

Emergency Rules

DECLARATION OF EMERGENCY

Department of Economic Development Racing Commission

Account Wagering (LAC 35:XIII.Chapter 120)

Editor's Note: The Effective Date on this Emergency Rule is August 31, 2000.

The Louisiana State Racing Commission is exercising the emergency provisions of the Administrative Procedures Act, R.S. 49:953(B), and pursuant to the authority granted under R.S. 4:141 et seq., adopts the following Emergency Rule (chapter) effective August 31, 2000, and it shall remain in effect for 120 days or until this Rule takes effect through the normal promulgation process, whichever comes first.

The Louisiana State Racing Commission finds it necessary to adopt this rule chapter to provide for account wagering at Louisiana race tracks, off-track wagering facilities and other locations which may have the potential of increasing the handle by allowing patrons to set up an account whereby wagers will be placed in lieu of cash transactions.

Title 35 HORSE RACING Part XIII. Wagering

Chapter 120. Account Wagering

§12001. Definitions

*Account Holder*Ca person authorized by the licensee to place wagers via account wagering.

*Account Wager*Ca wager placed by means of account wagering.

*Account Wagering*Ca form of pari-mutuel wagering in which an individual may deposit money in an account with a licensee and use the account balance to pay for pari-mutuel wagering authorized by R.S. 4:149.5 to be conducted by the licensee. An account wager may be made by the account holder in person, via telephonic device or by communication through other electronic media.

*Account Wagering Center*Cthe facility or facilities for maintaining and administering the account wagering system.

Wagering Account or *Account*Cthe account maintained and administered through an account wagering center for account holders who wish to place account wagers and otherwise participate in account wagering.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12003. Authorization

A. A system of account wagering may be operated only by a licensee, or employees or agents of such licensee, who is/are authorized to do so pursuant to R.S. 4:149.5(B)(1). The authorized licensee may, subject to applicable state and federal laws, conduct account wagering on any races conducted at its facility and on any races conducted at other facilities, within or outside of this state. Wagering accounts

may be established for an individual whose principal residence is outside this state if the racing association complies with all applicable provisions of federal and state law. All wagers placed through the licensee's system of account wagering shall be considered to have been made in this state.

B. An authorized licensee may not accept wagers from residents located in proximity to the racing facility of another licensee as provided for in R.S. 4:214(A)(3), without having provided the commission with sufficient evidence of how the authorized licensee intends to identify such account holders and pay to such other licensee the source market percentage required to be paid pursuant to R.S. 4:149.5(B)(2).

C. A licensee of race meetings shall provide the commission with written evidence of its consent to the acceptance, by an operator of a system of account wagering located outside this state, of wagers placed with such account wagering system by residents or other persons located within or outside of this state on races conducted in this state by that licensee. In the absence of such written evidence, no system of account wagering located outside this state may accept such wagers.

D. A licensee of race meetings authorized pursuant to R.S. 4:149.5(B)(1) to conduct account wagering in this state shall provide the commission with written evidence of its consent to the acceptance, by an operator of a system of account wagering located outside this state, of wagers placed with such account wagering system by residents or other persons located within this state on races conducted outside this state. In the absence of such written evidence, no system of account wagering located outside this state may accept such wagers.

E. A licensee, as defined in R.S. 4:149.5, may conduct account wagering made in person, by telephonic device or by communication through other electronic media. The maintenance and operation of account wagering shall be in accordance with the *Rules of Racing* and R.S. 4:149.5. The licensee shall request authorization and receive approval from the commission before a system of account wagering is offered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12005. Establishment

A. The licensee may offer a system of account wagering to its patrons whereby wagers are debited in, and payouts credited to, an account in the name of the patron, that is held by the licensee. The licensee shall notify the patron, at the time of opening the account, of any rules or procedures the licensee has adopted concerning deposits, withdrawals, average daily balances, user or service fees, interest payments, hours of operation, and any other aspect of the operation of the account. The licensee shall notify the patron whenever the rules governing the account are changed and shall endeavor to provide such notification before the new

rules are applied to the account and including the opportunity to close or cash-in the account. The patron shall be deemed to have accepted the rules of account operation upon opening or not closing the account.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12007. Compliance

A. Account wagering shall be conducted in compliance with the *Rules of Racing* and all applicable state and federal laws. Unless elsewhere specifically set forth, an account wager shall be subject to the statutory provisions and rules and regulations which govern all pari-mutuel wagers placed within the enclosure at which the licensee is authorized to conduct race meetings. From each account wager, there shall be deducted the same percentage as is deducted on a wager if made in person in the same wagering pool at the licensee's race track.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12009. Wagering Pools

A. The total amount of all account wagers shall be included in the respective pools for each race and shall be combined into the licensee's pools or, with approval of the commission, directly into the corresponding pools of a host track in another jurisdiction. The amount wagered in such pools from wagering accounts shall be debited accordingly, and any winnings shall be automatically credited to such accounts upon the race being declared official.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12011. Hours of Operation

A. Account wagers shall be accepted during such times and on such days as designated by the licensee, subject to state law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12013. Service Fees

A. As part of its rules, the licensee may, with the approval of the commission and prior notice to the account holder, impose user or service fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12015. Account Wagering Center

A. The licensee shall operate an account wagering center(s) for the purpose of keeping wagering accounts, recording wagers, maintaining records of credits and debits to the accounts, and otherwise administering the account wagering system. The location of such account wagering center(s) shall be subject to the approval of the commission.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12017. Licensee's Employees and Agents

A. The licensee shall appoint officers, employees or agents of the licensee to have management and control of the various aspects of the account wagering system for the licensee, including the account wagering center. As used herein, "licensee" includes the officers, directors and employees of the licensee, and persons, agents or other entities with the authority to accept deposits and wagers on behalf of the licensee and otherwise maintain and administer the system of account wagering. Such persons or entities may also provide services linking transactions from an account holder to a totalizator company.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12019. Wagering Accounts

A. Only those persons who have a wagering account with an account wagering center shall be permitted to wager through account wagering. An account may be established at an account wagering center, at a racetrack or off-track wagering facility within the state, by mail, or by other means approved by the commission.

B. The licensee shall accept accounts in the name of a natural person only. The licensee shall not accept any corporate, partnership, limited liability company, joint, trust, estate, beneficiary or custodial account. The account is nontransferable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12021. Account Holder's Responsibilities

A. Wagering accounts are for the personal use of the account holder. Account holders are responsible for all bets placed through their accounts by any person using the account. The account holder bears full responsibility for maintaining the secrecy of his/her account number and confidential identification code.

B. Except as otherwise set forth herein, no person shall in any manner place any account wager on behalf of an account holder, or otherwise directly or indirectly act as an intermediary, transmitter or agent in the placing of wagers for an account holder. The licensee is not prohibited from conducting account wagering through employees or agents. Nothing in §2021 is intended to prohibit the use of credit or debit cards or other means of electronic funds transfer, or the use of checks, money orders or negotiable orders of withdrawal.

C. Neither the licensee nor any officer, director, employee or agent of the licensee shall be responsible for any loss arising from the use of or access to a wagering account by any person or persons other than the account holder, except where the licensee or its employees or agents act without good faith or fail to exercise ordinary care. The account holder must immediately notify the account wagering center of a breach of the account's security.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12023. Minors Prohibited

A. No person below the age of 18 shall be permitted to open an account or place a wager, directly or indirectly, through account wagering.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12025. Others Prohibited

A. No officer, director or employee of any firm, entity or agency which is retained by the licensee with responsibility for the operation or maintenance of the account wagering system or of the account wagering center shall be permitted to place a wager, directly or indirectly, through the licensee's system of account wagering.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12027. Opening Wagering Account

A. An applicant for a wagering account shall make application in writing on the appropriate form supplied by the licensee at an account wagering center, at a racetrack or off-track wagering facility within the state, by mail, or by other means approved by the commission. The applicant shall provide his/her full name, current address and telephone number, social security number, and such additional information as the licensee may require. It is the account holder's responsibility to keep his/her mailing address current with the account wagering center. The application shall be signed by the applicant or otherwise authorized in a manner acceptable to the commission. Applicants must state in their application whether they are below the age of 18.

