

IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201018 JUNE 1, 2010



Home health rates for State Fiscal Year 2011

This bulletin notifies all home health providers of new Indiana Health Coverage Programs (IHCP) rates for reimbursement of home health services effective July 1, 2010.

Reimbursement rates

Pursuant to Indiana Administrative Code (IAC) 405 IAC 1-4.2-4, the standard statewide reimbursement rates for home health services were calculated and are effective July 1, 2010. The SFY 2010 rates are applicable through June 30, 2010. The new rates are calculated based on the most recently completed Medicaid cost reports that were required to be filed by all home health providers billing the IHCP for services.

During SFY 2010, the Office of Medicaid Policy and Planning (OMPP) promulgated an emergency rule – LSA Document # 10-187(E) – to avoid an anticipated budgetary shortfall and to remain within the available Medicaid appropriation. The result was a 5 percent reduction in the SFY 2010 Medicaid home health rates effective April 1, 2010, through June 30, 2010. The 5 percent rate reduction also applies to the SFY 2011 Medicaid home health rates.

Computation of the total reimbursement rate

Pursuant to 405 IAC 1-4.2, each provider's hourly staffing rate for each discipline and overhead rate are arrayed high to low. Each provider's historical costs in the arrays are inflated from the midpoint of the cost report period to the midpoint of the expected rate period, using the CMS Home Health Agency Market Basket inflation index. From this array, a median rate for each staffing discipline and overhead is calculated. For an even number of rates, the median is calculated by dividing the middle two rates by two. Per 405 IAC 1-4.2, the statewide rates for Medicaid home health agencies are

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calculated as 95 percent of the median rate. The statewide Medicaid home health agency rates are effective July 1 and remain in effect for the entire state fiscal year.

Overhead cost rate

The overhead cost rate per visit for each home health provider is based on total patient-related costs, less the direct staffing and employee benefit costs, less the semivariable costs, divided by the total number of home health agency visits during the Medicaid reporting period for that provider. The result of this calculation is the overhead cost per visit for each home health provider that was included in the statewide overhead array. The semivariable cost was removed from the overhead cost rate calculated and included in the staffing cost rates calculated in the table below, based on hours worked.

Staffing cost rate

The staffing cost rate per hour for each discipline in the home health agency is based on the total patient-related direct staffing and employee benefit costs, plus the semivariable cost divided by the total number of home health agency hours worked. The result of this calculation is the staffing cost rate per hour, per discipline for each home health agency.

The table below specifies the home health rates for State Fiscal Year 2011.

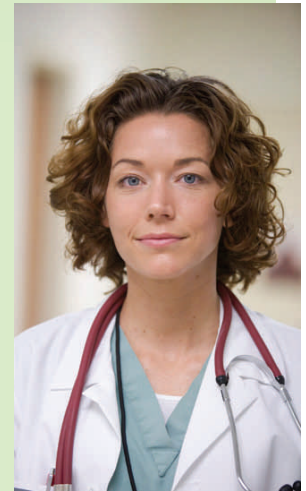


Table 1 – Home health rates for SFY 2011

| Service | SFY 2011 rate (95% of median) | New SFY 2011 rate – 5% reduction (LSA 10-187 (E) effective for dates of service on or after July 1, 2010 |
|--|----------------------------------|--|
| Overhead | \$36.10 | \$34.30 per provider, per recipient, per day |
| Registered nurse (RN) – 99600 TD | \$39.33 | \$37.36 per hour |
| Licensed practical nurse (LPN) –99600 TE | \$26.33 | \$25.01 per hour |
| Home health aide – 99600 | \$19.31 | \$18.34 per hour |
| Physical therapy – G0151 | \$15.15 | \$14.39 per 15-minute increments |
| Occupational therapy – G0152 | \$14.37 | \$13.65 per 15-minute increments |
| Speech therapy – G0153 | \$15.69 | \$14.91 per 15-minute increments |

Billing and repayment

Use the new rates listed in the table above for services billed on or after July 1, 2010. If a provider has billed and been paid at the old rate for these dates of service, the provider can choose to wait for HP to automatically reprocess the claims

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through a mass adjustment. Providers will be notified of the mass adjustment. Providers are not prohibited from completing adjustment forms prior to the automatic reprocessing.

The mass adjustment will pay the claims at the new rates. Mass adjusted claims are identified on the Remittance Advice (RA) with region number 56 as the first two digits of the internal control number (ICN). If a claim submitted for dates of service on or after July 1, 2010, was underpaid, the net difference is paid and reflected on the RA. If a claim submitted for



dates of service on or after July 1, 2010, was overpaid, the net difference appears as an accounts receivable. The accounts receivable will be recouped at 100 percent from future claims paid to the respective provider number.

Billing procedures remain the same. However, to ensure appropriate reimbursement, traditional Medicaid home health claims must be submitted using the UB-04 claim form. The UB-04 claim form includes fields for reporting overhead amounts and Healthcare Common Procedure Coding System (HCPCS) codes applicable to the service provided. For convenience, the HCPCS codes re-

lated to each home health discipline are outlined in the table above. Additionally, if providing services under both the IHCP waiver and traditional Medicaid programs, the appropriate provider number should be indicated on claim forms. The table summarizes rates effective July 1, 2010.

QUESTIONS?

If you have questions about this bulletin, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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