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. Starting in 2024 with Release 17, state- and county- level results are updated annually to reflect a more recent calendar year. For all releases prior, State- and county-level results were updated quarterly. The following currently included:

• *October 1, 2014 to September 30, 2015* • *January 1, 2015 to December 31, 2015* • *April 1, 2015 to March 31, 2016* • *July 1, 2015 to June 30, 2016* • *October 1, 2015 to September 30, 2016* • *January 1, 2016 to December 31, 2016* • *April 1, 2016 to March 31, 2017* • *July 1, 2016 to June 30, 2017*	• *October 1, 2016 to September 30, 2017* • *January 1, 2017 to December 31, 2017* • *April 1, 2017 to March 31, 2018* • *July 1, 2017 to June 30, 2018* • *October 1, 2017 to September 30, 2018* • *January 1, 2018 to December 31, 2018* • *April 1, 2018 to March 31, 2019* • *July 1, 2018 to June 30, 2019*	• *October 1, 2018 to September 30, 2019* • *January 1, 2019 to December 31, 2019* • *April 1, 2019 to March 31, 2020* • *July 1, 2019 to June 30, 2020* • *October 1, 2019 to September 30, 2020* • *January 1, 2020 to December 31, 2020* • *April 1, 2020 to March 31, 2021* • *July 1, 2020 to June 30, 2021*	• *October 1, 2020 to September 30, 2021* • *January 1, 2021 to December 31, 2021* • *April 1, 2021 to March 31, 2022* • *July 1, 2021 to June 30, 2022* • *October 1, 2021 to September 30, 2022* • *January 1, 2022 to December 31, 2022* • *April 1, 2022 to March 31, 2023* • *July 1, 2022 to June 30, 2023*	• *October 1, 2022 to September 30, 2023* • *January 1, 2023 to December 31, 2023* • *January 1, 2024 to December 31, 2024*

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, an 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 an FFS beneficiary using different criteria, such as requiring the beneficiary to be enrolled in the FFS program every month during the reference period**.**

In the Federal Register, the State of Connecticut formally requested the Census Bureau to adopt the State's nine planning regions as county-equivalent geographics units, replacing the State's eight counties. Effective 2024, the Census Bureau operations and publications will use the State's nine new county-equivalent boundaries internally and externally. For reference periods after 2023, this change is reflected in the State-County data for the State of Connecticut. https://www.federalregister.gov/documents/2022/06/06/2022-12063/change-to-county-equivalents-in-the-state-of-connecticut

Exclusionary Criteria

There are three exclusionary criteria imposed on the state/county data at the county, state, and national levels. 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 spanning January 1, 2017 to December 31, 2024, have been removed due to incomplete data from the source dataset from which the dual eligibility metrics are calculated.