"The Medicare Chronic Conditions Dashboard: State Level presents information on the prevalence, utilization and Medicare spending for Medicare beneficiaries with chronic conditions for 2014. The Dashboard includes 19 chronic conditions that are consistent with the conditions suggested by the HHS Strategic Framework on Multiple Chronic Conditions (http://www.hhs.gov/ash/initiatives/mcc/) and is the same set of conditions included in the Office of Information Products and Data Analytics (OIPDA) program statistics examining chronic conditions among Medicare beneficiaries (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/index.html). Chronic conditions are 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. Detailed information on the identification of chronic conditions in the CCW is available at http://www.ccwdata.org/chronic-conditions/index.htm.

The 19 conditions include Alzheimer's disease/ dementia; Arthritis (including rheumatoid and osteoarthritis); Asthma; Atrial fibrillation; Autism spectrum disorders; Cancer (breast, colorectal, lung, and prostate); Chronic kidney disease; COPD; Depression; Diabetes (excluding diabetic conditions related to pregnancy); Heart failure; Hepatitis (Chronic Viral B & C); HIV/AIDS; Hyperlipidemia (High cholesterol); Hypertension (High blood pressure); Ischemic heart disease; Osteoporosis; Schizophrenia/Other psychotic disorders; Stroke/Transient ischemic attack.

The Dashboard includes information on the 19 specific chronic conditions as well as on multiple chronic conditions, based upon counting the number of conditions and grouping into four categories (0-1, 2-3, 4-5, and 6 or more). For the specific chronic conditions, we present prevalence information. For multiple chronic conditions, we present prevalence as well as utilization and per capita Medicare spending by the number of chronic conditions. Information is presented for the 50 U.S. states and, Washington, DC.

The utilization metrics include 30-day hospital readmissions and emergency department (ED) visits. A readmission was defined as an admission to an acute care hospital for any cause within 30 days of discharge from an acute care hospital. Except when the patient died during the stay, each inpatient stay was classified as an index admission, a readmission, or both. Transfer from one acute care hospital to another on the same day was counted as a single stay and, thus, one index admission. Under this definition, a readmission for a given year (e.g., 2014) could occur as late as January 30 of the following year (e.g., 2015). The total number of emergency department visits a beneficiary had in 2014 included visits where the beneficiary was released from the outpatient setting and where the beneficiary was admitted to an inpatient setting. ED visits are presented as the number of visits per 1,000 beneficiaries.

Medicare spending includes total Medicare payments for all Medicare Part A and B covered services. Medicare spending is presented as Medicare payments per beneficiary (per capita costs). To make Medicare payments across geographic areas comparable and reflect variation due to utilization patterns, payments have been standardized to remove geographic differences in payment rates for individual services, such as those that account for local wages or input prices. While standardization does account for the different amounts Medicare pays for the same service in different areas, it does not adjust for differences in beneficiaries’ health status. For more information on the standardization methodology see the Technical Supplement on Standardization available for download at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/index.html.

The Dashboard allows the user to select information for specific Medicare beneficiary sub-groups defined by gender, age group and Medicare-Medicaid enrollment, also known as dual eligibles. Medicare beneficiaries were classified as dual eligibles if in any month in the given calendar year they were receiving full or partial Medicaid benefits.

The data source is CMS’s Chronic Condition Data Warehouse (CCW), which contains 100 percent of Medicare claims for beneficiaries who are enrolled in the fee-for-service (FFS) program as well as enrollment and eligibility data. The information in the Dashboard is restricted to Medicare FFS beneficiaries who were continuously enrolled in Medicare FFS, both parts A and B, for 2014. Beneficiaries who were enrolled in a Medicare Advantage (MA) plan at any point during the year were excluded. Beneficiaries who died during the year were included up to their date of death if they met the other inclusion criteria. The study population includes 34,096,898 FFS Medicare beneficiaries.

CMS is obligated by the federal Privacy Act, 5 U.S.C. Section. 552a and the HIPAA Privacy Rule, 45 C.F.R Parts 160 and 164, to protect the privacy of individual beneficiaries and other persons. All direct identifiers have been removed from this data file. In addition, information is suppressed that is based upon fewer than eleven (11) beneficiaries in the population and is indicated by a blank cell.

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