B. Each account shall have a unique identification account number (and such other methods of identification as the licensee may require). Such number may be changed at any time provided the licensee informs the account holder in writing of the change.

C. At the time of applying for an account, each applicant shall select a confidential identification code to be used as further identification when wagering. Both the licensee and the account holder have the right to change this code at any time without explanation by informing the other party in writing of such change and the effective date thereof.

D. An account holder shall receive at the time the account is opened a unique identification account number; an identification card; a summary of the rules; an explanation of the procedures then in force for depositing to, withdrawing from and closing the account; a telephone number to be utilized by the account holder; a description of the mechanics of wagering; and such other information as the licensee or commission may deem appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12029. Deposits and Withdrawals

A. Deposits to and withdrawals from existing accounts shall be permitted in such form and by such procedures as the licensee may require, provided that any requirements set forth in these rules shall be included therein.

B. Deposits made to a wagering account may be made as follows:

1. Deposits made to a wagering account by the account holder shall be submitted or mailed by the account holder to the staff or agents of the licensee at such locations and addresses as the licensee may designate from time to time, and shall be in the form of one of the following:

a. cash given to the staff at an account wagering center, or a racetrack or off-track wagering facility within the state; or

b. check, money order or negotiable order of withdrawal; or

c. charges made to an account holder's credit or debit card or other means of electronic funds transfer, upon the direct and personal instruction of the account holder, which may be given by telephone or other electronic device (or other means approved by the commission) to the licensee by the account holder if the use of the card or other means of funds transfer has been approved by the account wagering center.

2. Credit for winnings from wagers placed with funds in a wagering account, credit for account wagers on horses that are scratched, and other payments or refunds to which the account holder is entitled shall be posted to the account by the account wagering center.

3. The account wagering system shall not accept wagers or information assisting in the placement of wagers in excess of the amount posted to the credit of an account at the time the wager is placed.

C. Debits to a wagering account may be made as follows.

1. Upon receipt by a licensee of a wager or information assisting in the placement of wagers properly placed under applicable statutes and the *Rules of Racing*, the licensee shall debit the account holder's account in the amount of the wager.

2. A licensee may authorize a withdrawal from a wagering account when one of the following exists:

a. The holder of a wagering account applies in person at an account wagering center, or a racetrack or off-track wagering facility within the state, and provides proper identification, the correct personal identification account number, and a properly completed and signed withdrawal form.

b. The account holder has authorized the licensee to make such a withdrawal. Where there are sufficient funds in the account to cover the withdrawal, the account wagering center shall, within five business days of receipt, send a check to the account holder at the current address on record for the wagering account. The check shall be payable to the holder of the account and in the amount of the requested withdrawal, subject to compliance with the *Rules of Racing*, the licensee's rules, and federal and state laws (including but not limited to compliance with federal rules concerning the reporting or withholding of federal income tax). If funds are not sufficient to cover the withdrawal, or the full amount requested is otherwise not being sent, the account holder will be notified in writing and those funds in the account, subject to compliance with the *Rules of Racing*, the licensee's rules, and federal and state laws, will be withdrawn and sent to the account holder within five business days. Electronic transfers may be used for withdrawals in lieu of a check at

the discretion of the account holder and the account wagering center.

3. A licensee may debit an account for fees for service or other transaction-related charges.

D. Checks offered for deposit shall not be posted to the credit of the account holder until the "hold" period established by the licensee has elapsed. Holding periods will be determined by the licensee and advised to the account holder.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12031. Deceased Account Holder

A. In the event an account holder is deceased, funds accrued in the account shall be released to the decedent's legal representative upon receipt of a copy of a court order or judgment of possession.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12033. Licensee's Rights and Responsibilities

A. Notwithstanding any other rules, the licensee, through its managing employee of the account wagering center, or other employee or agent designated by the licensee, shall have the following rights and responsibilities.

1. The licensee has the right to refuse the establishment or maintenance of accounts for what it deems good and sufficient reason.

2. The licensee has the right to refuse deposits to accounts for what it deems good and sufficient reason.

3. The licensee has the right at any time to refuse to accept all or part of any wager for what it deems good and sufficient reason.

4. The licensee has the right at any time to declare the account wagering system closed for receiving wagers on any pari-mutuel pool, race, group of races, or closed for all wagering.

5. The licensee has the right to suspend or close any account at any time. When an account is closed, the licensee shall, within five business days, return to the account holder such monies as are on deposit at the time of said action, subject to compliance with the *Rules of Racing*, the licensee's rules, and federal and state laws, by sending a check to the account holder's current address.

6. The licensee has the right to close any account when the holder thereof attempts to operate with an insufficient balance or when the account is dormant for a period established by the licensee. In either case, the licensee shall refund the remaining balance of the account, subject to compliance with the *Rules of Racing*, the licensee's rules, and federal and state laws.

7. No employee or agent of the licensee employed or engaged at the account wagering center shall divulge any confidential information related to the placing of any wager or any confidential information related to the operation of the account wagering center, except to the account holder or the commission, as required by these rules, and as otherwise required by federal or state law, or the *Rules of Racing*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

§12035. Account Operations and Procedures

A. Account wagers shall be accepted during such times and on such days as designated by the licensee, subject to state law.

B. The account holder shall provide the licensee with the correct personal identification account number previously assigned by the licensee to the holder of the wagering account, as well as the account holder's confidential identification code.

C. Any account wagering system must provide for the account holder's review and finalization of a wager or information assisting in the placement of a wager before it is accepted by the licensee. The wager shall not be changed after the account holder has reviewed and finalized the wager, and the conversation or wagering transaction has been concluded.

D. Payment on winning account wagers shall be posted as a credit to the account of the account holder as soon as practicable after the race is declared official.

E. No licensee may accept an account wager, or series of account wagers, in an amount in excess of funds on deposit in the account of the account holder placing the wager. Funds on deposit include amounts credited and in the account at the time the account wager or account wagers are placed. Account wagers will not be accepted which would exceed the available balance in the account.

F. When an account holder is entitled to a payout or refund, such monies will be credited to the respective accounts, thus increasing the credit balance. It is the responsibility of the account holder to verify proper credits and, if in doubt, notify the licensee within the agreed upon time frame for consideration. Unresolved disputes may be forwarded to the commission by the licensee or the account holder. No claim will be considered by the commission unless submitted in writing and accompanied by supporting information or evidence.

G. Monies deposited with the licensee for account wagering shall not bear any interest to the account holder.

H. The licensee shall maintain equipment capable of recording all wagering conversations and transactions conducted through the account wagering system. The recording device must be used at all times when wagering communications are received.

I. For wagers made by voice telephone, the licensee shall make a voice recording of the entire transaction and shall not accept any such wager if the voice recording system is inoperable. The voice recording of the transaction shall be deemed to be the actual wager, regardless of what was recorded by the pari-mutuel system.

J. All wagering conversations, transactions or other wagering communications through the account wagering system, verbal or electronic, shall be recorded by means of the appropriate electronic media, and the tapes or other records of such communications kept by the account wagering center for a period of time which the commission may establish. These tapes and other records shall be made available to commissioners, employees and/or designees of the commission in accordance with the *Rules of Racing*.

