2019 Medicaid Provider Rate Review Analysis Report

Appendix A – Glossary

Appendix A provides explanations of common terms used throughout the 2019 Medicaid Provider Rate Review Analysis Report (2019 Analysis Report).

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Active Provider – Any provider with at least one Colorado Medicaid paid claim in a given month between July 2015-June 2018 for one of the services under review.

Benchmark Rates – Rates to which Colorado Medicaid rates are compared.

Billing Provider – Based on the billing provider ID, which is generally associated with the entity enrolled with Medicaid. This can be agencies, large provider groups, or individuals.

Colorado Repriced – This amount represents the application of current Colorado Medicaid rates to the most recent and complete Colorado utilization data, obtained from claims data.

Comparison Repriced – This amount represents the application of comparators' most recently-available fee schedule rates to the most recent and complete Colorado utilization data, obtained from claims data.

County Classification – Three regional descriptors applied to counties by the Regional Accountable Entities (RAEs).

Distinct Utilizers – The total number of distinct utilizers.

Drive Time – Measures the percent of Colorado Medicaid members who are estimated to have traveled within four drive time bands (e.g. 0-30 minutes, 30-45 minutes, 45-60 minutes, over an hour) to receive services.

Member-to-Provider Ratio – The total number of Colorado Medicaid members residing in a geographic area compared to the total number of active providers in that geographic area; calculated as providers per 1,000 members. It allows for comparison across areas with large differences in population size.

Penetration Rate – The estimated percentage of total Colorado Medicaid members that received the service in a geographic area (by county).

Professional Portion of Services – Services submitted on a CMS-1500 claim form, which is the form used for submitting physician and professional claims for providers. This form is different from the UB-04 form, which is the claim form for institutional facilities, such as hospitals and outpatient facilities.

Provider Count – A distinct count of the number of providers who billed for the service. Whether the provider is a billing provider or rendering provider is identified in the report.

Rate Benchmark Comparison – This percentage represents how Colorado Medicaid payments compare to other payers. It is calculated by dividing the Colorado Repriced amount by the Comparison Repriced amount.

Rate Ratio – The rate ratio is the division of the corresponding Colorado rate to the Benchmark Rate. For example, if procedure code 99217 has a Colorado Medicaid rate of $56.08 and Medicare has a rate of $73.94 then the resulting rate ratio is $56.08/$73.94 = 0.7585, expressed as a percentage as 75.85%.

Regional Accountable Entity (RAE) – A regional organization that assists in the management of physical and behavioral health care. Many behavioral health services are managed and reimbursed through RAEs.

Rendering Provider – The provider who rendered the service.

Units – Quantities associated with a procedure; they may vary depending on type of service. The most common unit is one and represents the delivery of one unit of a service. Other services, such as physician-administered drugs, have a denomination reflected by the drug dosage (e.g., 1 mL, 5 mL, etc.). Some therapy and radiology services define units by time (e.g., 15 minutes). Not all payers share the same unit definitions and adjustments are sometimes incorporated to account for payer differences.

Utilizer Density – The number of distinct utilizers in each county.

Utilizers per Provider – The average number of members seen per active provider, also called Panel Size.