Medicaid Managed Care

Data Dictionary

Variable Name	Term Name	Definition
	State	This is the state in which the recipient resides. In the case of providers, this is the state that the provider operates from.
	County	This is the county in which the recipient resides. In the case of providers, this is the county that the provider operates from.
	MCO Name	This is the name of the managed care organization being assessed.
	Service Category	This is the provider specialty being assessed.
	Number of Active Patients	This definition varies based upon the Service Category being assessed. For Pediatric Dental: Active pediatric dental patients were identified as those recipients under 21 who received at least one managed care dental service in the represented county or managed care plan during the period of review. Rather than show all recipients within a plan, this count identifies only those patients actively receiving some form of medical treatment in the state, county, or plan. For Behavioral Health: Active behavioral health patients were identified as those recipients who received at least one managed care behavioral health service (a claim with an ICD-10 diagnosis starting with the letter F as the first diagnosis on the claim) in the represented county or managed care plan during the period of review. Rather than show all recipients within a plan, this count identifies only those patients actively receiving some form of medical treatment in the state, county, or plan. For Prenatal OB/GYN Active prenatal OB/GYN patients were identified as those recipients that are females between 15 and 44 years of age who received at least one managed care prenatal service from an identified prenatal provider in the represented county or managed care plan during the period of review. Rather than show all recipients within a plan, this count identifies only those patients actively receiving some form of medical treatment in the state, county, or plan.

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Variable Name	Term Name	Definition
	Number of Eligible MCO Patients	This definition varies based upon the Service Category being assessed. Eligible MCO patients for the Pediatric Dental specialty are those patients under the age of 21 actively enrolled in a managed care plan. This is determined by identifying those recipients under 21 with at least one claim paid to any provider for any service by the plan OR if the state made a capitation payment to the managed care plan on their behalf. Eligible MCO patients for the Behavioral Health specialty are those patients actively enrolled in a managed care plan. This is determined by identifying those recipients with at least one claim paid to any provider for any service by the plan OR if the state made a capitation payment to the managed care plan on their behalf. Eligible MCO patients for the Prenatal OB/GYN specialty are those patients actively enrolled in a managed care plan. This is determined by identifying those female recipients between 15 and 44 with at least one claim that was paid by the managed care plan OR if the state made a capitation payment to the managed care plan on their behalf. Medicaid services can be supplied in several ways, and states vary on the method used to pay for these services. For example, dental services can be provided by traditional fee-for-service programs, comprehensive (or all-encompassing) managed care plans that provide a variety of services, or specialized managed care plans that only address one service type. States that pay for dental services using a fee-for-service or specialized plan are said to 'carve out' these services from their comprehensive plans.
	Number of Providers	This definition varies based upon the Service Category being assessed. Pediatric Dental providers were identified by selecting providers that billed dental CDT (Current Dental Terminology) codes for Medicaid patients under 21 (per EPSDT guidelines) years of age on the date of service. To be included, a provider had to have a minimum of ten distinct recipients receiving a CDT and have billed at least three different CDT codes. Providers are identified by their state-assigned Medicaid ID codes. Behavioral Health providers were identified by selecting outpatient providers that billed 70% of more of their office visit claims with a behavioral health diagnosis (ICD 10 codes starting with the letter F as the first diagnosis on the claim). In addition, these providers had to bill a minimum of 10 claims. Providers are identified by their state-assigned Medicaid ID codes. Providers supplying pregnancy-related OB/GYN care were identified by their billing patterns. Providers were selected if they billed either a pregnancy-specific CPT or diagnosis codes for at least 5% of their Medicaid patient population. In addition, providers had to bill for pregnancy services on at least ten unique recipients. Providers are flagged by their state-assigned Medicaid ID codes. This calculation identifies only those providers that are actively supplying prenatal services for patients in the applicable state, county, or plan. Additional notes: Care related to pregnancy/prenatal services can be provided by a wide variety of specialties. In addition, pregnancy services may make up a comparatively minimal percentage of a provider's scope of care. As a result, CMS identified a minimal percentage, or threshold of care in order to be considered a pregnancy provider. The population threshold of 5% was identified by evaluating the use of pregnancy specific codes.
	Percent of Eligible Patients Receiving Services	This calculation is the number of Active Patients of the noted specialty divided by the number of Eligible MCO Patients.
	Number of Services per Active Patient	This ratio was calculated by dividing the number of services of the noted specialty by the number of active patients. This metric is an indication of utilization.

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Variable Name	Term Name	Definition
	Number of Active Patients per Provider	The patient to provider ratio was calculated by dividing the number of active patients within the noted specialty into the number of identified providers for that specialty. Higher ratios are indicative of a higher level of patient demand for providers in each area or plan.
	Calendar Year	This is the year under review, based upon claim date of service.
	Plan Category	States have the authority to develop many different types of managed care plan types. Some plan types are comprehensive, which pay for services across a wide variety of specialties. Other plans may be specialty plans, which focus on paying for services in only one area or specialty. Examples of this may be Dental-only plans, or Behavioral Health plans. This field identifies the type of plan each identified managed care organization is, and what services they cover.