

Emergency Rules

DECLARATION OF EMERGENCY

Department of Agriculture and Forestry Office of the Commissioner

Chloramphenicol in Shrimp and CrawfishC Testing and Sale
(LAC 7:XXXV.137 and 139)

The Commissioner of Agriculture and Forestry hereby adopts the following Emergency Rules governing the testing and sale of shrimp and crawfish in Louisiana and the labeling of foreign shrimp and crawfish. These Rules are being adopted in accordance with R.S. 3:2A, 3:3B, R.S. 3:4608 and the Emergency Rule provisions of R.S. 49:953.B of the Administrative Procedure Act.

The Louisiana Legislature, by SCR 13 of the 2002 Regular Session, has urged and requested that the Commissioner of Agriculture and Forestry require all shrimp and crawfish, prior to sale in Louisiana, meet standards relating to chloramphenicol that are consistent with those standards promulgated by the United States Food and Drug Administration, (FDA). The legislature has also urged and requested the commissioner to promulgate Rules and regulations necessary to implement the standards relating to chloramphenicol in shrimp and crawfish that are consistent with those standards promulgated by the FDA, and which Rules and regulations require all shrimp and crawfish sold in Louisiana to meet the standards adopted by the commissioner, prior to sale.

Chloramphenicol is an antibiotic the FDA has restricted for use in humans only in those cases where other antibiotics or medicines have not been successful. The FDA has banned the use of chloramphenicol in animals raised for food production [see, 21 CFR 522.390(3)]. The FDA has set a zero tolerance level for chloramphenicol in food.

Chloramphenicol is known to cause aplastic anemia, which adversely affects the ability of a person's bone marrow to produce red blood cells. Aplastic anemia can be fatal. In addition, according to the National Institute on Environmental and Health Sciences, chloramphenicol can reasonably be anticipated to be a human carcinogen. In widely accepted references such as "Drugs in Pregnancy and Lactation," the use of chloramphenicol is strongly dissuaded during pregnancy, especially late pregnancy. Chloramphenicol can be transmitted to an unborn child through the placenta and to an infant through the mother's milk. The dosage transmitted to an unborn child is essentially the same dosage as is taken in by the mother. However, the unborn child is unable to metabolize chloramphenicol as efficiently, thereby causing the risk of an increasing toxicity level in the unborn child. Although the effect on an infant as a result of nursing from a mother who has taken chloramphenicol is unknown, it is known that such an infant will run the risk of bone marrow depression.

Recently, European Union inspectors found chloramphenicol residues in shrimp and crawfish harvested from and produced in China. The inspectors also found "serious deficiencies of the Chinese residue control system and problems related to the use of banned substances in the veterinary field," which may contribute to chloramphenicol residues in Chinese shrimp and crawfish. The Chinese are known to use antibiotics, such as chloramphenicol, in farm-raised shrimp. They are also known to process crawfish and shrimp harvested in the wild in the same plants used to process farm-raised shrimp.

The European Union, in January of this year, banned the import of shrimp and crawfish from China because chloramphenicol has been found in shrimp and crawfish imported from China. Canada has, this year, banned the import of shrimp and crawfish that contain levels of chloramphenicol above the level established by Canada. Between 1999 and 2000, imports of Chinese Shrimp to the United States doubled, from 19,502,000 pounds to 40,130,000 pounds. With the recent bans imposed by the European Union and Canada there is an imminent danger that the shrimp and crawfish that China would normally export to the European Union and Canada will be dumped and sold in the United States, including Louisiana.

The sale of such shrimp and crawfish in Louisiana will expose Louisiana's citizens, including unborn children and nursing infants, to chloramphenicol, a known health hazard. The sale, in Louisiana, of shrimp and crawfish containing chloramphenicol presents an imminent peril to the public's health, safety and welfare.

This peril can cause consumers to quit buying shrimp and crawfish from any source, including Louisiana shrimp and crawfish. If consumers cease to buy, or substantially reduce, their purchases of Louisiana shrimp and seafood, Louisiana aquaculture and fisheries will be faced with substantial economic losses. Any economic losses suffered by Louisiana's aquaculture and fisheries will be especially severe in light of the current economic situation, thereby causing an imminent threat to the public welfare.

Consumers of shrimp and crawfish cannot make an informed decision as to what shrimp or crawfish to purchase and the commissioner cannot adequately enforce the regulations regarding the sampling and testing of shrimp and crawfish unless shrimp and crawfish produced in foreign countries are properly labeled as to the country of origin.

The Commissioner of Agriculture and Forestry has, therefore, determined that these Emergency Rules are necessary to immediately implement testing of shrimp and crawfish for chloramphenicol, to provide for the sale of shrimp and crawfish that are not contaminated with chloramphenicol and to provide for the labeling of shrimp and crawfish harvested from or produced, processed or packed in countries other than the United States. These Rules become effective upon signature, May 22, 2003, and will remain in effect 120 days, unless renewed by the commissioner or until permanent Rules are promulgated.

Title 7

AGRICULTURE AND ANIMALS

Part XXXV. Agro-Consumer Services

Chapter 1. Weights and Measures

§137. Chloramphenicol in Shrimp and Crawfish Prohibited; Testing and Sale of

A. Definitions

Food Producing Animals—both animals that are produced or used for food and animals, such as dairy cows, that produce material used as food.

Geographic Area—a country, province, state, or territory or definable geographic region.

Packaged Shrimp or Crawfish—any shrimp or crawfish, as defined herein, that is in a package, can, or other container, and which is intended to eventually be sold to the ultimate retail purchaser in the package, can or container.

Shrimp or Crawfish—any such animals, whether whole, de-headed, de-veined or peeled, and any product containing any shrimp or crawfish.

B. No shrimp or crawfish may be held, offered or exposed for sale, or sold in Louisiana if such shrimp or crawfish contain chloramphenicol.

C. No shrimp or crawfish may be held, offered or exposed for sale, or sold in Louisiana without being accompanied by the following records and information, written in English.

1. The records and information required are:
 - a. the quantity and species of shrimp and crawfish acquired or sold;
 - b. the date the shrimp or crawfish was acquired or sold;
 - c. the name and license number of the wholesale/retail seafood dealer or the out-of-state seller from whom the shrimp or crawfish was acquired or sold;
 - d. the geographic area where the shrimp or crawfish was harvested;
 - e. the geographic area where the shrimp or crawfish was produced processed or packed;
 - f. the trade or brand name under which the shrimp or crawfish is held, offered or exposed for sale or sold; and
 - g. the size of the packaging of the packaged shrimp or crawfish.

2. Any person maintaining records and information as required to be kept by the Louisiana Department of Wildlife and Fisheries in accordance with R.S. 56:306.5, may submit a copy of those records, along with any additional information requested herein, with the shrimp or crawfish.

3. Any shrimp or crawfish not accompanied by all of this information shall be subject to the issuance of a stop-sale, hold or removal order until the shrimp or crawfish is tested for and shown to be clear of chloramphenicol, or the commissioner determines that the shrimp or crawfish does not come from a geographic area where chloramphenicol is being used on or found in food producing animals, or in products from such animals.

D. No shrimp or crawfish that is harvested from or produced, processed or packed in a geographic area, that the commissioner declares to be a location where chloramphenicol is being used on or found in food producing animals, or in products from such animals, may be held, offered or exposed for sale, or sold in Louisiana without first meeting the requirements of Subsection F.

E. The commissioner may declare a geographic area to be a location where chloramphenicol is being used on or found in food producing animals, or in products from such animals, based upon information that would lead a reasonable person to believe that chloramphenicol is being used on or found in food producing animals, or in products from such animals, in that geographic area.

1. Any such declaration shall be subject to promulgation in accordance with the provisions of the Administrative Procedure Act.

2. The commissioner may release any such geographic area from a previous declaration that chloramphenicol is being used on food producing animals in that location. Any such release shall be subject to promulgation in accordance with the Administrative Procedure Act.

F. Shrimp or crawfish, that comes from a geographic area declared by the commissioner to be a location where chloramphenicol is being used on, or is found in food producing animals, or in products from such animals, must meet the following requirements for sampling, identification, sample preparation, testing and analysis before being held, offered or exposed for sale, or sold in Louisiana.

1. Sampling

a. The numbers of samples that shall be taken are as follows:

- i. two samples are to be taken of shrimp or crawfish that are in lots of 50 pounds or less;
- ii. four samples are to be taken of shrimp or crawfish that are in lots of 51 to 100 pounds;
- iii. twelve samples are to be taken of shrimp or crawfish that are in lots of 101 pounds up to 50 tons;
- iv. twelve samples for each 50 tons are to be taken of shrimp or crawfish that are in lots of over fifty tons.

b. For packaged shrimp or crawfish, each sample shall be at least eight ounces, (226.79 grams), in size and shall be taken at random throughout each lot of shrimp or crawfish. For all other shrimp or crawfish, obtain approximately one pound (454 grams), of shrimp or crawfish per sample from randomly selected areas.

c. If the shrimp or crawfish to be sampled consists of packages of shrimp or crawfish grouped together, but labeled under two or more trade or brand names, then the shrimp or crawfish packaged under each trade or brand name shall be sampled separately. If the shrimp or crawfish to be sampled are not packaged, but are segregated in such a way as to constitute separate groupings, then each separate grouping shall be sampled separately.

d. A composite of the samples shall not be made. Each sample shall be tested individually. Each sample shall be clearly identifiable as belonging to a specific group of shrimp or crawfish. All samples shall be kept frozen and delivered to the lab.

2. Each sample shall be identified as follows:

- a. any package label;
- b. any lot or batch numbers;
- c. the country, province and city of origin;
- d. the name and address of the importing company;
- e. unique sample number identifying the group or batch sample and subsample extension number for each subsample.

3. Sample Preparation. For small packages of shrimp or crawfish up to and including one pound, use the entire sample. Shell the shrimp or crawfish, exercising care to exclude all shells from sample. Grind sample with food processor type blender while semi-frozen or with dry ice. Divide the sample in half. Use half of the sample for the original analysis portion and retain the other half of the sample in a freezer as a reserve.

4. Sample Analysis

a. Immunoassay test kits may be used if the manufacturer's published detection limit is one part per billion (1 ppb), or less. Acceptable test kits include r-iopharm ridascreen chloramphenicol enzyme immunoassay kit and the Charm II Chloramphenicol kit. The commissioner may authorize other immunoassay kits with appropriate detection limits of 1 ppb or below to be used. Each sample must be run using the manufacturer's test method. The manufacturer's specified calibration curve must be run with each set. All results 1 ppb or above must be assumed to be chloramphenicol unless further testing by approved GC/LC method indicates the result to be an artifact.

b. HPLC-MS, GC-ECD, GC-MS methods currently approved by FDA, the United States Department of Agriculture or the Canadian Food Inspection Agency with detection limits of 1 ppb or below may also be used.

c. Other methods for sampling, identification, sample preparation, testing and analysis may be used if expressly approved in writing by the commissioner.

5. Any qualified laboratory may perform the testing and analysis of the samples unless the laboratory is located in any geographic area that the commissioner has declared to be a location where chloramphenicol is being used on or found in food producing animals, or in products from such animals. The commissioner shall resolve any questions about whether a laboratory is qualified to perform the testing and analysis.

6. The laboratory that tests and analyzes a sample or samples for chloramphenicol shall certify the test results in writing.

7. A copy of the certified test results along with the written documentation necessary to show the methodology used for the sampling, identification, sample preparation, testing and analysis of each sample shall be sent to and actually received by the department prior to the shrimp or crawfish being held for sale, offered or exposed for sale, or sold in Louisiana.

a. The test results and accompanying documentation must contain a test reference number.

b. The certified test results and the accompanying documentation must be in English and contain the name and address of the laboratory and the name and address of a person who may be contacted at the laboratory regarding the testing of the shrimp or crawfish.

8. Upon actual receipt by the department of a copy of the certified test results and written documentation required to accompany the certified test results then the shrimp or crawfish may be held, offered or exposed for sale, or sold in Louisiana, unless a written stop-sale, hold or removal order is issued by the commissioner.

