cms.hhs.gov
- IRF: IRF.questions@cms.hhs.gov
- LTCH: LTCHQualityQuestions@cms.hhs.gov
- SNF: SNFQualityQuestions@cms.hhs.gov

Please include “Health Equity Feedback” in the subject line of your email.