COLORADO
Department of Health Care Policy & Financing

2021 Medicaid Provider Rate Review Analysis Report – Appendix A

Appendix A - Glossary

Appendix A provides explanations for common terms used throughout the 2021 Medicaid Provider Rate Review Analysis Report.

Active Provider - Any provider who billed Medicaid at least once between March 2017 and December 2019 for one of the procedure codes 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 (FY 2018-19) 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 members who utilized a service.

Drive Time - Measures the percent of Colorado Medicaid members who 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 number of total Medicaid members per active rendering provider within a geographic area; calculated as providers per 1,000 members. It allows for comparison across areas with large differences in population size.

Panel Size Estimate - The average number of clients seen per rendering provider.

Penetration Rate - The total share of enrolled Colorado Medicaid members who utilized a service; calculated per 1,000 members.

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 - For each service code, and relevant modifier, 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%.

Rendering Provider - The provider who rendered, or directly provided, the service.

Total Members – The total number of enrolled Colorado Medicaid members.

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 of a service in each county.

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