K. The address provided in writing by the account holder to the account wagering center is deemed to be the proper

address for the purposes of mailing checks, account statements, account withdrawals, notices, or any other appropriate correspondence. It is the account holder's responsibility to maintain a current address of record with the account wagering center. The mailing of checks or other correspondence to the address given by the account holder shall be at the sole risk of the account holder.

L. The account wagering center shall, from time to time, but not less than once per year, provide written statements of account activity during the period to all account holders. In addition, an account holder has the right to request and be provided a statement at any time. Unless written notice to the contrary is received by the licensee within 30 days of the date that any such statement is rendered to an account holder, said statement shall be deemed accepted as correct in any and all particulars.

M. Subject to commission approval, the licensee may implement procedures for the use of wagering accounts for wagering while at facilities in this state where pari-mutuel wagering is permitted and for wagering by any other electronic means.

N. The commission may review and audit the account wagering system's equipment configuration and account wagering center. Any telephone communications system, whether touch tone, voice response, or operator controlled, and all other electronic media utilized for account wagers, shall be linked to a totalizator system in a manner approved by the commission. For the purposes of account wagering, totalizator equipment utilized by or linked to the licensee shall be capable of accounting for all wagering and other transactions which may affect customer accounts. The licensee must maintain complete records of every deposit, withdrawal, wager, refund and winning payout for each account. These records shall be made available to the commission in accordance with the *Rules of Racing*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 4:149, R.S. 4:149.1, R.S. 4:149.2 and R.S. 4:149.5.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Racing Commission, LR 27:

Charles A. Gardiner III
Executive Director

0011#016

DECLARATION OF EMERGENCY

Office of the Governor Board of the Trustees of the State Employees Group Benefits Program

Exclusive Provider Organization (EPO)C Plan of Benefits
(LAC 32:V.101-107, 301, 307-317,
325, 403, 501, 511-515, 601 and 701)

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

The board finds that it is necessary to revise and amend the EPO Plan Document. Failure to adopt this Rule on an

emergency basis will adversely affect the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state.

Accordingly, the following Emergency Rule, is effective October 29, 2000 through December 31, 2000 and shall remain in effect, revising and amending the EPO Plan of Benefits in the following particulars.

Title 32

EMPLOYEE BENEFITS

Part V. Exclusive Provider (EPO)C Plan of Benefits

Chapter 1. Eligibility

§101. Persons to be Covered

Eligibility requirements apply to all participants in the Program, whether in the PPO Plan, the EPO Plan or an HMO plan.

A. Employee Coverage

1. - 2. ...

3. Effective Dates of Coverage, New Employee, Transferring Employee. Coverage for each employee who completes the applicable enrollment form and agrees to make the required payroll contributions to his participant employer is to be effective as follows:

a. - b. ...

c. Employee coverage will not become effective unless the employee completes an enrollment form within 30 days following the date of employment. An employee who completes an enrollment form after 30 days following the date of employment will be considered an overdue applicant.

d. An employee that transfers employment to another participating employer must complete a Transfer Form within 30 days following the date of transfer in order to maintain coverage without interruption. An employee who completes a Transfer Form after 30 days following the date of transfer will be considered an overdue applicant.

A.4. - G.3. ...

H. Medicare Risk HMO Option for Retirees (Effective July 1, 1999)

H.1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1804 (October 1999), LR 27:

§103. Continued Coverage

A. - B.2. ...

C. Surviving Dependents/Spouse. The provisions of this section are applicable to surviving dependents who elect to continue coverage following the death of an employee or retiree. On or after July 1, 1999, eligibility ceases for a covered person who becomes eligible for coverage in a group health plan other than Medicare. Coverage under the group health plan may be subject to HIPAA.

1. Benefits under the plan for covered dependents of a deceased covered employee or retiree will terminate on the last day of the month in which the employee's or retiree's death occurred unless the surviving covered dependents elect to continue coverage.

a. ...

b. The surviving unmarried (never married) children of an employee or retiree may continue coverage until they are eligible for coverage under a group health plan

other than Medicare, or until attainment of the termination age for children, whichever occurs first;

C.1.c. - D. ...

E. Family and Medical Leave Act (F.M.L.A.) Leave of Absence. An employee on approved F.M.L.A. leave may retain coverage for the duration of such leave. The participant employer shall pay the employer's share of the premium during F.M.L.A. leave, whether paid leave or leave without pay. The participant employer shall pay the employees share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the employee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1806 (October 1999), LR 27:

§107. Change of Classification

A. Adding or Deleting Dependents. The plan member must notify the program whenever a dependent is added to, or deleted from, the plan member's coverage that would result in a change in the class of coverage. Notice must be provided within 30 days of the addition or deletion.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999), LR 27:

Chapter 3. Medical Benefits

§301. Medical Benefits Apply When Eligible Expenses are Incurred by a Covered Person

A. Eligible expenses are the charges incurred for the following items of service and supply. These charges are subject to the applicable deductibles, limits of the Fee Schedule, Schedule of Benefits, exclusions and other provisions of the Plan. A charge is incurred on the date that the service or supply is performed or furnished. Eligible expenses are:

1. - 8.l. ...

9. Services of licensed speech therapist when prescribed by a physician and pre-approved through outpatient procedure certification for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease;

10. - 11.c. ...

d. Accidental injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

12. durable medical equipment, subject to the lifetime maximum payment limitation as listed in the Schedule of Benefits [The program will require written certification by the treating physician to substantiate the medical necessity for the equipment and the length of time that it will be used. The purchase of durable medical equipment will be considered an eligible expense only upon showing that the rental cost would exceed the purchase price. Under no circumstances may the eligible expense for an item of durable medical equipment exceed the purchase price of such item].

13. - 18. ...

19. Acupuncture when rendered by a medical doctor licensed in the state in which the services are rendered;

20. - 20.d. ...

21. Services of a Physical Therapist and Occupational Therapist licensed by the state in which the services are rendered when:

a. - e. ...

f. approved through case management when rendered in the home;

22. - 23.c.iii. ...

24. Not subject to the annual deductible:

a. ...

b. mammographic examinations performed according to the following schedule:

i. one mammogram during the five-year period a person is 35-39 years of age;

24.b.ii. - 26. ...

27. Services rendered by the following, when billed by the supervising physician:

a. Perfusionists and Registered Nurse Assistants assisting in the operating room;

b. Physician's Assistants and Registered Nurse Practitioners.

28. - 32. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1810 (October 1999), LR 27:

§307. Utilization Review - Pre-Admission Certification, Continued Stay Review

A. - A.2. ...

B. For a routine vaginal delivery, PAC is not required for a stay of 2 days or less. If the mother's stay exceeds or is expected to exceed 2 days, PAC is required within 24 hours after the delivery or the date on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, PAC is required within 72 hours of the mother's discharge and a separate pre-certification number must be obtained for the baby. In the case of a Caesarian Section, PAC is required if the mother's stay exceeds or is expected to exceed 4 days;

C. No benefits will be paid under the Plan:

1. ...

2. Unless PAC is requested within two business days following admission in the case of an emergency;

C.3. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), LR 27:

§309. Outpatient Procedure Certification

A. - A.2. ...

B. OPC is required on the following procedures:

1. - 6. ...

7. Speech Therapy;

7.a. - d. ...

C. No benefits will be paid for the facility fee in connection with outpatient procedures, or the facility and professional fee in connection with speech therapy:

C.1. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), LR 27:

§311. Case Management

A. - E.8. ...

9. Physical and occupational therapy rendered in a home setting.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), LR 27:

§313. Dental Surgical Benefits

A. ...

B. Eligible expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care, anesthesia, radiology, and pathology services, and facility charges are subject to the deductible, co-insurance and the maximum benefit provisions of the Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), LR 27:

§315. Medicare Reduction

A. ...

B. Retiree 100-Medicare COB - Upon enrollment and payment of the additional monthly premium, a plan member and dependents who are covered under Medicare, both parts A and B, may choose to have full coordination of benefits with Medicare. Enrollment must be made within 30 days of eligibility for Medicare or within 30 days of retirement if already eligible for Medicare and at the annual open enrollment.

§317. Exceptions and Exclusions for All Medical Benefits

A. No benefits are provided under this Plan for:

1. - 24. ...

25. repealed

26. - 40. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), LR 26:488 (March 2000), LR 27:

§325. Prescription Drug Benefits

A. This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor, requiring a prescription, and dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a covered person as an inpatient Hospital patient or an outpatient hospital patient, including insulin, Retin-A dispensed for covered persons under the age of 26, Vitamin B12 injections, prescription Potassium Chloride, and over-the-counter diabetic supplies including, but not limited to, strips, lancets and swabs.

A.1. - 2. ...

B. The following drugs, medicines, and related services are not covered:

1. - 10. ...

11. Drugs for Treatment of impotence.

C. ...

1. Upon presentation of the group benefits program health benefits identification card at a network pharmacy, the Plan Member will be responsible for copayment of \$6.00 per prescription when a generic drug is dispensed, \$20 per prescription when a preferred brand name drug is dispensed, and \$30 per prescription when a non-preferred brand name drug is dispensed. The copayment cannot exceed the actual charge by the pharmacy for the drug.

2. - 5.c. ...

6. *Acute or Non-maintenance Drug* covered drug other than a maintenance drug as define herein.

7. *Brand Drug* the trademark name of a drug approved by the U. S. Food and Drug Administration.

8. *Generic Drug* chemically equivalent copy of a brand name drug.

9. *Maintenance Drug* covered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition

10. *Non-Preferred Brand Drug* brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the *Pharmacy and Therapeutic Committee*.

11. *Pharmacy and Therapeutic Committee* committee created by the program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a *Preferred Brand Drug* or a *Non-Preferred Brand Drug*. In making these determinations, the *Pharmacy and Therapeutic Committee* relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

12. *Preferred Brand Drug* brand name drug that has received a classification of *Preferred Brand* from the *Pharmacy and Therapeutic Committee* based on the following criteria:

- a. clinical uniqueness of the medication;
- b. positive efficacy profile;
- c. good side effect, safety, and drug interaction profile;
- d. positive quality of the implications;
- e. clinical experience with the medication; and
- f. cost (only considered when clinical parameters are equal to other products in its class).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1815 (October 1999), LR 27:

Chapter 4. Uniform Provisions

§403. Properly Submitted Claim Form

A. For plan reimbursements, all bills must show:

1. employee's name;
2. name of patient;
3. name, address, and telephone number of the provider of care;
4. diagnosis;

5. type of services rendered, with diagnosis and/or procedure codes;
6. date of service;
7. charges;
8. employee's member number;
9. provider Tax Identification number;
10. medicare explanation of benefits, if applicable.

B. The program can require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish the requested information within 90 days of the request will constitute reason for the denial of benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999), LR 27:

Chapter 5. Claims Review and Appeal

§501. Claims Review Procedures and Appeals

A. ...

B. The request for review must be directed to Attention: Appeals and Grievances within 90 days after the date of the notification of denial of benefits, denial of eligibility, or denial after review by the utilization review, pharmacy benefit or mental health contractors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1818 (October 1999), LR 27:

§511. Subpoena of Witnesses; Production of Documents

A. - B. ...

C. No subpoena will be issued requiring the attendance and giving of testimony by witnesses unless a written request therefor is received in the office of the program, Attention: Appeals and Grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoenas must contain the names of the witnesses and a statement of what is intended to be proved by each witness. No subpoenas will be issued until the party requesting the subpoena deposits with the program a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled.

D. No subpoena for the production of books, papers and other documentary evidence will be issued unless written request therefor is received in the office of the program, Attention: Appeals and Grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoena for books, papers, and other documentary evidence must contain a description of the items to be produced in sufficient detail for identification and must contain the name and street address of the person who is to be required to produce the items and a brief statement of what is intended to be proved by each item.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1819 (October 1999), LR 27:

§513. Appeals Decisions

A. ...

B. Appeals Heard by Referee: At the conclusion of the hearing, the referee will take the matter under submission

and, as soon as is reasonably possible thereafter, prepare a recommended decision in the case which will be based on the evidence adduced at the hearing or otherwise included in the hearing records. The decision will contain findings of fact and statement of reasons. The recommended decision will be submitted to the committee for review.

C. The committee may adopt or reject the recommended decision. In the case of adoption, the referee's decision becomes the decision of the committee. In the case of rejection, the committee will render its decision, which will include a statement of reasons for disagreement with the referee's decision. The decision of the committee will be final. A copy will be mailed by certified mail to the covered person and any representative thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1819 (October 1999), LR 27:

§515. Rehearing

A. - B. ...

C. The request for rehearing must be filed with the program, Attention: Appeals and Grievances on or before 30 calendar days after the mailing of the appeal decision of the committee. The request will be deemed filed on the date it is received in the office of the program.

D. ...

E. When the committee grants a rehearing, an order will be issued setting forth the grounds. A copy of the order will be sent, along with notice of the time and place fixed for the rehearing, to the appealing party and any representative by certified mail.

F. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1819 (October 1999), LR 27:

Chapter 6. Definitions

§601. Definitions

* * *

*Accidental Injury*Ca condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

* * *

*Acute or Non-maintenance Drug*Ca covered drug other than a maintenance drug as define herein.

* * *

*Brand Drug*Cthe trademark name of a drug approved by the U. S. Food and Drug Administration.

* * *

Children:

1. any legitimate, duly acknowledged, or legally adopted Children of the Employee and/or the Employee's legal spouse dependent upon the Employee for support;

2. - 4. ...

* * *

*Generic Drug*Ca chemically equivalent copy of a brand name drug.

* * *

Maintenance Drug Covered drug that is determined by the program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition.

Non-Preferred Brand Drug Ca brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the *Pharmacy and Therapeutic Committee*.

Pharmacy and Therapeutic Committee Ca committee created by the Program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a *Preferred Brand Drug* or a *Non-Preferred Brand Drug*. In making these determinations, the *Pharmacy and Therapeutic Committee* relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

Preferred Brand Drug Ca brand name drug that has received a classification of *Preferred Brand* from the *Pharmacy and Therapeutic Committee* based on the following criteria:

1. clinical uniqueness of the medication;
2. positive efficacy profile;
3. good side effect, safety, and drug interaction profile;
4. positive quality of the implications;
5. clinical experience with the medication; and
6. cost (only considered when clinical parameters are equal to other products in its class).

Well-Baby Care Croutine care to a well newborn infant from the date of birth until age 1. This includes routine physical examinations, active immunizations, check-ups, and office visits to a physician and billed by that physician, except for the treatment and/or diagnosis of a specific illness. All other health services coded with wellness procedures and diagnosis codes are excluded.

