Market Saturation & Utilization State-County Methodology

Data and Analysis Population

The analysis is based on paid Medicare Fee-for-Service (FFS) claims data from the CMS Integrated Data Repository (IDR). The IDR contains Medicare FFS claims, beneficiary data, provider data, and plan data. FFS claims data are analyzed for a 12-month reference period. State- and county-level results are updated quarterly to reflect a more recent 12-month reference period and currently include the following reference periods:

- October 1, 2014 through September 30, 2015
- January 1, 2015 through December 31, 2015
- April 1, 2015 through March 31, 2016
- July 1, 2015 through June 30, 2016
- October 1, 2015 through September 30, 2016
- January 1, 2016 through December 31, 2016
- April 1, 2016 through March 31, 2017
- July 1, 2016 through June 30, 2017
- October 1, 2016 through September 30, 2017
- January 1, 2017 through December 31, 2017
- April 1, 2017 through March 31, 2018
- July 1, 2017 through June 30, 2018
- October 1, 2017 through September 30, 2018
- January 1, 2018 through December 31, 2018
- April 1, 2018 through March 31, 2019
- July 1, 2018 through June 30, 2019
- October 1, 2018 through September 30, 2019
- January 1, 2019 through December 31, 2019

Provider and Beneficiary Location

The Market Saturation and Utilization methodology is different from other public use data with respect to determining the geographic location of a provider. In this analysis, claims are used to define the geographic area(s) served by a provider rather than the provider’s practice address. Further, a provider is defined as “serving a county” if, during the one-year reference period, the provider had paid claims for more than ten beneficiaries located in a county. A provider is defined as “serving a state” if that provider serves any county in the state. Similar to the county-level definition, a provider is defined as “serving a CBSA” if, during the one-year reference period, the provider had paid claims for more than ten beneficiaries located in that CBSA. The CBSA location is an aggregation of county level data.

The Market Saturation and Utilization methodology is also different from other public use data with respect to determining the number of Medicare beneficiaries who are enrolled in a fee-for-service (FFS) program. In this analysis, a FFS beneficiary is defined as being enrolled in Part A and/or Part B with a coverage type code equal to “9” (FFS coverage) for at least one month of the 12-month reference
period. Beneficiaries must not have a death date for that month and must have a valid zip code so that they can be assigned to a county. Other public use data may define a FFS beneficiary using different criteria, such as requiring the beneficiary to be enrolled in the FFS program every month during the reference period.

Exclusionary Criteria

There are three exclusionary criteria imposed on the state/county data. In particular:

1. If a beneficiary's county of residence cannot be determined, then that beneficiary is excluded. This generally represents a very small percent of the population (<1%).
2. Providers are excluded if they had paid claims for 10 or fewer beneficiaries located in the county.
3. Counties are excluded if 10 or fewer beneficiaries who had paid claims resided in the county.

Additionally, Arkansas' data for the three dual eligibility metrics and the corresponding percentage change metrics for reference periods 10 to 18, spanning January 1, 2017 to December 31, 2019, have been removed due to incomplete data from the source dataset from which the dual eligibility metrics are calculated.