2019 Regular Session

HOUSE BILL NO. 390

BY REPRESENTATIVE WHITE

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

MEDICAID: Relative to reimbursement rates paid to providers of disability services

AN ACT

To enact Part II-A of Chapter 5-E of Title 40 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 40:1250.1 through 1250.41, relative to services for persons with disabilities; to provide relative to Medicaid reimbursement rates paid to such providers by the Louisiana Department of Health; to establish procedures by which the department shall set such rates; to provide for factors and data elements to be utilized in the calculation of such rates; to require that rates meet certain conditions and standards for adequacy; to provide for a rate review process; to require the department to publish online and make available in printed form certain information pertaining to rate-setting; to provide for legislative findings and intent; to provide for definitions; to require administrative rulemaking; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Part II-A of Chapter 5-E of Title 40 of the Louisiana Revised Statutes of 1950, comprised of R.S. 40:1250.1 through 1250.41, is hereby enacted to read as follows:

PART II-A. DISABILITY SERVICE PROVIDER REIMBURSEMENT

SUBPART A. GENERAL PROVISIONS

§1250.1. Short title

This Part shall be known and may be cited as the "Disability Services Reimbursement Rate Act".

§1250.2. Legislative findings; declaration

A. The legislature hereby finds all of the following:

(1) Access to quality services for persons with developmental, intellectual, age-related, or physical disabilities furnished by private providers is essential for the health, safety, and well being of those persons.

(2) Reliable and sufficient Medicaid reimbursement rates for private providers are necessary to create and maintain a sustainable statewide system of services for eligible individuals with disabilities.

(3) A statewide system of services is sustainable only if reimbursement rates are sufficient to enlist providers in numbers great enough to allow eligible individuals a choice among different providers who are capable of delivering quality services that will meet the assessed needs of those individuals in a timely manner.

(4) Historically, instabilities in provider networks and systems of services in various states resulted in decades of litigation in federal courts challenging reimbursement rates set by state Medicaid agencies for providers of disability services; in April of 2015, the United States Supreme Court, in *Armstrong v. Exceptional Child Center, Inc.,* 135 S.Ct. 1378 (2015), foreclosed further use of the federal courts for guidance and remedies relating to such reimbursement rates.

B. The legislature hereby declares that this state must take steps to foster and maintain a robust network that attracts and retains quality providers which are capable of maintaining a stable workforce and are sufficient in number to allow for meaningful choices among providers by individuals eligible to receive disability services.

§1250.3. Purposes; intent; construction

A. The purposes of this Part are to provide for a reliable legal framework to guide the Louisiana Department of Health, or any successor state Medicaid agency, in setting reimbursement rates for providers of disability services for persons with developmental, intellectual, age-related, or physical disabilities.

B. The intent of this Part is to supplement the requirements of Medicaid law applicable to reimbursement rates for services provided to persons with disabilities.

C.(1) This Part, being necessary for the welfare of the people of this state, shall be liberally construed so as to effect its purposes.

(2) Nothing in this Part shall be construed to limit the rights or remedies to which recipients or providers may be entitled under other applicable laws.

§1250.4. Definitions

As used in this Part, the following terms have the meaning ascribed to them in this Section:

(1) "Department" means the Louisiana Department of Health.

(2) "Direct support professional" means an individual who works directly with a person with a developmental, intellectual, age-related, or physical disability to provide a service or a component of a service as an employee or independent contractor of a provider.

(3) "Methodology" means the aggregate of methods, principles, assumptions, variables, factors, and procedures used to determine a reimbursement rate.

(4) "Personal planning process" means a process of planning with a recipient for the identification of needs and coordination and delivery of services that reflect the personal preferences of the recipient.

(5) "Provider" means a person, public agency, nonprofit corporation, or a for-profit business entity that provides services under a contract or other agreement with the department.

(6) "Rate" means the amount of money per unit of time for a service performed or the amount of money for a service performed for a flat fee, such as a per diem.