9. A copy of the test results, including the test reference number, shall either accompany every shipment

and be attached to the documentation submitted with every shipment of such shrimp or crawfish sent to each location in Louisiana or shall be immediately accessible to the department, upon request, from any such location.

G. Any person who is seeking to bring shrimp or crawfish that is required to be sampled and tested under this Section, into Louisiana, or who holds, offers or exposes for sale, or sells such shrimp or crawfish in Louisiana shall be responsible for having such shrimp or crawfish sampled and tested in accordance with Subsection F. Any such person must, at all times, be in full and complete compliance with all the provisions of this Section.

H. The commissioner may reject the test results for any shrimp or crawfish if the commissioner determines that the methodology used in sampling, identifying, sample preparation, testing or analyzing any sample is scientifically deficient so as to render the certified test results unreliable, or if such methodology was not utilized in accordance with, or does not otherwise meet the requirements of this Section.

I. In the event that any certified test results are rejected by the commissioner then any person shipping or holding the shrimp or crawfish will be notified immediately of such rejection and issued a stop-sale, hold or removal order by the commissioner. Thereafter, it will be the duty of any such person to abide by such order until the commissioner lifts the order in writing. Any such person may have the shrimp or crawfish retested in accordance with this Section and apply for a lifting of the commissioner's order upon a showing that the provisions of this Section have been complied with and that the shrimp or crawfish are certified as being free of chloramphenicol.

J. The department may inspect, and take samples for testing, any shrimp or crawfish, of whatever origin, being held, offered or exposed for sale, or sold in Louisiana.

K. A stop-sale, hold or removal order, including a prohibition on disposal, may be placed on any shrimp or crawfish that does not meet the requirements of this Section. Any such order shall remain in place until lifted in writing by the commissioner.

L. The department may take physical possession and control of any shrimp or crawfish that violate the requirements of this Section if the commissioner finds that the shrimp or crawfish presents an imminent peril to the public health, safety and welfare and that issuance of a stop-sale, hold or removal order will not adequately protect the public health, safety and welfare.

M. The commissioner declares that he has information that would lead a reasonable person to believe that chloramphenicol is being used on or found in food producing animals, or in products from such animals, in the following geographic area(s).

1. The geographic area or areas are:

a. the country of the People's Republic of China.

2. All shrimp and crawfish harvested from or produced, processed or packed in any of the above listed geographic areas are hereby declared to be subject to all the provisions of this Section, including sampling and testing provisions.

N. The records and information required under this Section shall be maintained for two years and shall be open to inspection by the department.

O. Penalties for any violation of this Section shall be the same as and assessed in accordance with R. S. 3:4624.

P. The effective date of this Section is May 24, 2002.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2, 3:3 & 3:4608.

HISTORICAL NOTE: Promulgated by the Department of Agriculture & Forestry, Office of the Commissioner, LR 29:

§139. Labeling of Foreign Shrimp and Crawfish by Country of Origin

A. Definitions

Foreign Shrimp or Crawfish Any shrimp or crawfish, as defined herein that is harvested from or produced, processed or packed in a country other than the United States.

Shrimp or Crawfish Any shrimp or crawfish, whether whole, de-headed, de-veined or peeled, and any product containing any shrimp or crawfish.

B. All foreign shrimp or crawfish, imported, shipped or brought into Louisiana shall indicate the country of origin, except as otherwise provided in this Section.

C. Every package or container that contains foreign shrimp or crawfish, shall be marked or labeled in a conspicuous place as legibly, indelibly, and permanently as the nature of the package or container will permit so as to indicate to the ultimate retail purchaser of the shrimp or crawfish the English name of the country of origin.

1. Legibility must be such that the ultimate retail purchaser in the United States is able to find the marking or label easily and read it without strain.

2. Indelibility must be such that the wording will not fade, wash off or otherwise be obliterated by moisture, cold or other adverse factors that such shrimp or crawfish are normally subjected to in storage and transportation.

3. Permanency must be such that, in any reasonably foreseeable circumstance, the marking or label shall remain on the container until it reaches the ultimate retail purchaser unless it is deliberately removed. The marking or label must be capable of surviving normal distribution and storing.

D. When foreign shrimp or crawfish are combined with domestic shrimp or crawfish, or products made from or containing domestic shrimp or crawfish, the marking or label on the container or package or the sign included with any display shall clearly show the country of origin of the foreign shrimp or crawfish.

E. In any case in which the words "United States," or "American," the letters "U.S.A.," any variation of such words or letters, or the name of any state, city or location in the United States, appear on any container or package containing foreign shrimp or crawfish, or any sign advertising such foreign shrimp or crawfish for sale, and those words, letters or names may mislead or deceive the ultimate retail purchaser as to the actual country of origin of the shrimp or crawfish, then the name of the country of origin preceded by "made in," "product of," or other words of similar meaning shall appear on the marking, label or sign. The wording indicating that the shrimp or crawfish is from a country other than the United States shall be placed in close proximity to the words, letters or name that indicates the shrimp or crawfish is a product of the United States in a legible, indelible and permanent manner. No provision of this Section is intended to or is to be construed as authorizing the use of the words "United States," or "American," the letters "U.S.A.," any variation of such

words or letters, or the name of any state, city or location in the United States, if such use is deceptive, misleading or prohibited by other federal or state law.

F. Foreign shrimp or crawfish shall not have to be marked or labeled with the country of origin if such shrimp or crawfish are included as components in a product manufactured in the United States and the shrimp or crawfish is substantially transformed in the manufacturing of the final product. But in no event shall thawing, freezing, packing, packaging, re-packing, re-packaging, adding water, de-heading, de-veining, peeling, partially cooking or combining with domestic shrimp or crawfish shall not be considered to be a substantial transformation.

G. The commissioner shall have all the powers granted to him by law, or in accordance with any cooperative endeavor with any other public agency, to enforce this Section, including the issuance of stop-sale, hold or removal orders and the seizing of shrimp or crawfish mislabeled or misbranded as to the country of origin.

H. Penalties for any violation of this Section shall be the same as and assessed in accordance with R. S. 3:4624.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2, 3:3 & 3:4608.

HISTORICAL NOTE: Promulgated by the Department of Agriculture & Forestry, Office of the Commissioner, LR 29:

Bob Odom
Commissioner

0306#004

DECLARATION OF EMERGENCY

**Department of Economic Development
Office of Business Development**

Louisiana Economic Development
Corporation University Foundation Investment Program
(LAC 19:VII.Chapter 27)

The Department of Economic Development, Office of Business Development, Louisiana Economic Development Corporation, pursuant to the emergency provision of the Administrative Procedure Act, R.S. 49:9536(B), adopts the following Emergency Rule implementing the University Foundation Investment Program as authorized by R.S. 51:2312(A)(2), (D)(1), and (D)(3). This Emergency Rule is adopted June 5, 2003 in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., shall become effective June 5, 2003 and shall remain in effect for the maximum period allowed under the Act or until adoption of a permanent Rule, whichever occurs first.

The Department of Economic Development, Office of Business Development, Louisiana Economic Development Corporation has found an immediate need to promote and enhance Louisiana Department of Economic Development's cluster development, the goals of Vision 20/20, Louisiana's long-term plan for economic development, and related public policy for the university systems of Louisiana to transfer technologies developed in the research universities in order to build Louisiana businesses and commercialize these technologies. This Rule is being adopted to take advantage of imminent opportunities to commercialize, within Louisiana, technology that has been developed by

Louisiana Universities. Without the emergency adoption of this Rule, those technologies may be exported out of Louisiana for development. If the commercialization of such technologies are exported, the state will lose crucial opportunities for the development of wealth, production capabilities and quality jobs based upon high technology concepts born in Louisiana universities.

Title 19

CORPORATIONS AND BUSINESS

Part VII. Economic Development Corporation

Subpart 2. Louisiana Venture Capital Program

Chapter 27. University Foundation Investment Program

§2701. Purpose

A. The purpose of this program is to promote and enhance Louisiana Department of Economic Development's cluster development, the goals of Vision 20/20, Louisiana's long-term plan for economic development, and related public policy for the university systems of Louisiana to transfer technologies developed in the research universities in order to build Louisiana businesses and commercialize these technologies. Universities that form technology transfer foundations and/or other vehicles to form seed investment funds need commitments of funding or funding to start-up these seed funds. The intent of this program is to provide initial funding for university-formed seed fund investments that include sound business plans and private, independent management that is attractive to experienced institutional and private investors in keeping with traditional venture capital fund structures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(A)(2), (B), (D)(1), and (D)(2).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development Services, Louisiana Economic Development Corporation, LR 29:

§2703. Definitions

*Applicant*Cthe University Research and Technology Foundation and its subsidiary entity requesting the funding from the Louisiana University Foundation Investment Program for seed funds that provide early stage funding for the statewide development of University research based companies that seek to commercialize the results of their work through technology transfer in accordance with sound business strategies. In order to be eligible for this program, the applicant must provide a program for engagement of all research universities in the state. The program must indicate that it is seeking inclusion and coordination of effort on a statewide basis and is proceeding in accordance with a sound business plan in a manner consistent with the Rules hereinafter provided.

*Award*Cthe funding of the project by the LEDC under this program to eligible applicants.

*LEDC Board*Cthe Board of Directors of the Louisiana Economic Development Corporation and when referred to herein in terms of approval of an award, shall mean that the award has been approved in accordance with the by-laws and procedures of the Board of Directors whether such approval requires or does not require board approval under those by-laws and procedures.

*Agreement*Cthe funding agreement of contract hereinafter referred to between DED, LEDC, and applicant through which the parties by cooperative endeavor or otherwise,

include appropriate documentation necessary to conventionally protect the interest of the LEDC in the funding of the award, and set forth the terms, conditions and performance objectives of the award provided pursuant to these Rules.

*LEDC*the Louisiana Department of Economic Development charged by statute with administering the Louisiana University Foundation Investment Program and the relevant LED Cluster and Service Directors and assigned staff shall administer the program provided for by these Rules.

*Secretary*Cthe Secretary of the LED, who is also the President of LEDC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(A)(2), (B), (D)(1), and (D)(2).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development Services, Louisiana Economic Development Corporation, LR 29:

§2705. General Principles

A. The following general principles will direct the administration of the Louisiana Project Equity Fund.

1. Awards are not to be construed as an entitlement for Louisiana University Foundations or their subsidiary entities locating and are subject to the discretion of the LED, the Secretary of the LED and the LEDC.

2. An award must reasonably be expected to be a significant factor in improving or enhancing economic development, including cluster development, whether in a particular circumstance, or overall.

3. Awards must reasonably be demonstrated to result in the enhanced economic well-being of the state and local communities.

4. The anticipated economic benefits to the state will be considered in making the award.

5. Whether or not an award will be made is entirely at the discretion of the LED, its cluster and service directors, the secretary and the LEDC Board and shall depend upon the facts and circumstances of each case, funds available, funds already allocated, and other such factors as the board may, in its discretion deem to be pertinent. The grant or rejection of an application for an award shall not establish any precedent and shall not bind the LED, its cluster directors, the secretary, or the LEDC Board to any future course of action with respect to any application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(A)(2), (B), (D)(1), and (D)(2).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development Services, Louisiana Economic Development Corporation, LR 29:

§2707. Eligibility

A. In order to be eligible for an award pursuant to this program, the applicant and company must demonstrate to the satisfaction of the board that the award sought must be consistent with the provisions set forth above, and the applicant and company must demonstrate a need for the award consistent with the requirements set forth below. Where it is represented that certain contingent actions will be taken in order to comply with these conditions, then the LEDC may, upon recommendation of the LED and its Contract Monitor, withhold funding until there is substantial performance of the contingencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(A)(2), (B), (D)(1), and (D)(2).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development Services, Louisiana Economic Development Corporation, LR 29:

§2709. Qualification for an Award

A. Applications for awards may be made in phases that are representative of the applicant's overall business plan and design. The application shall state whether or not funds are sought for a phase of operation, or whether it represents the total amount sought by the applicant from the fund.

B. Each application must set forth the following:

1. the establishment or plan for establishment of the subsidiary investment entity;

2. the hiring or plan for hiring, including qualifications, of the chief executive officer of the subsidiary entity;

3. the establishment or plan for establishment of an investment advisory board, including qualifications of its members and scope of its authority;

4. the hiring or plan for hiring, including qualifications of an investment fund manager;

5. a preliminary business plan for the subsidiary entity, including therein a plan for statewide inclusion and coordination of the economic development of technology transfer initiatives;

6. the amount of funding being sought by the applicant, and if phased, the total amount of funding that the applicant anticipates will be sought;

7. the goals and objectives of the funding, and the performance measures to be met by the applicant in order to obtain the funding.

C. Depending upon the nature of the funding being sought, applications for funding shall include goals, objectives and performance measures that to the satisfaction of the department and the LEDC, provide for the following:

1. the amount of funding being sought by the applicant;

2. the business plan of the applicant and the relationship between the funding sought and the plan;

3. the minimum and maximum total amount of capital to be raised including the commitment by the state as evidenced by the funding for which the application is being made and a timetable for raising funds and including goals and objectives for funding and milestones for completion of raising capital;

4. the plan for cluster development, proposed markets for the use of the funds sought, the industry and business development sought by the fund and any new areas for development of the funding; specific involvement of the appropriate department cluster directors in the formation of the plan is recommended;

5. the plan for technology commercialization and transfer and/or the commercialization and transfer of other University based research that will be implemented through use of the funds;

6. the proposed market of the applicant including the types of businesses that the fund will finance, the extent to which the fund intends to specialize in certain industries, or if special circumstances will be addressed;

7. a survey of the possible avenues of rural development; actual and potential uses of the fund in

enhancing the quality of life in the areas of the state most affected by poverty;

8. financing instruments that are intended to be utilized for investments, e.g., debentures, notes, preferred stock, royalties, etc., and a plan reflecting flexibility and adjustment to economic opportunity that may arise from the use of the funds;

9. whether applicant anticipates taking in all of the committed capital investment at closing, or whether applicant plans a phase in. If a phase-in is planned, specify the proposed schedule. It is permissible to have different scenarios based on the actual amount of capital raised;

10. applicant's plans for the fund to provide management and/or technical assistance to companies for which the fund provides financing;

11. plans and procedures for monitoring its financing, and enforcing provisions of loan or investment agreements and the handling of problem loans and investments;

12. plans for the management of any idle funds, long-term plans and strategies for providing a tangible return to the investors, and relevant tax and accounting issues for the fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(A)(2), (B), (D)(1), and (D)(2).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development Services, Louisiana Economic Development Corporation, LR 29:

§2711. LEDC Investment Criteria

A. In considering applicant's application for funding, LEDC may require, but not be limited to the following considerations:

1. that the secretary or his designee sits upon the Foundation's Board of Directors; and that another representative of the department, designated by the LEDC, sit upon the Board of Investment Advisors;

2. that LEDC's funding be accompanied by other investment; and that future funding be conditioned upon the ability of the applicant to attract other investment and that applicant provide a specific business plan and time table for raising those funds;

3. that LEDC's funds shall be considered equity in the fund with any funds that were used for initial expenses to be counted as equity for carry and distribution purposes;

4. that LEDC shall participate in the distributions in its pro-rate share;

5. that if there are any other investors that receive state tax credits, then LEDC's return on investment shall be calculated on an equal basis;

6. that the professional fund manager or the chief executive officer of the applicant provide the LEDC Board with semi-annual reports detailing the investments made, return on investment, and the applicant's meeting of the goals and objectives and performance measures under which the application was approved;

7. that LEDC may condition the applicant's use of investment capital as up-front operating funding upon submission of a quarterly accounting for the use of funds and a quarterly budget. Additionally, applicant may be required to submit quarterly and annual financial and narrative reports on the use of monies and all investments

made by the fund during the reporting period. The narrative report shall include the number of applications received in addition to other activities. The narrative report shall include a listing of all investors in each business and all subsequent financings. Additionally, the reports shall contain information on the number of jobs created by the portfolio business, the payroll figures, the amount of any state tax incentive or other incentives utilized, and state taxes paid by the businesses;

8. that LEDC may condition applicant's funding as may be appropriate and may require such securitization or other documentation as may be appropriate to the investment goals and objectives and performance measures;

9. that LEDC may condition investment upon performance of such additional requirements as may be negotiated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(A)(2), (B), (D)(1), and (D)(2).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development Services, Louisiana Economic Development Corporation, LR 29:

§2713. Contract Between LEDC and Applicant

A. LEDC and applicant shall enter into such terms of agreement as may be customary in the industry for the creation and maintenance of venture capital funding, provided that the agreement shall fully reflect the representations made by applicant as provided in qualification for award and investment criteria as set forth above.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2312(A)(2), (B), (D)(1), and (D)(2).

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Business Development Services, Louisiana Economic Development Corporation, LR 29:

Don J. Hutchinson
Secretary

0306#033

DECLARATION OF EMERGENCY

**Office of the Governor
Division of Administration
Office of Group Benefits**

EPO Plan of BenefitsC Employer Responsibility
(LAC 32:V.417)

Pursuant to the authority granted by R.S. 42:801(C) and 802(B)(2), vesting the Office of Group Benefits (OGB) with the responsibility for administration of the programs of benefits authorized and provided pursuant to Chapter 12 of Title 42 of the Louisiana Revised Statutes, and granting the power to adopt and promulgate Rules with respect thereto, OGB, hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

OGB finds that it is necessary to revise and amend provisions of the EPO Plan Document relative to employer responsibility with respect to re-employed retirees. This action is necessary to avoid sanctions or penalties from the United States in connection with the administration of claims for Medicare covered retirees who return to active

employment. Accordingly, the following Emergency Rule, revising and amending the EPO Plan of Benefits, is effective June 29, 2003, and shall remain in effect for a maximum of 120 days, or until the final Rule is promulgated, which ever occurs first.

Title 32

EMPLOYEE BENEFITS

Part V. Exclusive Provider (EPO) Plan of Benefits

Chapter 4. Uniform Provisions

§417. Employer Responsibility

A. It is the responsibility of the *participant employer* to submit enrollment and change forms and all other necessary documentation on behalf of its employees to the *program*. Employees of a *participant employer* will not by virtue of furnishing any documentation to the *program* on behalf of a *plan member*, be considered agents of the *program*, and no representation made by any such person at any time will change the provisions of this *plan*.

B. A *participant employer* shall immediately inform the OGB Program whenever a retiree with OGB coverage returns to full-time employment. The employee shall be placed in the *re-employed retiree* category for premium calculation. The *re-employed retiree* premium classification applies to retirees with Medicare and without Medicare. The premium rates applicable to the *re-employed retiree* premium classification shall be identical to the premium rates applicable to the classification for *retirees* without Medicare.

C. Any participant employer that receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the Office of Group Benefits, MSP Adjuster, within 15 days of receipt. If timely forwarded to OGB, then OGB will assume responsibility for any medical benefits, interest, fines or penalties due to Medicare for a *covered employee*. If not timely forwarded to OGB, then OGB will assume responsibility only for *covered plan document* medical benefits due to Medicare, for a *covered employee*. The *participant employer* will be responsible for any interest, fines or penalties due.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1837 (October 1999), amended LR 29:

A. Kip Wall
Chief Executive Officer

0306#041

DECLARATION OF EMERGENCY

**Office of the Governor
Division of Administration
Office of Group Benefits**

PPO Plan of BenefitsC Employer Responsibility
(LAC 32:III.417)

Pursuant to the authority granted by R.S. 42:801(C) and 802(B)(2), vesting the Office of Group Benefits (OGB) with the responsibility for administration of the programs of

benefits authorized and provided pursuant to Chapter 12 of Title 42 of the Louisiana Revised Statutes, and granting the power to adopt and promulgate Rules with respect thereto, OGB, hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

OGB finds that it is necessary to revise and amend provisions of the PPO Plan Document relative to employer responsibility with respect to re-employed retirees. This action is necessary to avoid sanctions or penalties from the United States in connection with the administration of claims for Medicare covered retirees who return to active employment. Accordingly, the following Emergency Rule, revising and amending the PPO Plan of Benefits, is effective June 29, 2003, and shall remain in effect for a maximum of 120 days, or until the final Rule is promulgated, which ever occurs first.

Title 32
EMPLOYEE BENEFITS

Part III. Preferred Provider (PPO) Plan of Benefits

Chapter 4. Uniform Provisions

§417. Employer Responsibility

A. It is the responsibility of the *participant employer* to submit enrollment and change forms and all other necessary documentation on behalf of its employees to the *program*. Employees of a *participant employer* will not by virtue of furnishing any documentation to the *program* on behalf of a *plan member*, be considered agents of the *program*, and no representation made by any such person at any time will change the provisions of this *plan*.

B. A participant employer shall immediately inform the OGB Program whenever a *retiree* with OGB coverage returns to full-time employment. The employee shall be placed in the *re-employed retiree* category for premium calculation. The *re-employed retiree* premium classification applies to retirees with Medicare and without Medicare. The premium rates applicable to the *re-employed retiree* premium classification shall be identical to the premium rates applicable to the classification for *retirees* without Medicare.

C. Any *participant employer* that receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the Office of Group Benefits, MSP Adjuster, within 15 days of receipt. If timely forwarded to OGB, then OGB will assume responsibility for any medical benefits, interest, fines or penalties due to Medicare for a *covered employee*. If not timely forwarded to OGB, then OGB will assume responsibility only for *covered plan document* medical benefits due to Medicare, for a *covered employee*. The *participant employer* will be responsible for any interest, fines or penalties due.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(2).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1837 (October 1999), amended LR 29:

A. Kip Wall
Chief Executive Officer

0306#040

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Bureau of Community Supports and Services

Home and Community Based Services Waivers
New Opportunities Waiver
(LAC 50:XXI.Chapter 137)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services adopts LAC 50.XXI.Subpart 11 as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated 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 final Rule, whichever occurs first.

Act 1147 of the 2001 Regular Session of the Louisiana Legislature created the Disability Services and Supports System Planning Group composed of representatives from groups including, but not limited to, individuals with disabilities, developmental disabilities and mental illness. The mission of the planning group is to consider and propose provisions for comprehensive efforts to enhance Louisiana's long term care system which include informed choice and quality supports for individuals of all ages with disabilities. Based on recommendations made by the planning group and a stakeholder task force, the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services proposes to implement a new home and community based services waiver designed to enhance the support services available to individuals with developmental disabilities. This new home and community based services waiver shall be titled the New Opportunities Waiver.

This action is being taken to promote the health and welfare of those individuals with developmental disabilities or mental retardation who are in need of such services and are on a request for services registry. It is estimated that implementation of this Emergency Rule will increase program expenditures by approximately \$54,357,522 for state fiscal year 2003-2004.

Effective for dates of service on and after July 1, 2003, the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services adopts the following provisions governing the establishment of the New Opportunities Waiver in accordance with Section 1915(c) of the Social Security Act and the approved waiver application document and attachments.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXI. Home and Community Based
Services Waivers

Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13701. Introduction

A. The New Opportunities Waiver (NOW), hereafter referred to as NOW, is designed to enhance the long term

services and supports available to individuals with developmental disabilities or mental retardation, who would otherwise require an intermediate care facility for the mentally retarded (ICF-MR) level of care. The mission of NOW is to utilize the principle of self determination and supplement the family and/or community supports that are available to maintain the individual in the community. In keeping with the principles of self-determination, NOW will include a self-directed option. This will allow for greater flexibility in hiring, firing, training, and general service delivery issues. NOW will replace the current Mentally Retarded/Developmentally Disabled (MR/DD) waiver after recipients of that waiver have been transitioned into NOW.

B. All NOW recipient's services are accessed through the case management agency of the recipient's choice. All services must be prior authorized and delivered in accordance with the Bureau of Community Supports and Services (BCSS) approved comprehensive plan of care (CPOC). The CPOC shall be developed using a person-centered process coordinated by the individual's case manager.

C. Providers must maintain adequate documentation to support service delivery and compliance with the approved plan of care and will provide said documentation at the request of BCSS.

D. In order for the NOW provider to bill for services, the individual and the direct service provider, professional or other practitioner rendering service must be present at the time the service is rendered. The service must be documented in service notes describing the source rendered and progress towards the recipient's personal outcomes and CPOC.

E. NOW services shall not be provided for or billed for the same hours on the same day as any other NOW service except for Substitute Family, Residential Habilitation and Skilled Nursing services.

F. The average recipient expenditures for all waiver services shall not exceed the average Medicaid expenditures for ICF-MR services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13703. Recipient Qualifications

A. In order to qualify for NOW, an individual must be three years of age or older, offered a waiver opportunity (slot) and meet all of the following:

1. meet the definitions for mental retardation or developmentally disability as specified in R.S. 28:380;
2. be on the Mentally Retarded/Developmentally Disabled (MR/DD) Request for Services Registry (RFSR);
3. meet the financial eligibility requirements for the Medicaid Program;
4. meet the medical certification eligibility requirements for an ICF-MR level of care and meet the health and welfare assurance requirements;
5. be a resident of Louisiana; and
6. be a citizen of the United States or a qualified alien.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

Chapter 139. Covered Services

§13901. Individualized and Family Support Services

A. Individualized and Family Support (IFS) are direct support and assistance services provided in the home or the community that allow the recipient to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community or for the relief of the primary caregiver. Transportation is included in the reimbursement for these services. Reimbursement for these services include the development of a service plan for the provision of these services, based on the BCSS approved CPOC.

1. IFS-Day (IFS-D) services will be authorized during waking hours for up to 16 hours when natural supports are unavailable in order to provide continuity of services to the recipient. Waking hours are the period of time when the recipient is awake and not limited to traditional daytime hours.

2. IFS-Night (IFS-N) services are direct support and assistance provided to individuals during sleeping hours for up to eight hours. The IFS-N worker must be immediately available and in the same residence and able to respond. Night hours are the period of time when the recipient is asleep and not limited to traditional nighttime hours.

B. IFS services may be shared by related waiver recipients who live together or up to three unrelated waiver recipients who live together. Waiver recipients may share IFS services staff when agreed to by the recipients and health and welfare can be assured for each individual. When recipients share supports, this is known as shared support services, both day and night.

C. IFS (day or night) services include:

1. assisting and prompting with the following activities of daily living (ADL):

- a. personal hygiene;
- b. dressing;
- c. bathing;
- d. grooming;
- e. eating;
- f. toileting;
- g. ambulation or transfers;
- h. other personal care and behavioral support needs;

and

i. any medical task which can be delegated.

2. assisting and/or training in the performance of tasks related to maintaining a safe, healthy and stable home, such as:

- a. housekeeping;
- b. laundry;
- c. cooking;
- d. evacuating the home in emergency situations;
- e. shopping; and
- f. money management.

3. personal support and assistance in participating in community, health, and leisure activities;

4. support and assistance in developing relationships with neighbors and others in the community and in strengthening existing informal social networks and natural supports;

5. enabling and promoting individualized community supports targeted toward inclusion into meaningful integrated experiences; and

6. providing orientation and information to acute hospital nursing staff concerning the recipient's specific ADLs, communication, positioning and behavioral needs.

D. Exclusions. The following exclusions apply to IFS services.

1. Reimbursement shall not be paid for services furnished by a legally responsible relative. A legally responsible relative is defined as the natural parent, foster parent, adoptive parent, stepparent or legal guardian of a minor child or the recipient's spouse.

2. Family members shall not serve as the IFS-D or IFS-N worker in Supported Independent Living, regardless of the degree of relationship.

3. In compliance with licensing regulations, IFS-D and IFS-N services shall not include services provided in the IFS-D or IFS-N worker's residence, regardless of the relationship, unless the worker's residence is a certified foster care home.

E. Staffing Criteria and Limitations

1. IFS-D or IFS-N services may be provided by a member of the recipient's family, except for Supervised Independent Living services, provided that the recipient does not live in the family member's residence and the family member is not the legally responsible relative.

2. Family members who provide IFS services must meet the same standards as providers or direct care staff who are unrelated to the individual.

3. An IFS-D worker shall not work more than 16 hours in a 24-hour period unless there is a documented emergency. An IFS-D shared supports worker shall not work more than 16 hours in a 24-hour period.

4. An IFS-N worker or an IFS-N shared supports worker shall not work more than eight hours in a 24-hour period.

5. The IFS-N worker shall not be the same person as the IFS-D worker in a 24-hour period.

F. Place of Service

1. IFS services shall be provided in the State of Louisiana. Consideration shall be given to requests for the provision of IFS services outside the state on a case-by-case basis for time-limited periods or emergencies.

2. IFS services shall not be authorized for provision outside of the continental United States.

G. Provider Requirements. Providers must possess a current, valid license as a Personal Care Attendant agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13903. Center-Based Respite Care

A. Center-Based Respite (CBR) Care is temporary, short-term care provided to a recipient with mentally retarded or developmental disabilities who requires support and/or supervision in his/her day-to-day life due to the absence or relief of the primary caregiver. While receiving center-based respite care, the recipient's routine is maintained in order to attend school, work or other community activities/outings. The respite center is

responsible for providing transportation for community outings, as that is included as part of their reimbursement.

B. Exclusions. The cost of room and board is not included in the reimbursement paid to the respite center.

C. Service Limits. CBR services shall not to exceed 720 hours per recipient, per CPOC year.

D. Provider Requirements. The provider shall possess a current, valid license as a Respite Care Center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13905. Community Integration Development

A. Community Integration Development (CID) facilitates the development of opportunities to assist recipients in becoming involved in their community through the creation of natural supports. The purpose of CID is to encourage and foster the development of meaningful relationships in the community reflecting the recipient's choices and values. Reimbursement for this service includes the development of a service plan. The recipient must be 18 years of age or older and must be present in order to receive this service. The recipient may share CID services with one other NOW recipient.

B. Transportation costs are included in the reimbursement for CID services.

C. Service Limitations. Services shall not to exceed 60 hours per recipient per CPOC year.

D. Provider Qualifications. The provider must possess a current, valid license as a Supervised Independent Living agency or Personal Care Attendant agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13907. Residential Habilitation-Supported Independent Living

A. Residential Habilitation-Supported Independent Living (SIL) assists the recipient to acquire, improve or maintain those social and adaptive skills necessary to enable an individual to reside in the community and to participate as independently as possible. SIL services include assistance and/or training in the performance of tasks such as personal grooming, housekeeping and money management. Payment for this service includes oversight and administration and the development of service plans for the enhancement of socialization with age-appropriate activities that provide enrichment and may promote wellness. These services also assist the individual in obtaining financial aid, housing, advocacy and self-advocacy training as appropriate, emergency support, trained staff and assisting the recipient in accessing other programs for which he/she qualifies. SIL recipients must be 18 years or older.

B. Place of Service. Services are provided in the recipient's residence and the community. The recipient's residence includes his/her apartment or house, provided that he/she does not live in the residence of any immediate family members. An exception will be considered when the recipient lives in the residence of a spouse or disabled parent, or a parent age 70 or older.

C. Exclusions

1. Family members may not be SIL providers or SIL workers.

2. SIL shall not include the cost of:

- a. meals or the supplies needed for preparation;
- b. room and board;
- c. home maintenance, or upkeep and improvement;
- d. direct or indirect payment to members of the recipient's family;
- e. routine care and supervision which could be expected to be provided by a family or a group home provider; or
- f. activities or supervision for which a payment is made by a source other than Medicaid e.g., Office for Citizens with Developmental Disabilities (OCDD), etc.

D. Service Limit. SIL services are limited to one service per day, per CPOC year.

E. Provider Qualifications. The provider must possess a current, valid license for the Independent Living Services module issued by the Department of Social Services, Bureau of Licensing.

F. Provider Responsibilities

1. Minimum direct services by the SIL agency include three documented contacts per week, with at least one contact being face-to-face in addition to the approved direct support hours.

2. The provider must furnish back up staff that is available on a 24-hour basis.

3. Residential habilitation services shall be coordinated with any services listed in the BCSS approved CPOC, and may serve to reinforce skills or lessons taught in school, therapy or other settings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13909. Substitute Family Care

A. Substitute Family Care (SFC) provides for day programming, transportation, independent living training, community integration, homemaker, chore, attendant care and companion services, and medication oversight (to the extent permitted under state law) to recipients residing in a licensed substitute family care home. The service is a stand-alone family living arrangement for individuals age 18 and older. The SFC house parents assume the direct responsibility for the individual's physical, social, and emotional well-being and growth, including family ties. Immediate family members, which include mother, father, brother and sister cannot be substitute family care parents. Reimbursement for this service includes the development of a service plan based on the approved CPOC.

B. Service Limits. SFC services are limited to one service per day.

C. Provider Qualifications. The provider must possess a current, valid license as a Substitute Family Care agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13911. Day Habilitation

A.1. Day habilitation is assistance with social and adaptive skills necessary to enable the recipient to reside in a community setting and to participate as independently as possible in the community. These services focus on socialization with meaningful age-appropriate activities which provide enrichment and promote wellness, as indicated in the person-centered plan. Day habilitation services must be directed by a service plan and provide assistance and/or training in the performance of tasks related to acquiring, maintaining or improving skills including, but not limited to:

- a. personal grooming;
- b. housekeeping;
- c. laundry;
- d. cooking;
- e. shopping; and
- f. money management.

2. Habilitation services shall be coordinated with any therapy, facility-based employment, employment-related training, or supported employment models that the recipient may be receiving. The recipient does not receive payment for the activities in which they are engaged. The recipient must be 18 years of age or older in order to receive day habilitation services.

B. Service Limits. Services shall not be provided more than six hours per day, five days per week and cannot exceed 6,240 1/4 hour units of service per Comprehensive Plan of Care (CPOC) year.

C. Licensing Requirements. The provider must possess a current, valid license as an Adult Day Care Center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13913. Supported Employment

A. Supported employment is competitive work in an integrated work setting, or employment in an integrated work setting in which the individuals are working toward competitive work that is consistent with the strengths, resources, priorities, interests and informed choice of individuals for whom competitive employment has not traditionally occurred. The recipient must be 18 years of age or older in order to receive supported employment services.

B. These are services provided to individuals who are not served by Louisiana Rehabilitation Services, need more intense, long-term follow along and usually cannot be competitively employed because supports cannot be successfully phased out.

C. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed by waiver recipients to sustain paid work, including supervision and training and is based on an individualized service plan. Supported employment includes assistance and prompting with:

1. personal hygiene;
2. dressing;
3. grooming;
4. eating;

5. toileting;
 6. ambulation or transfers;
 7. other personal care and behavioral support needs;
- and
8. any medical task which can be delegated.

D. Supported Employment Models. Reimbursement for supported employment includes an individualized service plan for each model.

1. A one to one model of supported employment is a placement strategy in which an employment specialist (job coach) places a person into competitive employment, provides training and support and then gradually reduces time and assistance at the work site. This service is time limited to six to eight weeks in duration.

2. Follow along services are designed for individuals who are in supported employment and have been placed in a work site and only require the oversight of a minimum of two visits per month for follow along at the job site.

3. Mobile Work Crew/Enclave is an employment setting in which a group of eight or fewer workers with disabilities who perform work in a variety of locations under the supervision of a permanent employment specialist (job coach/supervisor). Typically, this service is up to eight hours per day, five days per week.

E. Service Exclusions

1. Services shall not be used in conjunction or simultaneously with any other waiver service.

2. When supported employment services are provided at a work site in which persons without disabilities are employees, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

3. Services are not available to individuals who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401(16) and (71).

F. Service Limits

1. One to one intensive services shall not exceed 4,160 1/4 hour units per CPOC year. Services shall be limited to eight hours a day, five days a week, for six to eight weeks.

2. Follow along services shall not exceed 24 days per CPOC year.

3. Mobile Crew/Enclave services shall not exceed 8,320 1/4 hour units of service per CPOC year, without additional documentation. This is six hours per day, five days per week, for 52 weeks.

G. Licensing Requirements. The provider must possess a current, valid license as an Adult Day Care Center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13915. Transportation for Day Habilitation and Supported Employment Models

A. Transportation provided between the recipient's residence and the site of the day habilitation or supported employment model, or between the day habilitation and

supported employment model site (if the recipient receives services in more than one place) is reimbursable when day habilitation or supported employment model has been provided. Reimbursement will be a daily rate for a round trip fare. Round trip is defined as pickup from the recipient's place of residence and return to the recipient's place of residence.

B. Licensing Requirements. Transportation providers must possess a current, valid license as an Adult Day Care Center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13917. Employment-Related Training

A. Employment related training consists of paid employment for recipients for whom competitive employment at or above the minimum wage is unlikely, and who need intensive ongoing support to perform in a work setting because of their disabilities. Services are aimed at providing recipients with opportunities for employment and related training in work environments one to eight hours a day, one to five days a week at a commensurate wage in accordance with U.S. Department of Labor regulations and guidelines. The recipient must be 18 years or older in order to receive employment-related training services. Reimbursement for these services includes transportation and requires an individualized service plan.

B. Employment-related training services include, but are not limited to:

1. assistance and prompting in the development of employment related skills. This may include:
 - a. assistance with personal hygiene;
 - b. dressing;
 - c. grooming;
 - d. eating;
 - e. toileting;
 - f. ambulation or transfers;
 - g. behavioral support needs; and
 - h. any medical task which can be delegated;
2. employment at a commensurate wage at a provider facility for a set or variable number of hours;
3. observation of an employee of an area business in order to obtain information to make an informed choice regarding vocational interest;
4. instruction on how to use equipment;
5. instruction on how to observe basic personal safety skills;
6. assistance in planning appropriate meals for lunch while at work;
7. instruction on basic personal finance skills;
8. information and counseling to a recipient and, as appropriate, his/her family on benefits planning and assistance in the process.

C. Exclusions. The following service exclusions apply to employment-related training.

1. Services are not available to recipients who are eligible to participate in programs funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act, 20 U.S.C. 1401(16) and (71).

D. Service Limits. Services shall not exceed eight hours a day, five days a week, and cannot exceed 6,240 1/4 hour units of service per CPOC year.

E. Licensing Requirements. The provider must possess a current, valid license as an Adult Day Care Center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13919. Environmental Accessibility Adaptations

A. Environmental accessibility adaptations are physical adaptations to the home or a vehicle that are necessary to ensure the health, welfare and safety of the recipient or that enable him/her to function with greater independence in the home and/or community. Without these services, the recipient would require additional supports or institutionalization.

B. Such adaptations may include the installation of non-portable ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies for the welfare of the individual.

C. Requirements for Authorization. Items reimbursed through NOW funds shall be supplemental to any adaptations furnished under the Medicaid State Plan.

1. Any service covered under the Medicaid State Plan shall not be authorized by NOW. The environmental accessibility adaptation(s) must be delivered, installed, operational and reimbursed in the CPOC year in which it was approved. Three written itemized detailed bids, including drawings with the dimensions of the existing and proposed floor plans relating to the modification, must be obtained and submitted for prior authorization. Modifications may be applied to rental or leased property with the written approval of the landlord. Reimbursement shall not be paid until receipt of written documentation that the job has been completed to the satisfaction of the recipient.

2. Three bids may not be required if the environmental accessibility adaptations are available from only one supplier due to the distance of the recipient's home from other environmental accessibility adaptations providers. Justification and agreement by the service planning/support team for not providing three bids must be included with any request for prior approval.

3. Excluded are those adaptations or improvements to the residence that are of general utility or maintenance and are not of direct medical or remedial benefit to the individual, including, but not limited to:

- a. air conditioning or heating;
- b. flooring;
- c. roofing, installation or repairs;
- d. smoke and carbon monoxide detectors, sprinklers, fire extinguishers, or hose; or
- e. furniture or appliances.

4. Adaptations which add to the total square footage or add to the total living area under the roof of the residence are excluded from this benefit.

5. Home modification is not intended to cover basic construction cost.

6. Excluded are those vehicle adaptations which are of general utility or for maintenance of the vehicle or repairs to adaptations.

D. Service Limits. There is a cap of \$4,000 per recipient for environmental accessibility adaptations. Once a recipient reaches 90 percent or greater of the cap and the account has been dormant for three years, the recipient may access another \$4,000. Any additional environmental accessibility expenditures during the dormant period reset the three-year time frame.

E. Provider Qualifications. The provider must comply with applicable state and local laws governing licensure and/or certification. All persons performing the services (building contractors, plumbers, electricians, engineers, etc.) must meet all state or local requirements for licensure or certification. When state and local building or housing code standards are applicable, modifications to the home shall meet such standards.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13921. Specialized Medical Equipment and Supplies

A. Specialized Medical Equipment and Supplies (SMES) are devices, controls or appliances which enable the recipient to:

1. increase his/her ability to perform the activities of daily living;
2. ensure safety; or
3. perceive and control the environment in which he/she lives.

B. The service includes medically necessary durable and nondurable medical equipment not covered under the Medicaid State Plan. NOW shall not be used as a substitute for any medical equipment and will not cover supplies furnished or denied under the Medicaid State Plan. All items shall meet applicable standards of manufacture, design and installation.

C. All alternate funding sources that are available to the recipient shall be pursued before a request for the purchase or lease of specialized equipment and supplies will be considered.

D. Exclusion. Excluded are specialized equipment and supplies that are of general utility or maintenance and are not of direct medical or remedial benefit to the individual. Refer to the New Opportunities Waiver Provider Manual for a list of examples.

E. Service Limitations. There is a cap of \$4,000 per individual for specialized equipment and supplies. Once a recipient reaches 90 percent or greater of the cap and the account has been dormant for three years, the recipient may access another \$4,000. Any additional specialized equipment and supplies expenditures during the dormant period reset the three year time frame.

F. Provider Qualifications. Providers must be enrolled in the Medicaid Program as a durable medical equipment provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13923. Personal Emergency Response Systems

A. Personal Emergency Response Systems (PERS) is an electronic device connected to the person's phone and programmed to signal a response center which enables an individual to secure help in an emergency.

B. Recipient Qualifications. Personal emergency response systems (PERS) services are available to those persons who:

1. live alone without the benefit of a natural emergency back-up system;
2. live alone and would otherwise require extensive IFS services or other NOW services;
3. due to cognitive limitations need support until they are educated on the use of PERS;
4. have is a demonstrated need for quick emergency back-up;
5. where older or disabled care givers are involved; or
6. other communications systems are not adequate to summon emergency assistance.

C. Coverage of the PERS is limited to the rental of the electronic device. PERS services shall include the cost of maintenance and training the recipient to use the equipment.

D. Provider Qualifications. The provider must an authorized distributor of the Personal Emergency Response System.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13925. Professional Consultation

A. Professional Consultation are services designed to evaluate, develop programs, and train natural and formal care givers to implement training or therapy programs, which will increase the individual's independence, participation, and productivity in his/her home, work, and community. These services are not meant to be long-term on-going services. They are normally meant be short-term or intermittent services to develop critical skills which may be self-managed by the individual or maintained by natural and formal care givers. The recipient must be present in all aspects of the consultation in order to for the professional to receive payment for these services. Service intensity, frequency and duration will be determined by individual need. These services may include assessments, periodic reassessments and may be direct or indirect. Documentation of services provided must be available on-site. The professional consultation services are to be used only when the services are not covered under the Medicaid State Plan. The recipients must be 21 years or older in order to receive professional consultation services.

B. Professional consultation shall include the following services:

1. Nursing Consultation. Consultation provided by a licensed registered nurse regarding those medically necessary nursing services ordered by a physician that exceed the service limits for home health services under the Medicaid State Plan. Services must comply with the Louisiana Nurse Practice Act. Consultations may address health care needs related to prevention and primary care activities.

2. Psychological Consultation. Evaluation and education performed by a licensed psychologist as specified

by state law and licensure. These services are for the treatment of behavioral or mental conditions that address personal outcomes and goals desired by the recipient and his/her team. Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with mental retardation or developmental disabilities. Consultation provides the recipient, family, care givers or team with information necessary to plan and implement plans for the recipient.

3. Social Work Consultation. Highly specialized consultation services furnished by a licensed clinical social worker and designed to meet the unique counseling needs of individuals with mental retardation and development disabilities. Counseling may address areas such as human sexuality, depression, anxiety disorders and social skills. Services must only address those personal outcomes and goals listed in the BCSS approved CPOC.

C. Service Limits. Professional consultation services are limited to a \$750 cap per individual per CPOC year for the combined range of professional consultations.

D. Provider Qualifications. The provider of professional consultation services must possess a current, valid license as a personal care attendant (PCA), supervised independent living (SIL) or home health (HH) agency. Each professional rendering services must:

1. possess a current, valid Louisiana license to practice in his/her field;
2. have at least one year experience in his/her filed of expertise; and
3. be contracted or employed with an enrolled PCA, SIL or HH agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13927. Professional Services

A. Professional services are services designed to increase the individual's independence, participation and productivity in the home, work and community. The recipient must be 21 years of age or older in order to receive these services. Professional services are to be used only when the services are not covered under the Medicaid State Plan. Professional services are limited to the following services. Professional services must be delivered with the recipient present and be provided based on the approved CPOC and an individualized service plan.

1. Psychological services are direct services performed by a licensed psychologist, as specified by state law and licensure. These services are for the treatment of a behavioral or mental condition that addresses personal outcomes and goals desired by the recipient and his or her team. Services must be reasonable and necessary to preserve and improve or maintain adaptive behaviors or decrease maladaptive behaviors of a person with mental retardation or developmental disabilities. Service intensity, frequency and duration will be determined by individual need.

2. Social work services are highly specialized direct counseling services furnished by a licensed clinical social worker and designed to meet the unique counseling needs of individuals with mental retardation and development disabilities. Counseling may address areas such as human

sexuality, depression, anxiety disorders and social skills. Services must only address those personnel outcomes and goals listed in the BCSS approved CPOC.

3. Nursing services are medically necessary direct services provided by a licensed registered nurse or licensed practical nurse. Services must be ordered by a physician and comply with the Louisiana Nurse Practice Act. Direct services may address health care needs related to prevention and primary care activities, treatment and diet. Reimbursement is only available for the direct service performed by a nurse, and not for the supervision of a nurse performing the hands-on direct service.

B. Service Limits. There shall be a \$1,500 cap per recipient per CPOC year for the combined range of professional services.

C. Provider Qualifications. The provider of professional services must possess a current, valid license as a personal care attendant, supervised independent living or home health agency. Each professional rendering services must possess a current, valid Louisiana license to practice in his/her field and have at least one year of experience in their area of expertise and be contracted or employed with an enrolled PCA, SIL or HH agency.

D. Non-reimbursable Activities. The following activities are not reimbursable:

1. friendly visiting, attending meetings;
2. time spent on paperwork or travel;
3. time spent writing reports and progress notes;
4. time spent on staff training;
5. time spent on billing of services;
6. other non-Medicaid reimbursable activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13929. Skilled Nursing Services

A. Skilled Nursing services are medically necessary nursing services ordered by a physician and provided to a medically fragile recipient in or outside of his/her home. Skilled nursing services shall be provided by a licensed, enrolled home health agency using licensed nurses. All Medicaid State Plan services must be utilized before accessing this service.

B. Recipient Criteria. The recipient must be 21 years of age or older and have a diagnosis of a chronic disease which requires the vigilance of a licensed nurse to provide prevention, evaluation and management of a disease; thereby limiting the need for frequent acute or emergency services. Skilled nursing services require a physician's order documenting medical necessity and individual nursing service plan. These services must be included in the individual's BCSS approved CPOC. Skilled nursing services shall be available to individuals who are medically fragile with chronic conditions who meet one of the following criteria:

1. have unstable or uncontrolled diabetes and are insulin dependent;
2. have insufficient respiratory capacity requiring use of oxygen therapy, a ventilator and/or tracheotomy;
3. require hydration, nutrition and/or medication via a gastro-tube;

4. have severe musculo-skeletal conditions/non-ambulatory status that requires increased monitoring and/or the treatment of decubitus;

5. have kidney failure requiring dialysis;

6. have cancer requiring radiation/chemotherapy;

7. require end-of-life care not covered by hospice services;

8. require the use of life-sustaining equipment to ensure sufficient body function (a ventilator, a suction machine, pulse oximeters, apnea monitors, or nebulizers); or

9. require the administration of medications which by law must be administered by a licensed nurse via mediports, central lines or intravenous therapy.

C. When there is more than one recipient in the home receiving skilled nursing services, services may be shared and payment must be coordinated with the service authorization system and each recipient's BCSS approved CPOC.

D. Provider Qualifications. The provider must possess a current, valid license as a home health agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13931. One Time Transitional Expenses

A. One time transitional expenses are those allowable expenses incurred by recipients who are being transitioned from an ICF-MR to their own home or apartment in the community of their choice. Own home shall mean the recipient's own place of residence and does not include any family members home or substitute family care homes. The recipient must be 18 years or older in order to receive this service.

B. Allowable transitional expenses include:

1. the purchase of essential furnishings such as:
 - a. bedroom and living room furniture;
 - b. table and chairs;
 - c. window blinds;
 - d. eating utensils; and
 - e. food preparation items.

2. moving expenses required to occupy and use a community domicile;

3. health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

C. Service Limits. Set-up expenses are capped at \$3,000 over a recipient's lifetime.

D. Service Exclusion. Transitional expenses shall not constitute payment for housing, rent or refundable security deposits.

E. Provider Qualifications. This service shall only be provided by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities (OCDD) with coordination of appropriate entities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13933. Transitional Professional Support Services

A. Transitional Professional Support Services is a system using specialized staff and resources to intervene and

stabilize in a situation caused by any severe behavioral or medical circumstance that could result in loss of a current community-based living arrangement. These services are limited to recipients who have transitioned out of a public developmental center and have reached the cap for professional services and professional consultation for the recipient's CPOC year. The recipient must be present for all services provided.

B. Recipient Criteria

1. These services are available for recipients who meet all of the following criteria:

a. have a developmental disability and one or more concurrent mental health diagnoses of autism or other pervasive developmental disorders;

b. have a history of recurrent challenging behaviors that risks injury to the individual or others, or results in significant property damage; and

c. have a need for professional services and/or professional consultation that exceeds the service limits for these services available under the Medicaid State Plan and NOW, as documented by a statement of necessity from the treating psychiatrist/psychologist; or

2. the recipient has an acute illness or injury which requires the added vigilance of a licensed nurse to provide treatment of disease symptoms that may avert and/or delay the consequence of advanced complications, thereby reducing the likelihood of further deterioration. Supporting documentation from the recipient's physician must be provided to demonstrate need.

C. Exclusion. All Medicaid State Plan services must be utilized before accessing this service.

D. Provider Qualifications. Providers of transitional professional support services must possess a current, valid license as a PCA, SIL or HH agency. Each professional rendering service must possess a valid Louisiana license to practice in his/her field and one year experience in their field of expertise.

E. Provider Responsibility. An agency that fulfills this role must possess specialized staff and resources to intervene in and stabilize a situation caused by any severe behavioral or medical circumstance that could result in loss of a current community-based living arrangement. The provider must develop and maintain a current service plan that details the program goals, plans, and expected outcomes from all individuals providing these services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

§13935. Reimbursement Methodology

A. Reimbursement for the following services shall be a prospective flat rate for each approved unit of service provided to the recipient. One quarter hour (15 minutes) is the standard unit of service, which covers both service provision and administrative costs.

1. Center-Based Respite
2. Community Integration Development
3. Day Habilitation
4. Employment Related Training
5. Individualized and Family Support-Day and Night
6. Professional Consultation
7. Professional Services

8. Skilled Nursing Services
9. Supported Employment, One to One Intensive and Mobile Crew/Enclave
10. Transitional Professional Support Services
11. Shared Supports (IFS-D and -N, Skilled Nursing, CID)C

a. services furnished to the first recipient will be reimbursed at the full rate;

b. services furnished to the second recipient will be reimbursed at 75 percent of the full rate; and

c. services furnished to the third recipient will be reimbursed at 66 percent of the full rate.

B. The following services are to be paid at cost, based on the need of the individual and when the service has been prior authorized and on the CPOC:

1. environmental accessibility adaptations;
2. specialized medical equipment and supplies; and
3. transitional expenses.

C. The following services are paid through a per diem:

1. substitute family care;
2. residential habitation-supported independent living; and
3. supported employment-follow along.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 29:

Implementation of this proposed Rule is subject to approval by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Barbara Dodge at the Bureau of Community Supports and Services, P.O. Box 91030, Baton Rouge, LA 70821-9030. She is responsible for responding to 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

0306#048

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Office of the Secretary
Bureau of Community Supports and Services**

**Mentally Retarded/Developmentally Disabled Waiver
Skilled Nursing Services**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services promulgates the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated 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 final Rule, whichever occurs first.

Under the provisions of Section 1915(c) of the Social Security Act, states may provide services not generally reimbursable by the Medicaid Program to groups of individuals in the community who meet the qualifications for institutional care. Such programs are known as home and community based services waivers. The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a Rule in June 1990 establishing the Mentally Retarded/Developmentally Disabled (MR/DD) Waiver and the provisions governing the services covered under the waiver (*Louisiana Register, Volume 16, Number 7*). The MR/DD Waiver is one of the five waivers that are currently administered by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services.

The Bureau of Community Supports and Services has determined that it is necessary to incorporate a new service into the MR/DD Waiver (*Louisiana Register, Volume 28, Number 10*). The Centers for Medicare and Medicaid Services has approved a waiver amendment to add skilled nursing services to the list of services provided under the MR/DD Waiver.

This Emergency Rule is being promulgated to continue the provisions of the November 1, 2002 Rule. This action is being taken to protect the health and welfare of MR/DD Waiver recipients by providing skilled nursing services to those individuals in need of such services.

Emergency Rule

Effective for dates of service on and after July 1, 2003, the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services amends the July 20, 1990 Rule to include skilled nursing services as a service in the Mentally Retarded/Developmentally Disabled Waiver.

Recipient Criteria

A. Skilled nursing services will be available to medically fragile individuals who meet the following criteria:

1. are ventilator dependent or non-ambulatory, or have undergone a tracheotomy, or gastrostomy; and
2. require life-sustaining equipment (ventilator, suction machines, and/or pulse oximeters, apnea monitors, nebulizers); and
3. are medically approved by their primary physician, as documented by a doctor's order and a letter of medical necessity from the physician.

Provider and Staff Qualifications

A. A home health agency must enroll as a MR/DD waiver service provider in order to provide skilled nursing services under the MR/DD Waiver.

B. Skilled nursing services shall be provided by either a licensed registered nurse or a licensed practical nurse employed by a Medicaid enrolled home health agency.

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 the person responsible for responding to 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

0306#053

DECLARATION OF EMERGENCY

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

Disproportionate Share Hospital Payment Methodologies (LAC 50:V.Chapter 3)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated 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 final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgated a Rule to adopt the provisions governing the disproportionate share payment methodologies for hospitals in May of 1999 (*Louisiana Register, Volume 25, Number 5*). The May 20, 1999 Rule was later amended to change the criteria used to define rural hospitals and to clarify the policy governing final payments and adjustments (*Louisiana Register, Volume 29, Number 1*).

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 made provisions for public hospitals to receive disproportionate share hospital adjustment payments up to 175 percent of their allowable uncompensated care cost. Act 1024 of the 2001 Regular Session directed the Department of Health and Hospitals, as the federally designated Medicaid state agency, to specify in the Medicaid State Plan how uncompensated care is defined and calculated and to determine what facilities qualify for uncompensated care payments and the amount of the payments. In determining payments, the department shall prioritize local access to primary health care for the medically indigent and uninsured, and shall not include unreimbursed costs resulting from excess inpatient hospital capacity. For the period July 1, 2003 through June 30, 2005, the state's Medicaid uncompensated care payments shall be distributed in proportion to the amount and type of uncompensated care reported by all qualified facilities as required by Senate Bill No. 883 of the 2001 Regular Session. Nothing shall be construed to impede or preclude the Department of Health and Hospitals from implementing the provisions in the Rural Hospital Preservation Act. Further, Senate Concurrent Resolution 94 of the 2001 Regular Session and Senate Concurrent Resolution 27 of the 2002 Regular Session of the Louisiana Legislature requested the Department of Health and Hospitals, the Louisiana State

University Health Sciences Center-Health Services Division, and the Louisiana State University Health Sciences Center-Shreveport to study and recommend common acute hospital payment methodologies for state and non-state hospitals participating in the Medicaid Program and the Medicaid Disproportionate Share Program. In accordance with the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 and the findings and recommendations contained in the final reports of the study committees, the department proposes to repeal and replace all provisions governing disproportionate share hospital payments. This action is being taken to enhance federal revenue. It is estimated that the implementation of this proposed Rule will increase revenues by approximately \$207,000,000 in federal funds only for state fiscal year 2003-04.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. This proposed Rule has no known impact on family functioning, stability, or autonomy as described in R.S. 49:972.

Effective July 1, 2003 the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing hereby repeals and replaces all Rules governing disproportionate share hospital payment methodologies.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Medical Assistance Program—Hospital Services

Subpart 1. Inpatient Hospitals

Chapter 3. Disproportionate Share Hospital Payment Methodologies

§301. General Provisions

A. The reimbursement methodology for inpatient hospital services incorporates a provision for an additional payment adjustment for hospitals serving a disproportionate share of low income patients.

B. The following provisions govern the disproportionate share hospital (DSH) payment methodologies for qualifying hospitals.

1. Total cumulative disproportionate share payments under any and all disproportionate share hospital payment methodologies shall not exceed the federal disproportionate share state allotment for Louisiana for each federal fiscal year or the state appropriation for disproportionate share payments for each state fiscal year. The department shall make necessary downward adjustments to hospital's disproportionate share payments to remain within the federal disproportionate share allotment and the state disproportionate share appropriated amount.

2. Appropriate action including, but not limited to, deductions from DSH, Medicaid payments and cost report settlements shall be taken to recover any overpayments resulting from the use of erroneous data, or if it is determined upon audit that a hospital did not qualify.

3. DSH payments to a hospital determined under any of the methodologies described in this Chapter 3 shall not exceed the hospital's net uncompensated cost as defined in §§305-313 or the disproportionate share limits as defined in Section 1923(g)(1)(A) of the Social Security Act for the state fiscal year to which the payment is applicable. Public hospitals included in §§305, 307 and 313 shall receive DSH

payments up to 175 percent of the hospital's net uncompensated costs.

4. Qualification is based on the hospital's latest filed cost report as of March 31 of the current state fiscal year and related uncompensated cost data as required by the department. Qualification for small rural hospitals is based on the latest filed cost report. Hospitals must file cost reports in accordance with Medicare deadlines, including extensions. Hospitals that fail to timely file Medicare cost reports and related uncompensated cost data will be assumed to be ineligible for disproportionate share payments. Only hospitals that return timely disproportionate share qualification documentation will be considered for disproportionate share payments. After the final payment during the state fiscal year has been issued, no adjustment will be given on DSH payments, even if subsequently submitted documentation demonstrates an increase in uncompensated care costs for the qualifying hospital. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization.

5. Hospitals and/or units which close or withdraw from the Medicaid Program shall become ineligible for further DSH pool payments for the remainder of the current DSH pool payment cycle and thereafter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:

§303. Disproportionate Share Hospital Qualifications

A. In order to qualify as a disproportionate share hospital, a hospital must:

1. have at least two obstetricians who have staff privileges and who have agreed to provide obstetric services to individuals who are Medicaid eligible. In the case of a hospital located in a rural area (i.e., an area outside of a metropolitan statistical area), the term *obstetrician* includes any physician who has staff privileges at the hospital to perform nonemergency obstetric procedures; or

2. treat inpatients who are predominantly individuals under 18 years of age; or

3. be a hospital which did not offer nonemergency obstetric services to the general population as of December 22, 1987; and

4. have a utilization rate in excess of one or more of the following specified minimum utilization rates:

a. Medicaid utilization rate is a fraction (expressed as a percentage). The numerator is the hospital's number of Medicaid (Title XIX) inpatient days. The denominator is the total number of the hospital's inpatient days for a cost reporting period. Inpatient days include newborn and psychiatric days and exclude swing bed and skilled nursing days. Hospitals shall be deemed disproportionate share providers if their Medicaid utilization rates are in excess of the mean, plus one standard deviation of the Medicaid utilization rates for all hospitals in the state receiving payments; or

b. hospitals shall be deemed disproportionate share providers if their low-income utilization rates are in excess of 25 percent. Low-income utilization rate is the sum of:

i. the fraction (expressed as a percentage). The numerator is the sum (for the period) of the total Medicaid patient revenues plus the amount of the cash subsidies for patient services received directly from state and local governments. The denominator is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the cost reporting period from the financial statements; and

ii. the fraction (expressed as a percentage). The numerator is the total amount of the hospital's charges for inpatient services which are attributable to charity (free) care in a period, less the portion of any cash subsidies as described in §303.A.4.b.i in the period which are reasonably attributable to inpatient hospital services. The denominator is the total amount of the hospital's charges for inpatient hospital services in the period. For public providers furnishing inpatient services free of charge or at a nominal charge, this percentage shall not be less than zero. This numerator shall not include contractual allowances and discounts (other than for indigent patients ineligible for Medicaid), i.e., reductions in charges given to other third-party payers, such as HMOs, Medicare, or Blue Cross; nor charges attributable to Hill-Burton obligations. A hospital providing "free care" must submit its criteria and procedures for identifying patients who qualify for free care to the Bureau of Health Services Financing for approval. The policy for free care must be posted prominently and all patients must be advised of the availability of free care and the procedures for applying. Hospitals not in compliance with free care criteria will be subject to recoupment of DSH and Medicaid payments; or

c. hospitals shall be deemed disproportionate share providers eligible for reimbursement for inpatient services if their inpatient uninsured utilization rates are in excess of 3 percent;

i. inpatient uninsured utilization rate is a fraction (expressed as a percentage). The numerator is the total amount of the hospital's charges for inpatient services furnished to uninsured persons for the period. The denominator is the total amount of the hospital's charges for inpatient services furnished to all persons for the period; or

d. hospitals shall be deemed disproportionate share providers eligible for reimbursement for outpatient services if their outpatient uninsured utilization rates are in excess of 3 percent;

i. outpatient uninsured utilization rate is a fraction (expressed as a percentage). The numerator is the total amount of the hospital's charges for outpatient services furnished to uninsured persons for the period. The denominator is the total amount of the hospital's charges for outpatient services furnished to all persons for the period; or

5. effective November 3, 1997, be a small rural hospital as defined in §311.A.1.a-h; and

6. in addition to the qualification criteria outlined in §303.A.1-5, effective July 1, 1994, must also have a Medicaid inpatient utilization rate of at least 1 percent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:

§305. High Uninsured Hospitals

A. Definitions

*High Uninsured Utilization Rate Hospital*Ca hospital that has an uninsured utilization rate in excess of the mean, plus one standard deviation of the uninsured utilization rates for all hospitals.

*Net Uncompensated Cost*Cthe cost of furnishing inpatient and outpatient hospital services to uninsured persons, supported by patient-specific data, net of any payments received from such patients.

B. It is mandatory that hospitals seek all third party payments including Medicare, Medicaid and other third party carriers and payments from patients. Hospitals must certify that excluded from net uncompensated cost are any costs for the care of persons eligible for Medicaid at the time of registration. Hospitals must maintain a log documenting the provision of uninsured care as directed by the department. Hospitals must adjust uninsured charges to reflect retroactive Medicaid eligibility determination. Patient specific data is required after July 1, 2003. Hospitals shall annually submit:

1. an annual attestation that patients whose care is included in the hospitals' net uncompensated cost are not Medicaid eligible at the time of registration; and

2. supporting patient-specific demographic data that does not identify individuals, but is sufficient for audit of the hospitals' compliance with the Medicaid ineligibility requirement as required by the department, including:

- a. patient age;
- b. family size;
- c. number of dependent children; and
- d. household income.

C. DSH payments to individual high uninsured hospitals shall be equal to 100 percent of the hospital's net uncompensated costs and subject to the adjustment provision in §301.B. DSH payments to individual public high uninsured hospitals shall be up to 175 percent of the hospital's net uncompensated costs and subject to the adjustment provision in §301.B.

D. In the event that it is necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment or the state DSH-appropriated amount, the department shall calculate a pro rata decrease for each high uninsured hospital based on the ratio determined by:

1. dividing that hospital's uncompensated cost by the total uncompensated cost for all qualifying high uninsured hospitals during the state fiscal year; and then

2. multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate allotment or state DSH-appropriated amount.

E. A hospital receiving DSH payments shall furnish emergency and nonemergency services to uninsured persons with family incomes less than or equal to 100 percent of the federal poverty level on an equal basis to insured patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:

§307. Other Uninsured Hospitals

A. Definitions

Net Uncompensated Cost the cost of furnishing inpatient and outpatient hospital services to uninsured persons, supported by patient-specific data, net of any payments received from such patients.

Other Uninsured Utilization Rate Hospital a qualifying hospital that is not included in §§305, 311, 313 or 315.

B. It is mandatory that hospitals seek all third party payments including Medicare, Medicaid and other third party carriers and payments from patients. Hospitals must certify that excluded from net uncompensated cost are any costs for the care of persons eligible for Medicaid at the time of registration. Hospitals must maintain a log documenting the provision of uninsured care as directed by the department. Hospitals must adjust uninsured charges to reflect retroactive Medicaid eligibility determination. Patient specific data is required after July 1, 2003. Hospitals shall annually submit:

1. an attestation that patients whose care is included in the hospitals' net uncompensated cost are not Medicaid eligible at the time of registration; and
2. supporting patient-specific demographic data that does not identify individuals, but is sufficient for audit of the hospitals' compliance with the Medicaid ineligibility requirement as required by the department, including:
 - a. patient age;
 - b. family size;
 - c. number of dependent children; and
 - d. household income.

C. DSH payments to an individual other uninsured hospital shall be based on the hospital's uninsured utilization rate and the distribution of all other uninsured hospitals uninsured utilization rates. DSH payments to hospitals in the first quintile of the distribution shall be equal to 25 percent of the hospital's net uncompensated costs and subject to the adjustment provision in §301.B. DSH payments to hospitals in the second through the fifth quintiles of the distribution shall be equal to 40, 55, 70 and 85 percent of the hospital's net uncompensated cost, respectively. DSH payments to individual public other uninsured hospitals shall be up to 175 percent of the hospital's net uncompensated costs and subject to the adjustment provision in §301.B.

D. In the event it is necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment or the state DSH-appropriated amount, the department shall calculate a pro rata decrease for each other uninsured hospital based on the ratio determined by:

1. dividing that hospital's uncompensated cost by the total uncompensated cost for all qualifying other uninsured hospitals during the state fiscal year; and then
2. multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate allotment or state DSH-appropriated amount.

E. A hospital receiving DSH payments shall furnish emergency and nonemergency services to uninsured persons with family incomes less than or equal to 100 percent of the federal poverty level on an equal basis to insured patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:

§309. High Medicaid Hospitals

A. Definition. *High Medicaid Utilization Rate Hospital* a hospital that has a Medicaid utilization rate in excess of the mean, plus one standard deviation of the Medicaid utilization rates for all hospitals in the state receiving payments and that is not included in §305.

1. Medicaid utilization rate is a fraction (expressed as a percentage). The numerator is the hospital's number of Medicaid (Title XIX) inpatient days. The denominator is the total number of the hospital's inpatient days for a cost-reporting period.

B. DSH payments to individual high Medicaid hospitals shall be based on actual paid Medicaid days for a six-month period ending on the last day of the last month of that period, but reported at least 30 days preceding the date of payment. Annualization of days for the purposes of the Medicaid days pool is not permitted. The amount will be obtained by DHH from a report of paid Medicaid days by service date.

C. Disproportionate share payments for individual high Medicaid hospitals shall be calculated based on the product of the ratio determined by:

1. dividing each qualifying high Medicaid hospital's actual paid Medicaid inpatient days for a six-month period ending on the last day of the month preceding the date of payment (which will be obtained by DHH from a report of paid Medicaid days by service date) by the total Medicaid inpatient days obtained from the same report of all qualified high Medicaid hospitals. Total Medicaid inpatient days include Medicaid nursery days but do not include skilled nursing facility or swing-bed days; and

2. multiplying by an amount of funds for high Medicaid hospitals to be determined by the director of the Bureau of Health Services Financing.

D. A pro rata decrease necessitated by conditions specified in §301.B. for high Medicaid hospitals will be calculated based on the ratio determined by:

1. dividing the hospitals' Medicaid days by the Medicaid days for all qualifying high Medicaid hospitals; then
2. multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate share allotment or the state disproportionate share appropriated amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:

§311. Small Rural Hospitals

A. Definitions

Net Uncompensated Cost the cost of furnishing inpatient and outpatient hospital services, net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, private payer payments, and all other inpatient and outpatient payments received from patients.

Small Rural Hospital a hospital (excluding a long-term care hospital, rehabilitation hospital, or freestanding

psychiatric hospital but including distinct part psychiatric units) that meets the following criteria:

a. had no more than 60 hospital beds as of July 1, 1994, and is located in a parish with a population of less than 50,000 or in a municipality with a population of less than 20,000; or

b. meets the qualifications of a sole community hospital under 42 CFR §412.92(a); or

c. had no more than 60 hospital beds as of July 1, 1999 and is located in a parish with a population of less than 17,000 as measured by the 1990 census; or

d. had no more than 60 hospital beds as of July 1, 1997 and is a publicly-owned and operated hospital that is located in either a parish with a population of less than 50,000 or a municipality with a population of less than 20,000; or

e. had no more than 60 hospital beds as of June 30, 2000 and is located in a municipality with a population, as measured by the 1990 census, of less than 20,000; or

f. had no more than 60 beds as of July 1, 1997 and is located in a parish with a population, as measured by the 1990 and 2000 census, of less than 50,000; or

g. was a hospital facility licensed by the department that had no more than 60 hospital beds as of July 1, 1994, which hospital facility:

i. has been in continuous operation since July 1, 1994;

ii. is currently operating under a license issued by the department; and

iii. is located in a parish with a population, as measured by the 1990 census, of less than 50,000;

h. has no more than 60 hospital beds or has notified the department as of March 7, 2002 of its intent to reduce its number of hospital beds to no more than 60, and is located in a municipality with a population of less than 13,000 and in a parish with a population of less than 32,000 as measured by the 2000 census.

B. Payment based on uncompensated cost for qualifying small rural hospitals shall be in accordance with the following two pools.

*Private Small Rural Hospitals*Csmall rural hospitals as defined in §311.A.1, that are privately owned.

*Public (Nonstate) Small Rural Hospitals*Csmall rural hospitals as defined in §311.A.1, which are owned by a local government.

C. Payment is equal to each qualifying rural hospital's pro rata share of uncompensated cost for all hospitals meeting these criteria for the latest filed cost report multiplied by the amount set for each pool. If the cost reporting period is not a full period (12 months), actual uncompensated cost data from the previous cost reporting period may be used on a pro rata basis to equate a full year.

D. Pro Rata Decrease

1. A pro rata decrease necessitated by conditions specified in §301.B. for rural hospitals described in this §311 will be calculated using the ratio determined by:

a. dividing the qualifying rural hospital's uncompensated costs by the uncompensated costs for all rural hospitals in §311; then

b. multiplying by the amount of disproportionate share payments calculated in excess of the federal DSH allotment or the state DSH appropriated amount.

2. No additional payments shall be made after the final payment for the state fiscal year is disbursed by the department. Recoupment shall be initiated upon completion of an audit if it is determined that the actual uncompensated care costs for the state fiscal year for which the payment is applicable is less than the actual amount paid.

E. Qualifying hospitals must meet the definition for a small rural hospital contained in §311.A.1. Qualifying hospitals must maintain a log documenting the provision of uninsured care as directed by the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:

§313. Public State-Operated Hospitals

A. Definitions

*Net Uncompensated Cost*Cthe cost of furnishing inpatient and outpatient hospital services, net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, private payer payments, and all other inpatient and outpatient payments received from patients.

*Public State-Operated Hospital*Ca hospital that is owned or operated by the State of Louisiana, Department of Health and Hospitals.

B. DSH payments to individual public state-owned or operated hospitals shall be up to 175 percent of the hospital's net uncompensated costs. Final payment will be based on the uncompensated cost data per the audited cost report for the period(s) covering the state fiscal year.

C. In the event that it is necessary to reduce the amount of disproportionate share payments to remain within the federal disproportionate share allotment or the state DSH-appropriated amount, the department shall calculate a pro rata decrease for each public state-owned or operated hospital based on the ratio determined by:

1. dividing that hospital's uncompensated cost by the total uncompensated cost for all qualifying public state-owned or operated hospitals during the state fiscal year; and then

2. multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate allotment or state DSH-appropriated amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:

§315. Psychiatric Hospitals

A. Definitions

*Net Uncompensated Cost*Cthe cost of furnishing inpatient and outpatient hospital services, net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have

insurance for services provided, private payer payments, and all other inpatient and outpatient payments received from patients.

*Psychiatric Hospital*Ca free standing psychiatric hospital that is not included in §313.

B. DSH payments to individual free standing psychiatric hospitals shall be based on actual paid Medicaid days for a six-month period ending on the last day of the last month of that period, but reported at least 30 days preceding the date of payment. Annualization of days for the purposes of the Medicaid days pool is not permitted. The amount will be obtained by DHH from a report of paid Medicaid days by service date.

C. Disproportionate share payments for individual free standing psychiatric hospitals shall be calculated based on the product of the ratio determined by:

1. dividing each qualifying free standing psychiatric hospital's actual paid Medicaid inpatient days for a six-month period ending on the last day of the month preceding the date of payment (which will be obtained by DHH from a report of paid Medicaid days by service date) by the total Medicaid inpatient days obtained from the same report of all qualified free standing psychiatric hospitals. Total Medicaid inpatient days include Medicaid nursery days but do not include skilled nursing facility or swing-bed days; and

2. multiplying by an amount of funds for free standing psychiatric to be determined by the director of the Bureau of Health Services Financing

D. A pro rata decrease necessitated by conditions specified in §301.B. for hospitals in §315 will be calculated based on the ratio determined by:

1. dividing the hospitals' Medicaid days by the Medicaid days for all qualifying hospitals in §315; then

2. multiplying by the amount of disproportionate share payments calculated in excess of the federal disproportionate share allotment or the state disproportionate share appropriated amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:

Implementation of the provisions of this Rule will be delayed until July 12, 2003 and shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Ben A. Bearden at the 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

0306#047

DECLARATION OF EMERGENCY

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

Early and Periodic Screening, Diagnosis and Treatment
Dental ProgramC Reimbursement
(LAC 50:XV.6903)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends LAC 50:XV.6903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated 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 final Rule, whichever occurs first.

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) requires national standards for electronic health care transactions and national identifiers for providers, health plans, and employers (*Federal Register*, Volume 65, Number 160). This includes standardized procedure codes and definitions. The Department of Health and Hospitals, Bureau of Health Services Financing is required to implement these codes and definitions or face monetary sanctions. In compliance with HIPAA requirements, the bureau clarified the descriptions for two Early and Periodic Screening, Diagnosis and Treatment (EPSDT) dental procedure codes and adjusted the reimbursement rates to conform with the HIPAA compliant procedure code descriptions (*Louisiana Register*, Volume 29, Number 2).

This Emergency Rule is promulgated to continue the provisions of the February 21, 2003 Emergency Rule. This action is being taken to avoid federal sanctions by complying with the mandates of the Health Insurance Portability and Accountability Act.

Effective for dates of services on or after June 22, 2003, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing clarifies the procedure descriptions and adjusts the reimbursement fees for the following Early and Periodic Screening, Diagnosis and Treatment dental procedure codes.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 5. Early and Periodic Screening,

Diagnosis, and Treatment

Chapter 69. Dental

§6903. Reimbursement

A. Reimbursement Fees are adjusted for certain designated procedure codes to the following rates.

Procedure Code	Procedure	Rate
* * *		
[See Prior Text in 00120 - 02931]		
02950	Core Buildup, including any pins	\$55
02954	Prefabricated Post and Core in addition to crown	\$75
* * *		
[See Prior Text in 03220 - 07210]		

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:

Interested persons may submit written comments to Ben A. Bearden at the 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 for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

0306#051

DECLARATION OF EMERGENCY

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

Medicaid EligibilityC Qualified Individuals
Medicare Part B Buy-in

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of 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 bureau promulgated a Rule in July 1998 adopting the provisions of Section 4732 of the Balanced Budget Act of 1997 governing the payment of Medicare Part B premiums for Qualified Individuals (QIs) in the two mandatory eligibility groups (*Louisiana Register, Volume 24, Number 7*). The provisions were effective for premiums payable beginning January 1, 1998 and ending December 31, 2002. Payment for the Medicare premiums is provided by 100% federal funds, which are provided as a capped annual grant. The number of QIs certified is limited by availability of these funds. Individuals in the first group of QIs (QI-1s) were eligible if their incomes were above 120 percent of the Federal poverty line, but less than 135 percent. The Medicaid benefit for QI-1s consisted of payment of the full Medicare Part B premium.

Federal statutory authority for the payment of Medicare Part B premiums benefits for QIs was originally intended to expire on December 31, 2002. A Continuing Resolution (Public Law No. 107-229, as amended by Public Law Nos. 107-240 and 107-244) was enacted to extend the QI-1 benefits at the current funding levels through January 21,

2003. The bureau promulgated an Emergency Rule to amend the July 20, 1998 Rule by extending the benefits for QI-1s (*Louisiana Register, Volume 28, Number 12*). The Continuing Resolution was again amended by Public Law No. 107-294, extending the QI-1 benefits at the current funding levels through March 12, 2003. The bureau promulgated an Emergency Rule to amend the January 1, 2003 Rule by extending the benefits for QI-1s (*Louisiana Register, Volume 29, Number 1*). Congress has subsequently passed the federal budget for fiscal year 2003 which includes an appropriation to extend the QI-1 benefits at the current funding levels through September 30, 2003. The bureau amended the January 21, 2003 Emergency Rule and again extended coverage of benefits for Qualifying Individuals-1 (*Louisiana Register, Volume 29, Number 3*). This Emergency Rule is being promulgated to continue the provisions of the March 21, 2003 Emergency Rule. This action is being taken to avoid federal sanctions by complying with changes in federal regulations.

Emergency Rule

Effective July 20, 2003, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the provisions of the January 21, 2003 Emergency Rule and extends payment of Medicare Part B premiums for Qualifying Individuals-1 through September 30, 2003.

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Ben A. Bearden at the 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 for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

0306#052

DECLARATION OF EMERGENCY

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

Pharmacy Benefits Management Program
Prescription Limit

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 2001-2002 General Appropriation Act which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening and utilization review, and other measures as allowed by federal law." This

Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing administers the Pharmacy Benefits Management Program under the Medicaid Program in accordance with federal and state regulations which govern Medicaid coverage of prescription drugs. Although federal regulations permit states to establish recipient service limits with a provision for exemption of certain recipient groups, the bureau has not established any limits on the number of prescriptions allowed to Medicaid recipients. In compliance with Executive Order MJF 02-29, the department established a limit of eight prescriptions per calendar month with provisions for exemption of federally mandated eligibles and for the prescriber to override the limit in medically necessary cases (*Louisiana Register, Volume 29, Number 3*).

This Emergency Rule is promulgated to continue the provisions contained in the March 3, 2003 Rule. This action is necessary to avoid a budget deficit in the medical assistance programs.

Emergency Rule

Effective July 2, 2003, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following regulations governing the provision of prescription drug benefits offered to Medicaid recipients under the Medicaid Pharmacy Benefits Management Program.

1. The Department of Health and Hospitals will pay for a maximum of eight prescriptions per calendar month for Medicaid recipients.

2. The following federally mandated recipient groups are exempt from the eight prescriptions per calendar month limitation:

- a. persons under 21 years of age;
- b. persons who are residents of long-term care institutions, such as nursing homes and ICF-MR facilities; and
- c. pregnant women.

3. The eight prescriptions per month limit can be exceeded when the prescriber determines an additional prescription is medically necessary and communicates to the pharmacist the following information in his own handwriting or by telephone or other telecommunications device:

- a. "medically necessary override;" and
- b. a valid ICD-9-CM Diagnosis Code that directly relates to each drug prescribed that is over eight. (No ICD-9-CM literal description is acceptable.)

4. The prescriber should use the Clinical Drug Inquiry (CDI). Internet web application developed by Unisys in his/her clinical assessment of the patient's disease state or medical condition and the current drug regime before making a determination that more than eight prescriptions per calendar month is required by the recipient.

5. Printed statements without the prescribing practitioner's signature, check-off boxes or stamped signatures are not acceptable documentation.

6. An acceptable statement and ICD-9-CM are required for each prescription in excess of eight for that month.

7. Pharmacists and prescribers are required to maintain documentation to support the override of a prescription limitation.

Implementation of this Emergency Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Ben A. Bearden at the 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

0306#054

DECLARATION OF EMERGENCY

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

Private HospitalsC Inpatient Services
Reimbursement Reduction

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Emergency Rule under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 2002-2003 General Appropriation Act, which states: "The secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law". This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a Rule in June of 1994 which established the prospective reimbursement methodology for inpatient services provided in private (non-state) acute care general hospitals (*Louisiana Register, Volume 20, Number 6*). The June 20, 1994 Rule was subsequently amended to establish a weighted average per diem for each hospital peer group (*Louisiana Register, Volume 22, Number 1*). This Rule was later amended 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 5*).

As a result of a budgetary shortfall, the bureau promulgated an Emergency Rule that reduced the reimbursement paid for inpatient services rendered in private (non-state) acute hospitals, including long term hospitals, to 85 percent of the per diem rates (a 15 percent reduction) in effect on March 31, 2003 (*Louisiana Register, Volume 29, Number 4*). Small rural hospitals as defined by the Rural Hospital Preservation Act (R.S. 40:1300.143) were excluded from this reimbursement reduction. Based on comments received in response to the public process notice, the bureau has determined that it is necessary to further reduce the reimbursement reduction to private (non-state) acute hospitals, including long term hospitals. This action is being taken in order to avoid a budget deficit in the medical assistance programs. Taking the reduction in per diem rates in state fiscal year 2002-2003 into consideration, the department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that private (non-state) inpatient hospital services under the state plan are available at least to the extent that they are available to the general population in the state. It is estimated that implementation of this Emergency Rule will reduce expenditures for private hospital inpatient services by approximately \$1,837,226 for state fiscal year 2002-2003.

Emergency Rule

Effective for dates of service from May 19, 2003 through June 30, 2003, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement paid for inpatient services rendered in private (non-state) acute hospitals, including long term hospitals. The reimbursement shall be 95 percent of the per diem rates (a 5 percent reduction) in effect on March 31, 2003 for private hospitals with a Medicaid inpatient days utilization rate of 25 percent or greater and 90 percent of the per diem rates (a 10 percent reduction) in effect on March 31, 2003 for private hospitals with a Medicaid inpatient days utilization rate of less than 25 percent. The Medicaid inpatient days utilization rate shall be calculated based on the filed cost report for the period ending in state fiscal year 2002 and received by the department prior to April 30, 2003. