

County Level Chronic Condition Data: Prevalence, Utilization and Cost
Methods
Data Source: CMS administrative claims data, January 2007- December 2011, accessed from the Chronic Condition Warehouse (CCW).
Year: 2007-2011
Geographic Variables: County level
Population : Medicare beneficiaries enrolled in fee-for-service (FFS) coverage of both Parts A and B for the entire year. Beneficiaries who were enrolled at any point during the year in a Medicare Advantage (MA) plan were excluded as were beneficiaries who first became eligible for Medicare after January of the calendar year. Beneficiaries who died during the year were included up to their date of death if they meet the other inclusion criteria. In addition, if the county assigned to the beneficiary was considered “missing”, then the beneficiary was excluded. The exclusion of the missing counties resulted in approximately < 0.03% of beneficiaries being dropped.
Chronic Condition Measures: For these tables, chronic conditions were identified through Medicare administrative claims. Medicare beneficiaries were considered to have a chronic condition if the CMS administrative data had a claim indicating that they were receiving a service or treatment for the specific condition. The data tables include information for beneficiaries with multiple chronic conditions (MCC), based upon counting the number from a set of 15 conditions. Detailed information on the identification of chronic conditions in the CCW is available at http://www.ccwdata.org/chronic-conditions/index.htm .
Spending Measure: Medicare spending is presented as standardized costs per beneficiary (per capita costs). Medicare spending includes total Medicare payments for all Medicare covered services. We standardize spending to remove geographic differences in payment rates for individual services as a source of variation. To standardize spending, we examined Medicare’s various FFS payment systems and identified the factors that lead to different payment rates for the same service. In general, those factors are adjustments that Medicare makes to account for local wages or input prices, and extra payments that Medicare makes to advance other program goals, such as compensating certain hospitals for the cost of training doctors. We then estimated what Medicare would have paid for each claim without those adjustments. Medicare spending reflects the costs for beneficiaries with the condition, not the costs necessarily attributable to that condition as beneficiaries can have more than one of the 15 conditions considered or have costs due to services received for conditions not included in the set of CCW predefined conditions.
Readmission Measure: Readmissions are presented as a readmission rate and expressed as the percentage of admissions with a readmission. Readmissions are defined as admissions that occur within 30 days of the initial discharge. The readmission rates presented are not risk-adjusted.
Emergency Department (ED) Visit Measure: ED visits are presented as ED visits per 1000 beneficiaries. ED visits include both visits to the ED that result in an admission and visits that do not result in an admission.
Data Suppression : An * indicates that the data have been suppressed because there are fewer than 11 Medicare beneficiaries in the cell.