Well-Child Care Croutine physical examinations, active immunizations, check-ups and office visits to a physician, and billed by a health care provider that has entered into a contract with the State Employees Benefits Program, except for the Treatment and/or diagnosis of a specific illness, from age 1 to age 16. All other health services coded with wellness procedures and diagnosis codes are excluded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1820 (October 1999), LR 27:

Chapter 7. Schedule of Benefits – EPO

§701 Comprehensive Medical Benefits

A. - A.3. ...

4. Prescription Drugs (no deductible) 50% non-Network in state

\$6 copayment for generic drugs, 80% non-Network out of state
 \$20 copayment for preferred brand name drugs, and
 \$30 copayment for non-preferred brand name drugs purchased at a network pharmacy

B. - E. ...

F. Physical/Occupational Therapy¹ See % payable after deductible \$15 copay for outpatient services

Speech Therapy² See % payable after deductible \$15 copay for outpatient services

G ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1820 (October 1999), LR 26:488 (March 2000), LR 27:

¹ ...

² Subject to Case Management Guideline if rendered in a home setting

³ Subject to Outpatient Procedure Certification Guidelines

A. Kip Wall
 Chief Executive Officer

0011#011

DECLARATION OF EMERGENCY

**Office of the Governor
 Board of the Trustees of the State Employees
 Group Benefits Program**

Preferred Provider Organization (PPO)
 Plan of Benefits
 (LAC 32:III.101-107, 301, 307-317,
 325, 403, 501, 511-515, 601 and 701)

Pursuant to the authority granted by R.S. 42:871(C) and 874(B)(2), vesting the Board of Trustees with the responsibility for administration of the State Employees Group Benefits Program and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

The board finds that it is necessary to revise and amend the PPO Plan Document. Failure to adopt this rule on an emergency basis will adversely affect the availability of services necessary to maintain the health and welfare of the covered employees and their dependents, which is crucial to the delivery of vital services to the citizens of the state.

Accordingly, the following Emergency Rule, is effective October 29, 2000 through December 31, 2000 and shall remain in effect, revising and amending the PPO Plan of Benefits in the following particulars.

Title 32

EMPLOYEE BENEFITS

Part III. Exclusive Provider (PPO) Plan of Benefits

Chapter 1. Eligibility

§101. Persons to be Covered

Eligibility requirements apply to all participants in the Program, whether in the PPO Plan, the EPO Plan or an HMO plan.

A. Employee Coverage

1. - 2. ...

3. Effective Dates of Coverage, New Employee, Transferring Employee. Coverage for each employee who completes the applicable enrollment form and agrees to make the required payroll contributions to his Participant Employer is to be effective as follows:

a. - b. ...

c. Employee coverage will not become effective unless the employee completes an enrollment form within 30 days following the date of employment. An employee who completes an enrollment form after 30 days following the date of employment will be considered an overdue applicant;

d. An employee that transfers employment to another participating employer must complete a Transfer Form within 30 days following the date of transfer in order to maintain coverage without interruption. An employee who completes a Transfer Form after 30 days following the date of transfer will be considered an overdue applicant.

A.4. - H.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1825 (October 1999), LR 27:

§103. Continued Coverage

A. - B.2. ...

C. Surviving Dependents/Spouse. The provisions of this section are applicable to surviving dependents who elect to continue coverage following the death of an employee or retiree. On or after July 1, 1999, eligibility ceases for a covered person who becomes eligible for coverage in a group health plan other than Medicare. Coverage under the group health plan may be subject to HIPAA.

1. Benefits under the plan for covered dependents of a deceased covered employee or retiree will terminate on the last day of the month in which the employee's or retiree's death occurred unless the surviving covered dependents elect to continue coverage.

a. ...

b. The surviving unmarried (never married) children of an employee or retiree may continue coverage until they are eligible for coverage under a group health plan other than Medicare, or until attainment of the termination age for children, whichever occurs first;

C.1.c - D.3. ...

E. Family and Medical Leave Act (F.M.L.A.) Leave of Absence. An employee on approved F.M.L.A. leave may retain coverage for the duration of such leave. The participant employer shall pay the employer's share of the premium during F.M.L.A. leave, whether paid leave or leave without pay. The participant employer shall pay the employee's share of the premium during unpaid F.M.L.A. leave, subject to reimbursement by the employee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1827 (October 1999), LR 27:

§107. Change of Classification

A. Adding or Deleting Dependents. The plan member must notify the program whenever a dependent is added to, or deleted from, the plan member's coverage that would result in a change in the class of coverage. Notice must be provided within 30 days of the addition or deletion.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1829 (October 1999), LR 26:

Chapter 3. Medical Benefits

§301. Medical Benefits Apply When Eligible Expenses are Incurred by a Covered Person.

A. Eligible expenses are the charges incurred for the following items of service and supply. These charges are subject to the applicable deductibles, limits of the Fee Schedule, Schedule of Benefits, exclusions and other provisions of the plan. A charge is incurred on the date that the service or supply is performed or furnished. Eligible expenses are:

1. - 8.1. ...

9. Services of licensed speech therapist when prescribed by a physician and pre-approved through outpatient procedure certification for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injuries or other similar structural or neurological disease;

10. - 11.c. ...

d. Accidental injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

12. durable medical equipment, subject to the lifetime maximum payment limitation as listed in the Schedule of Benefits; [The program will require written certification by the treating physician to substantiate the medical necessity for the equipment and the length of time that it will be used. The purchase of durable medical equipment will be considered an eligible expense only upon showing that the rental cost would exceed the purchase price. Under no circumstances may the eligible expense for an item of durable medical equipment exceed the purchase price of such item.]

13. - 18. ...

19. acupuncture when rendered by a medical doctor licensed in the state in which the services are rendered;

20. - 20.d. ...

21. services of a physical therapist and occupational therapist licensed by the state in which the services are rendered when:

a. - e. ...

f. Approved through case management when rendered in the home;

22. - 23.c.iii. ...

24. not subject to the annual deductible:

a. ...

b. Mammographic examinations performed according to the following schedule:

i. One mammogram during the five-year period a person is 35-39 years of age;

ii. - iii. ...

c. ...

25. - 26. ...

27. services rendered by the following, when billed by the supervising physician:

a. Perfusionists and Registered Nurse Assistants assisting in the operating room;

b. Physician's Assistants and Registered Nurse Practitioners;

28. - 32. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999), LR 27:

§307. Utilization ReviewC pre-admission Certification, Continued Stay Review

A. - A.2. ...

B. For a routine vaginal delivery, PAC is not required for a stay of 2 days or less. If the mother's stay exceeds or is expected to exceed 2 days, PAC is required within 24 hours after the delivery or the date on which any complications arose, whichever is applicable. If the baby's stay exceeds that of the mother, PAC is required within 72 hours of the mother's discharge and a separate pre-certification number must be obtained for the baby. In the case of a Caesarean Section, PAC is required if the mother's stay exceeds or is expected to exceed 4 days;

C. No benefits will be paid under the Plan:

1. ...

2. unless PAC is requested within two business days following admission in the case of an emergency;

C.3. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), LR 27:

§309. Outpatient Procedure Certification (OPC)

A. OPC certifies that certain outpatient procedures and therapies are Medically Necessary. OPC is required on the following procedures:

1. - 6. ...

7. Speech Therapy;

C. No benefits will be paid for the facility fee in connection with outpatient procedures, or the facility and professional fee in connection with speech therapy:

C.1. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), LR 27:

§311. Case Management

A. - E.8. ...

9. Physical and occupational therapy rendered in a home setting.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), LR 27:

§313. Dental Surgical Benefits

A. ...

B. Eligible expenses incurred in connection with the removal of impacted teeth, including pre-operative and post-operative care, anesthesia, radiology, and pathology services, and facility charges are subject to the deductible, co-insurance and the maximum benefit provisions of the Plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), LR 27:

§315. Medicare Reduction

A. ...

B. Retiree 100-Medicare COB - Upon enrollment and payment of the additional monthly premium, a plan member and dependents who are covered under Medicare, both parts A and B, may choose to have full coordination of benefits with Medicare. Enrollment must be made within 30 days of eligibility for Medicare or within 30 days of retirement if already eligible for Medicare and at the annual open enrollment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), LR 27:

§317. Exceptions and Exclusions for All Medical Benefits

A. No benefits are provided under this Plan for:

1. - 24. ...