(7) "Rebasing" means using cost report information to adjust reimbursement rates to the level dictated by the reimbursement methodology for each covered service.

(8) "Recipient" means a person with a developmental, intellectual, age-related, or physical disability receiving services from the department or a provider.

(9) "Reimbursement" means payment for a service in accordance with a specified rate.

(10) "Restructure" means any alteration in the methodology used to determine a rate.

(11) "Service" means a home- or community-based service, intermediate care facility service, or support coordination service provided to a recipient by a provider under a contract or other agreement with the department, regardless of whether the service is funded in whole or in part by Medicaid.

(12) "Service plan" means a plan resulting from the personal planning process for the delivery and coordination of specific authorized services to a recipient.

(13) "Staff-to-recipient ratio" means a ratio reflecting the number of direct support professionals designated to provide a service for one or more recipients.

(14) "Stakeholder" means a recipient, a parent or guardian of a recipient, any provider, and any association or organization representing or advocating on behalf of providers, recipients, or parents or guardians of recipients.

SUBPART B. RATE DESIGN AND METHODOLOGY

§1250.11. Rate design

A. The department shall design all rate-setting processes and methodologies to ensure that recipients have adequate access to services that satisfy all applicable standards and requirements of federal and state law for efficiency, economy, and quality of care. Such rate-setting processes and methodologies shall comply with the procedures, standards, and requirements provided in this Part.

B. The department shall consider innovative rate and payment structures designed to promote improvements in quality, adequacy, access, and sufficiency, and shall develop measures to assess the effectiveness of such rate and payment structures.

§1250.12. Rate methodology

A. The department shall establish all rates by a methodology that specifies and describes all factors, procedures, methods, and data used or considered in developing the respective rates, including but not limited to sources and methods of data collection, staff-to-recipient ratios, standards of reliability, formulas, calculations, assumptions, and variables.

B. The department shall design the methodology to ensure that all rates meet the sufficiency standards provided in R.S. 40:1250.14.

C. All data used or relied on in the methodology shall be reliable in accordance with standard principles of data reliability. No cost data that is more than two years old shall be deemed reliable.

D. The department shall ensure that its methodology results in rates that satisfy all of the following conditions:

(1) The rates allow for all recipients to have a choice of quality providers for each service offered.

(2) The rates allow all recipients to access services in a timely manner.

(3) The rates allow services to be provided in the most integrated setting for recipients, consistent with the holdings of the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999), and the Americans with Disabilities Act of 1990, as amended (42 U.S.C. 12101 et seq.).

(4) The rates can be incorporated consistently in both fee-for-service Medicaid and Medicaid managed care programs, and under both Medicaid waiver and Medicaid state plan authorities.

(5) The rates are sufficient to enlist a range of willing providers who are able to retain a qualified and stable workforce and take into account all other applicable workforce measures provided in R.S. 40:1250.14(4).

(6) The rates are subject to a review process that includes input from stakeholders and assesses the adequacy of access to services financed by the rates.

E. The department shall consider payment structures that ensure quality and value and improve adequacy, access, and sufficiency.

F. In connection with its design and implementation of the rate methodology required in this Section, the department shall develop a reporting system that disaggregates data by geography and demography and features specific information on access to services for population subgroups including, without limitation, people with developmental, intellectual, age-related, or physical disabilities.

§1250.13. Cost data; requirements

All rates shall be set based on reliable data of the actual or reasonably estimated costs of providing the service to be reimbursed. Such costs shall include, as applicable to the rate, all employee wages, benefits, qualifications, and training costs; staff-to-recipient ratios; equipment and vehicle costs; and costs of operating, maintaining, and managing a residential setting including taxes, administrative costs, and overhead costs, but excluding unreimbursed room and board costs.

§1250.14. Rate uniformity

Rates for similar services and supports shall be uniform in order to ensure that all providers receive the same rate for the same service for individuals with the same or similar needs, subject to reasonable adjustments for documented geographic variations in cost data.

