Medicaid Managed Care Dashboard Methodology

Overview

The Medicaid Managed Care Dashboard uses state Transformed Medicaid Statistical Information System (T-MSIS) data for Arizona, Michigan, Nevada, and New Mexico to identify various metrics for managed care plans within each state. These metrics are designed to allow users to compare plans in each state across different specialty areas and include the following:

- State
- County
- MCO Name
- Service Category
- Number of Active Patients
- Number of Eligible MCO Patients
- Number of Providers
- Percent of Eligible Patients Receiving Services
- Number of Services Per Active Patient
- Number of Active Patients Per Provider
- Calendar Year
- Plan Category

This Dashboard, updated quarterly, represents a point in time assessment of managed care provider networks for the following specialty types:

- Pediatric Dental,
- Behavioral Health, and
- Prenatal Obstetrics and Gynecology (OB/GYN).

Data Source

This data is gathered from T-MSIS data from Arizona, Michigan, Nevada, and New Mexico. This dataset does not include all available data in T-MSIS but utilized a subset to calculate the individual metrics identified. Detailed information on the T-MSIS data is available from the Medicaid.gov website.

Methods

Available T-MSIS data for each of the noted states was assessed to determine the following categories of information:

- Plan Category
- Number of Active Patients
- Number of Eligible MCO Patients
- Percent of Eligible Patients Receiving Services
- Number of Services Per Active Patient
- Number of Providers
- Number of Active Patients Per Provider

For each specialty provider type, there are slight differences in the methodology used to identify providers and patients.

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 use alternatives to comprehensive plans to pay for specialized services using a fee-for service or specialized plan are said to 'carve out' these services from their comprehensive plans. Carve out, or specialty plans are highlighted in the dashboard where applicable.

Active patient Identification:

- Pediatric Dental patients were identified as those recipients under 21 who received at least one managed care dental service (CDT) 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.
- 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.
- Prenatal 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 (or other service indicating pregnancy) 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.

Eligible MCO patients are those patients actively enrolled in a managed care plan. This is determined by identifying those recipients with at least one claim that was paid by the managed care plan OR at least one capitation payment made to the managed care plan on their behalf. Patients must also meet certain criteria to be considered in each category, for example the pediatric dental patient population was limited to those under the age of 21, and the prenatal OB/GYN population was limited to female patients between 15 and 44 years of age.

Provider Identification:

- 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% or 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 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. These calculations identify only those providers that are actively supplying services for patients in the applicable state, county, or plan.

CMS is obligated by the Federal Privacy Act, 5 U.S.C. Section 552a to protect the privacy of individual beneficiaries. Enrollee counts of 1-10 are suppressed and additional counts are counter-suppressed to prevent the recalculation of the suppressed counts of 1-10. All suppressed and counter-suppressed enrollee counts are denoted with an asterisk (*).