25. repealed

26. - 40. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1834 (October 1999), LR 26:488 (March 2000), LR 27:

§323. Prescription Drug Benefits

A. This Plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor, requiring a prescription, and dispensed by a licensed pharmacist or pharmaceutical company, but which are not administered to a covered person as an inpatient hospital patient or an outpatient hospital patient, including insulin, Retin-A dispensed for covered persons under the age of 26, Vitamin B12 injections, prescription Potassium Chloride, and over-the-counter diabetic supplies including, but not limited to, strips, lancets and swabs.

B. The following drugs, medicines, and related services are not covered:

1. - 10. ...

11. drugs for treatment of impotence.

C. ...

1. Upon presentation of the group benefits program health benefits identification card at a network pharmacy, the plan member will be responsible for copayment of \$6 per prescription when a generic drug is dispensed, \$20 per prescription when a preferred brand name drug is dispensed, and \$30 per prescription when a non-preferred brand name

drug is dispensed. The copayment cannot exceed the actual charge by the pharmacy for the drug.

2. - 5.c. ...

6. *Acute or Non-maintenance Drug* Ca covered drug other than a maintenance drug as define herein.

7. *Brand Drug* the trademark name of a drug approved by the U. S. Food and Drug Administration.

8. *Generic Drug* Ca chemically equivalent copy of a brand name drug.

9. *Maintenance Drug* Ca covered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition

10. *Non-Preferred Brand Drug* Ca brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the *Pharmacy and Therapeutic Committee*.

11. *Pharmacy and Therapeutic Committee* Ca committee created by the Program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a *Preferred Brand Drug* or a *Non-Preferred Brand Drug*. In making these determinations, the *Pharmacy and Therapeutic Committee* relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

12. *Preferred Brand Drug* Ca brand name drug that has received a classification of *Preferred Brand* from the *Pharmacy and Therapeutic Committee* based on the following criteria:

- a. clinical uniqueness of the medication;
- b. positive efficacy profile;
- c. good side effect, safety, and drug interaction profile;
- d. positive quality of the implications;
- e. clinical experience with the medication; and
- f. cost (only considered when clinical parameters are equal to other products in its class).

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1835 (October 1999), LR 27:

Chapter 4. Uniform Provisions

§403. Properly Submitted Claim Form

- A. For Plan reimbursements, all bills must show:
 1. employee's name;
 2. name of patient;
 3. name, address, and telephone number of the provider of care;
 4. diagnosis;
 5. type of services rendered, with diagnosis and/or procedure codes;
 6. date of service;
 7. charges;
 8. employee's member number;
 9. provider Tax Identification number;
 10. Medicare explanation of benefits, if applicable.

B. The Program can require additional documentation in order to determine the extent of coverage or the appropriate

reimbursement. Failure to furnish the requested information within 90 days of the request will constitute reason for the denial of benefits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), LR 27:

Chapter 5. Claims Review and Appeal

§501. Claims Review Procedures and Appeals

A. ...

B. The request for review must be directed to Attention: Appeals and Grievances within 90 days after the date of the notification of denial of benefits, denial of eligibility, or denial after review by the utilization review, pharmacy benefit or mental health contractors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1838 (October 1999), LR 27:

§511. Subpoena of Witnesses; Production of Documents

A. - B. ...

C. No subpoena will be issued requiring the attendance and giving of testimony by witnesses unless a written request therefor is received in the office of the Program, Attention: Appeals and Grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoenas must contain the names of the witnesses and a statement of what is intended to be proved by each witness. No subpoenas will be issued until the party requesting the subpoena deposits with the Program a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled.

D. No subpoena for the production of books, papers and other documentary evidence will be issued unless written request therefor is received in the office of the Program, Attention: Appeals and Grievances no later than 15 calendar days before the date fixed for the hearing. The request for subpoena for books, papers, and other documentary evidence must contain a description of the items to be produced in sufficient detail for identification and must contain the name and street address of the person who is to be required to produce the items and a brief statement of what is intended to be proved by each item.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1839 (October 1999), LR 27:

§513. Appeals Decisions

A. ...

B. Appeals Heard by Referee. At the conclusion of the hearing, the referee will take the matter under submission and, as soon as is reasonably possible thereafter, prepare a recommended decision in the case which will be based on the evidence adduced at the hearing or otherwise included in the hearing records. The decision will contain findings of fact and statement of reasons. The recommended decision will be submitted to the Committee for review.

C. The Committee may adopt or reject the recommended decision. In the case of adoption, the referee's decision becomes the decision of the committee. In the case of

rejection, the committee will render its decision, which will include a statement of reasons for disagreement with the referee's decision. The decision of the committee will be final. A copy will be mailed by certified mail to the covered person and any representative thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1839 (October 1999), LR 27:

§515. Rehearing

A. - B ...

C. The request for rehearing must be filed with the program, Attention: Appeals and Grievances on or before 30 calendar days after the mailing of the appeal decision of the committee. The request will be deemed filed on the date it is received in the office of the program.

D. ...

E. When the committee grants a rehearing, an order will be issued setting forth the grounds. A copy of the order will be sent, along with notice of the time and place fixed for the rehearing, to the appealing party and any representative by certified mail.

F. - G ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1840 (October 1999), LR 27:

Chapter 6. Definitions

§601. Definitions

*Accidental Injury*Ca condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an injury caused by external force.

*Acute or Non-maintenance Drug*Ca covered drug other than a maintenance drug as define herein.

*Brand Drug*Cthe trademark name of a drug approved by the U. S. Food and Drug Administration.

*Children*C

1. any legitimate, duly acknowledged, or legally adopted Children of the Employee and/or the Employee's legal spouse dependent upon the Employee for support;

2. - 4. ...

*Generic Drug*Ca chemically equivalent copy of a "brand name" drug.

*Maintenance Drug*Ccovered drug that is determined by the Program's contracted prescription benefits management firm, using standard industry reference materials, to be routinely taken over a long period of time for certain chronic medical conditions. The drug must be listed on the established maintenance drug list as an approved drug for the patient's condition.

*Non-Preferred Brand Drug*Ca brand drug for which there is an equally effective, less costly therapeutic alternative available, as determined by the *Pharmacy and Therapeutic Committee*.

*Pharmacy and Therapeutic Committee*Ca committee created by the Program's contracted prescription benefits management firm to advise its various plans on whether a drug has been accepted as safe and effective or investigations as well as whether a drug will be classified as a *Preferred Brand Drug* or a *Non-Preferred Brand Drug*. In making these determinations, the *Pharmacy and Therapeutic Committee* relies on the United States Food and Drug Administration as well as peer reviewed medical journals.

*Preferred Brand Drug*Ca brand name drug that has received a classification of *Preferred Brand* from the *Pharmacy and Therapeutic Committee* based on the following criteria:

1. clinical uniqueness of the medication;
2. positive efficacy profile;
3. good side effect, safety, and drug interaction profile;
4. positive quality of the implications;
5. clinical experience with the medication; and
6. cost (only considered when clinical parameters are equal to other products in its class).

*Well-Baby Care*Croutine care to a well newborn infant from the date of birth until age one. This includes routine physical examinations, active immunizations, check-ups, and office visits to a physician and billed by that physician, except for the treatment and/or diagnosis of a specific illness. All other health services coded with wellness procedures and diagnosis codes are excluded.

*Well-Child Care*Croutine physical examinations, active immunizations, check-ups and office visits to a Physician, and billed by a health care provider that has entered into a contract with the State Employees Group Benefits Program, except for the treatment and/or diagnosis of a specific illness, from age 1 to age 16. All other health services coded with wellness procedures and diagnosis codes are excluded.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1840 (October 1999), LR 27:

Chapter 7. Schedule of Benefits – PPO
§701 Comprehensive Medical Benefits

A. - A.3. ...

4. Prescription Drugs

(No deductible)	50% non-Network in state
\$8 copayment for generic drugs,	80% non-Network for out of state
\$25 copayment preferred brand name drugs, and \$40 copayment for non-preferred brand name drugs purchased at a network pharmacy	

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:871(C) and 874(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1843 (October 1999), LR 26:488 (March 2000), LR 27:

A. Kip Wall
Chief Executive Officer

0011#010

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Early and Periodic Screening, Diagnosis
and Treatment (EPSDT)C Hearing Aids

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is adopted in accordance with the Administrative Procedure Act, R. S. 49:953(B)(1) et seq. and shall be in effect for the maximum period allowed under the Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) hearing aid services under the Medicaid Program. The criteria for prior authorization of hearing aids was promulgated by reference in a rule that adopted the state and federal requirements and procedures governing the determination of Medicaid eligibility as contained in the Medicaid Eligibility Manual (*Louisiana Register*, Volume 22, Number 5). As a result of a change in the policy of the Office of Public Health on providing hearing aid services, the bureau has determined that it is necessary to amend the May 20, 1996 rule by replacing the existing prior authorization criteria for hearing aids. In addition to establishing new prior authorization criteria for hearing aids, the bureau proposes to remove the criteria from the Medicaid Eligibility Manual and to place it under the EPSDT Program.

This action is being taken to promote the health and welfare of EPSDT recipients by increasing access to medically necessary hearing aid services. It is estimated that implementation of this emergency rule will increase expenditures for EPSDT hearing aid services by approximately \$182,988 for state fiscal year 2000-2001.

Emergency Rule

Effective for dates of service on or after November 21, 2000, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the May 20, 1996 Rule to establish the following prior authorization criteria for hearing aids. In addition, the prior authorization criteria for hearing aids is removed from the Medicaid Eligibility Manual and placed under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

Prior Authorization Criteria

Hearing aids and related services are only covered for EPSDT recipients up to the age of 21. Approval is granted only when there is a significant hearing loss as documented by audiometric or electrophysiologic data from a licensed audiologist and medical clearance and prescription from an ear specialist (otologist).

The audiologist must furnish a report including an audiogram, if applicable, all test results and the degree and type of hearing loss. A hearing loss greater than 20 decibels average hearing level in the range 250-2000 Hz is considered significant. Additional required medical and social information shall include:

- 1) the recipient's age;
- 2) expected benefit of the hearing aid;
- 3) previous and current use of a hearing aid;
- 4) additional disabilities expected to influence the use of a hearing aid; and
- 5) referrals made on the recipient's behalf to early intervention programs, special education programs or other rehabilitative services.

Hearing aid repairs, batteries, and ear molds shall no longer require prior authorization. However, ear molds must be prescribed by a physician. Limitations on the purchase of ear molds are established as follows: One ear mold will be allowed every 90 days for EPSDT recipients from birth to age 4. One ear mold per year will be allowed for EPSDT recipients from age 5 to up to 21.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available at the parish Medicaid office for review by interested parties.

David W. Hood
Secretary

0011#065

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing**

Mentally Retarded/Developmentally
Disabled WaiverCWaiting List

The Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services adopts the following Emergency Rule under the Administrative Procedure Act, R.S. 49:950 et seq. The Emergency Rule shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted a rule governing the allocation of waiver slots, admission criteria and discharge criteria for the Mentally Retarded/Developmentally Disabled (MR/DD) Home and Community Based Services Waiver in

June, 1997 (*Louisiana Register*, Volume 23, Number 6). The rule was amended in March, 1998 to allow some slots allocated for the deinstitutionalization of Pinecrest and Hammond Developmental Centers residents to be alternatively used for the benefit of residents of private ICF/MR facilities (*Louisiana Register*, Volume 24, Number 3). The provisions governing the allocation of waiver slots contained in the March 20, 1998 rule were subsequently amended by a rule adopted to allow any slots vacated during the waiver year to be made available to residents leaving any publicly operated ICF-MR facility (*Louisiana Register*, Volume 25, Number 9). Certain slots for foster children in the custody of the Office of Community Services (OCS), and for the deinstitutionalization of residents of designated developmental centers or private ICF-MR facilities continued to be reserved under the September, 1999 rule.

The department now proposes to transfer responsibility for the waiting list to the Bureau of Community Supports and Services and to set forth provisions for the orderly transition from regional waiting lists to a single state-wide waiting list to be maintained in the state office. The department further proposes to adopt policy specifying the point of entry for the MR/DD waiver waiting list and the criteria for inclusion on and removal from the waiting list. Provisions contained in the previously cited rules that are not related to the MR/DD waiver waiting list are not affected by adoption of this Emergency Rule.

This action is being taken to protect the health and welfare of persons with mental retardation or developmental disabilities by providing an orderly process by which consideration for waiver services will be accomplished. It is estimated that the implementation of this Emergency Rule has no fiscal impact other than the administrative cost of promulgating the rule.

Emergency Rule

Effective October 27, 2000, the Department of Health and Hospitals transfers responsibility for the waiting list for the Mentally Retarded/Developmentally Disabled (MR/DD) Waiver to the Bureau of Community Supports and Services (BCSS). Regional MR/DD Waiver waiting lists shall be consolidated into a single state-wide list arranged in order of the date of the initial request. Those persons on regional waiting lists prior to the date of the transfer of responsibility to BCSS shall remain on the waiting list in the order of the date on record when the candidate initially requested a slot in the waiver, subject to a subsequent determination that he/she meets the criteria for inclusion on the waiting list. When a candidate is listed on more than one regional waiting list, the earliest date on record shall be considered the date of initial request. Persons who wish to be added to the waiting list shall contact a toll-free telephone number maintained by BCSS. In addition, the department adopts the following regulations regarding the waiting list for the MR/DD Waiver.

I. Inclusion Criteria

A. **Persons Currently on the Waiting List.** Persons on the waiting list prior to October 27, 2000, shall be screened to determine whether they are legitimate candidates for

waiver eligibility. Only persons found to meet the criteria for candidacy shall remain on the waiting list. However, if a waiver slot becomes available before the next person on the waiting list has been screened, that person shall be allowed to make application for the slot.

B. **Entry to the Waiting List.** On or after October 27, 2000, persons who wish to be entered on the waiting list shall be screened to determine whether they are legitimate candidates for waiver eligibility prior to their name being placed on the waiting list. Only persons who meet the criteria for candidacy shall be added to the waiting list for waiver services.

C. **Waiver Candidacy.** The candidate must provide documentation that there is a reasonable expectation that he/she meets the state's definition of being mentally retarded or developmentally disabled. In addition, the candidate must appear to meet the financial, disability, non-financial and ICF-MR level of care criteria for Medicaid eligibility, according to his/her own statement or the statement of a responsible party.

II. Exclusion Criteria

A. **Failure to Cooperate.** Potential candidates who fail to provide requested documentation or otherwise fail to cooperate within a reasonable length of time shall be excluded from the waiting list. The potential candidate shall be informed of the time limits involved when the information is requested.

B. **Insufficient Documentation of Disability.** Documentation of the type and degree of disability must support the contention that the potential candidate meets the state's definition of mentally retarded or developmentally disabled.

C. **Ineligibility Determined During Pre-screening.** Persons who do not meet the eligibility criteria for an ICF-MR level of care according to their own statement on a pre-screening tool devised by BCSS shall be eliminated from the MR/DD waiver waiting list.

D. **Subsequent Determination of Ineligibility.** BCSS may exercise its authority to eliminate a potential candidate from the waiting list when information provided about the potential candidate's situation indicates that he/she would not be eligible if he/she were to apply at the present point in time. For example, a candidate could not become eligible for a waiver slot if the candidate moved out of state with the intent to become a resident of that state, or was incarcerated and placed under the jurisdiction of the penal authorities, courts, or state juvenile authorities.

Interested persons may submit written comments to: Barbara Dodge, Bureau of Community Supports and Services, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

0011#067

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Public Nursing Facilities Reimbursement Methodology

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq. and shall be in effect for the maximum period allowed under the Act or until adoption of the rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage under the Medicaid Program for nursing facility services. Payments for nursing facility services are made in accordance with the prospective reimbursement methodology adopted effective August 1, 1984 (*Louisiana Register*, Volume 10, Number 6). This rule was subsequently amended by a rule adopted to discontinue the practice of automatically applying an inflation adjustment to the reimbursement rates in those years when the rates are not rebased (*Louisiana Register*, Volume 25, Number 6). As a result of a budgetary shortfall, an Emergency Rule was adopted to reduce the prospective per diem rates for private nursing facilities by 7 percent (*Louisiana Register*, Volume 26, Number 2). The March 1, 2000 Emergency Rule was later replaced by an Emergency Rule to restore the 7 percent reduction previously made to the prospective per diem rates for private nursing facilities (*Louisiana Register*, Volume 26, Number 8).

In compliance with the provisions of Act 143 of 2000 First Extraordinary Session of the Louisiana Legislature, the Bureau proposes to amend the reimbursement methodology for parish-owned nursing facilities in order to increase reimbursement to these facilities in proportion to their share of Medicaid days provided during the reporting period used to set rates. This action is being taken to enhance federal revenues in the Medicaid Program.

It is estimated that the implementation of this proposed Rule will increase annual aggregate expenditures for qualified nursing facilities by up to \$600 million for state fiscal year 2000-01.

Emergency Rule

Effective October 13, 2000, the Department of Health and Hospitals, Bureau of Health Services Financing creates an enhanced payment pool for qualifying nursing facilities, subject to the availability of funds and to the payment limits as set forth in 42 CFR 447.272.

Qualifying nursing facilities are parish-owned nursing facilities that meet the following criteria:

- 1) have an annual Medicaid occupancy level at or above 60 percent;
- 2) provide 12,000 or more Medicaid days of care annually; and
- 3) have entered into, or be part of a parish government that has entered into, a transfer agreement with the department to provide for an intergovernmental transfer of funds.

The nursing facility payment differential for any year shall be the difference between the upper limit of aggregate payments to nursing facilities as defined in 42 CFR §447.272 and the aggregate Medicaid per diem reimbursement paid to nursing facilities for the year. This is determined for all nursing facilities participating in the state's Medicaid Program, or for a subset of these facilities that includes parish-owned nursing facilities for which a separate upper payment limit calculation as in effect in that year is required by 42 CFR §447.272.

Total payments from the pool in any year shall not exceed a percentage of the nursing facility payment differential that will be determined by the department for each payment year. The enhancement pool payment amount shall be distributed to qualifying parish-owned nursing facilities based on their pro-rata share of the total annual Medicaid days of care of all qualifying parish-owned nursing facilities. Determination of annual Medicaid occupancy level and Medicaid days of care shall be based on the most recently filed cost reports on file with the department. Implementation of this emergency rule is subject to approval by the United States Department of Health and Human Services, Health Care Financing Administration.

Interested persons may submit written comments to the following address: Ben A. Bearden, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this emergency rule is available for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

0011#066

DECLARATION OF EMERGENCY

Department of Social Services Office of Family Support

Family Independence Temporary Assistance (FITAP) Program Increases in Flat Grant Amounts (LAC 67:III.1229)

The Department of Social Services, Office of Family Support, has exercised the emergency provision of the Administrative Procedure Act, R.S. 49:953(B) to adopt the following change in the Family Independence Temporary Assistance Program (FITAP), effective November 12, 2000. This declaration is necessary to extend the original Emergency Rule of July 12, 2000, since it is effective for a maximum of 120 days and will expire before the final Rule takes effect.

Whereas the cash assistance payment amount in Louisiana has not been increased since August 1981 despite continual increases in the cost of living, the agency has included a grant increase in its fiscal year 2000/2001 budget which was approved by Special Session of the Louisiana Legislature. Therefore, in an effort to improve the financial situation of FITAP recipients, the program will increase the FITAP grant amount for all assistance units by the amount of \$50 per month beginning July 2000. The funding source for this

increase is the federal Temporary Assistance for Needy Families (TANF) Block Grant to Louisiana.

Title 67

SOCIAL SERVICES

Part III. Office of Family Support

Subpart 2. Family Independence Temporary Assistance Program (FITAP)

Chapter 12. Application, Eligibility, and Furnishing Assistance

Subchapter B. Conditions of Eligibility

§1229. Income

- A. - C. ...
- D. Flat Grant Amounts

Number of Persons	Flat Grant Amount
1	\$122
2	188
3	240
4	284
5	327
6	366
7	402
8	441
9	477
10	512
11	551
12	590
13	630
14	670
15	712
16	757
17	791
18	839
18+	See note 1

Note 1: To determine the amount for households exceeding 18 persons, add the flat grant amount for the number in excess of 18 to the flat grant amount for 18 persons and subtract \$50.

E. - G ...

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474, R.S. 46:231.1.B., R. S. 46:231.2, R. S. 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 25:2449 (December 1999), amended LR 27:

J. Renea Austin-Duffin
Secretary

0011#047

DECLARATION OF EMERGENCY

**Department of Social Services
Office of Family Support**

**Kinship Care Subsidy Program Grant Increase
(LAC 67:III.5329)**

The Department of Social Services, Office of Family Support, has exercised the emergency provision of the Administrative Procedure Act, R.S. 49:953(B) to adopt the following change in the Kinship Care Subsidy Program (KCSP), effective November 24, 2000. This declaration is necessary to extend the original Emergency Rule of July 26, 2000, since it is effective for a maximum of 120 days and will expire before the final Rule takes effect.

In an effort to improve the financial situation of KCSP recipients, the program will increase the KCSP grant amount for eligible children by the amount of \$50 per month beginning July, 2000. The funding source for this increase is the federal Temporary Assistance for Needy Families (TANF) Block Grant to Louisiana. The agency has included a grant increase in its fiscal year 2000/2001 budget which was approved by the Louisiana Legislature.

Title 67

SOCIAL SERVICES

Part III. Office of Family Support

**Subpart 13. Kinship Care Subsidy Program (KCSP)
Chapter 53. Application, Eligibility, and Furnishing Assistance**

Subchapter B. Conditions of Eligibility

§5329. Income

- A. - B. ...
- C. Income After Pretest

1. The child is determined eligible for KCSP if the child's countable income is less than \$222. If the child's countable income is \$222 or more the child is ineligible.

D. Payment Amount

1. Payment amount is \$222 a month for each eligible child.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474, R.S. 46:231.1.B, R. S. 46:237.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 26:353 (February 2000), amended LR 27:

J. Renea Austin-Duffin
Secretary

0011#048