SUBPART C. MONITORING AND RATE ADJUSTMENT

§1250.21. Monitoring for adequacy and quality of services

A. The department shall maintain reliable data in a form that permits ongoing monitoring of factors that may be indicators of the adequacy of access to and quality of services that are subject to reimbursement rates. Such factors shall include all of the following:

(1) The numbers of individuals on wait lists who are eligible for services.

(2) The frequency and duration of delays in recipient placement with providers.

(3) The number and suitability of vendor responses to calls for recipient placements.

(4) The compiled number and character of unmet needs documented by personal planning processes for all recipients.

(5) The frequency and levels of crisis service usage and critical incident reporting.

(6) The frequency and character of recipient grievances and complaints filed.

(7) The levels of provider enrollment and participation.

(8) The turnover and vacancy rates of direct support professionals.

(9) The frequency and character of provider appeals and complaints filed.

B. The department shall maintain reliable data in a form that permits ongoing monitoring of trending factors that may affect the sufficiency of rates. Such factors shall include, without limitation, trends in cost of living and other economic indexes, wage rates, and changes in regulatory and policy requirements affecting provider costs.

C. The department may require reasonable, periodic financial reports from providers as needed to ensure the availability of reliable cost data. The department shall consult and collaborate with providers to develop reasonable financial reporting requirements.

§1250.22. Annual review of rates

The department shall conduct annual reviews of all rates by service category and shall make a determination of the level of sufficiency of each rate based on a review of all pertinent data including the factors identified in R.S. 40:1250.21(A) and (B).

§1250.23. Rate adjustment; procedures

A. The department shall follow all procedures provided in this Section when adjusting rates.

B. The department shall rebase rates at least once every two years using the most recent audited cost report data available per the prescribed reimbursement methodology calculations for each covered service.

C. The department shall trend reimbursement rates forward annually for all years between rate rebasing using the appropriate health market basket inflation index.

SUBPART D. REPORT TO LEGISLATURE

§1250.31. Annual report to the legislature

A. The department shall provide an annual report concerning disability service provider rates to the House Committee on Appropriations, the Senate Committee on Finance, and the legislative committees on health and welfare no later than forty-five days prior to the convening of each regular session of the legislature. The report shall encompass all determinations of sufficiency or insufficiency of rates made under the most recent annual review conducted by the department.

B. Upon request of any legislative committee identified in Subsection A of this Section, the secretary of the department or his designee shall appear in person before the committee to present the report required by this Section.

SUBPART E. RULEMAKING

§1250.41. Administrative rulemaking; limitation on emergency rules

A. The department shall promulgate all such rules in accordance with the Administrative Procedure Act as are necessary to implement the provisions of this Part.

B. Except in cases in which the conditions for adoption of an emergency rule provided in R.S. 49:953(B)(1)(a) are satisfied, the department shall promulgate all rules for implementation of the provisions of this Part through the notice process provided for in R.S. 49:953(A).

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 390 Original 2019 Regular Session White

Abstract: Requires the La. Department of Health to Relative to develop Medicaid reimbursement rates paid to providers of disability services according to certain guidelines.

Proposed law provides that its purpose is to provide for a reliable legal framework to guide the La. Department of Health (LDH) in setting reimbursement rates for providers of disability services for persons with developmental, intellectual, age-related, or physical disabilities.

Proposed law requires LDH to design all processes and methodologies for setting Medicaid reimbursement rates for providers of disability services to ensure that service recipients have adequate access to services that satisfy all applicable standards and requirements of federal and state law for efficiency, economy, and quality of care. Requires LDH to consider innovative rate and payment structures designed to promote improvements in quality, adequacy, access, and sufficiency, and to develop measures to assess the effectiveness of such rate and payment structures.

Proposed law requires LDH to establish all rates by a methodology that specifies and describes all factors, procedures, methods, and data used or considered in developing the respective rates, including but not limited to sources and methods of data collection, staff-to-recipient ratios, standards of reliability, formulas, calculations, assumptions, and variables. Stipulates that all data used or relied on in the methodology shall be reliable in accordance with standard principles of data reliability, and that no cost data that is more than two years old shall be deemed reliable.

Proposed law requires LDH to ensure that its methodology results in rates that satisfy all of the following conditions:

(1) The rates allow for all recipients to have a choice of quality providers for each service offered.

(2) The rates allow all recipients to access services in a timely manner.

(3) The rates allow services to be provided in the most integrated setting for recipients, consistent with the holdings of the Supreme Court in *Olmstead v. L.C.* and the Americans with Disabilities Act.

(4) The rates can be incorporated consistently in both fee-for-service Medicaid and Medicaid managed care programs, and under both Medicaid waiver and Medicaid state plan authorities.

(5) The rates are sufficient to enlist a range of willing providers who are able to retain a qualified and stable workforce.

(6) The rates are subject to a review process that includes input from stakeholders and assesses the adequacy of access to services financed by the rates.

Proposed law provides that in connection with its design and implementation of the rate methodology required in proposed law, LDH shall develop a reporting system that

disaggregates data by geography and demography and features specific information on access to services for population subgroups including, without limitation, people with developmental, intellectual, age-related, or physical disabilities.

Proposed law requires all rates to be set based on reliable data of the actual or reasonably estimated costs of providing the service to be reimbursed. Provides that such costs shall include, as applicable to the rate, all employee wages, benefits, qualifications, and training costs; staff-to-recipient ratios; equipment and vehicle costs; and costs of operating, maintaining, and managing a residential setting including taxes, administrative costs, and overhead costs, but excluding unreimbursed room and board costs.

Proposed law provides that rates for similar services and supports shall be uniform in order to ensure that all providers receive the same rate for the same service for individuals with the same or similar needs, subject to reasonable adjustments for documented geographic variations in cost data.

Proposed law requires LDH to maintain reliable data in a form that permits ongoing monitoring of factors that may be indicators of the adequacy of access to and quality of services that are subject to reimbursement rates. Provides that such factors shall include all of the following:

(1) The numbers of individuals on wait lists who are eligible for services.

(2) The frequency and duration of delays in recipient placement with providers.

(3) The number and suitability of vendor responses to calls for recipient placements.

(4) The compiled number and character of unmet needs documented by personal planning processes for all recipients.

(5) The frequency and levels of crisis service usage and critical incident reporting.

(6) The frequency and character of recipient grievances and complaints filed.

(7) The levels of provider enrollment and participation.

(8) The turnover and vacancy rates of direct support professionals.

(9) The frequency and character of provider appeals and complaints filed.

Proposed law requires LDH to maintain reliable data in a form that permits ongoing monitoring of trending factors that may affect the sufficiency of rates such as trends in cost of living and other economic indexes, wage rates, and changes in regulatory and policy requirements affecting provider costs.

Proposed law authorizes LDH to require reasonable, periodic financial reports from providers as needed to ensure the availability of reliable cost data. Requires LDH to consult and collaborate with providers to develop reasonable financial reporting requirements.

Proposed law requires LDH to conduct annual reviews of all rates by service category and make a determination of the level of sufficiency of each rate based on a review of all pertinent data.

Proposed law requires LDH to rebase rates at least once every two years using the most recent audited cost report data available per the prescribed reimbursement methodology calculations for each covered service. Requires LDH to trend reimbursement rates forward annually for all years between rate rebasing using the appropriate health market basket inflation index.

Proposed law requires LDH to provide an annual report to the House Committee on Appropriations, the Senate Committee on Finance, and the legislative committees on health and welfare which encompasses all determinations of sufficiency or insufficiency of rates made under its most recent annual review.

(Adds R.S. 40:1250.1-1250.41)