2018 Medicaid Provider Rate Review Analysis Report

Appendix A – Glossary

Appendix A provides explanations for common terms used throughout the 2018 Medicaid Provider Rate Review Analysis Report (2018 Analysis Report).

COLORADO
Department of Health Care Policy & Financing

Active Provider - Any provider who billed Medicaid at least once between January 2015 and December 2016 for one of the procedure codes under review.

Active Provider Months - The average number of months that providers billed Colorado Medicaid over a 24-month time frame.

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.

Client Count - A distinct count of all clients for which there is a claim for the service from January 2015 through December 2016.

Colorado Repriced – This amount represents the application of current Colorado Medicaid rates (FY 2017-18) to the most recent and complete Colorado utilization data, obtained from CY 2016 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 CY 2016 claims data.

Distance Metric - Measures the percent of Colorado Medicaid clients who traveled within 30 miles to receive services.

Health Statistics Region - The Colorado Department of Public Health and Environment developed 21 Colorado Health Statistics Regions using statistical and demographic criteria. The regions are displayed on p.5. For more information, see Colorado Health Data – Health Disparities Profiles.

Member-to-Provider (M:P) Ratio - The number of clients per active rendering provider.

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

Penetration Rate - The percent of enrolled Colorado Medicaid clients who utilized a service.

Place of Service - Place of Service (POS) codes are two-digit codes placed on professional claims to indicate the setting where a service was provided. POS codes are frequently categorized into non-facility and facility settings. For a list of POS codes, see the Center for Medicare and Medicaid Service's (CMS) Place of Service Codes for Professional Claims.

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 or outpatient facilities.

Provider Count - A distinct count of the number of providers who billed for the service. Whether the provider is 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 the service. Rendering provider information is the default information provided in all ACI metric calculations. However, this field is not always complete, so the billing provider is considered in lieu of the rendering provider when there was no rendering provider on the claim.

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.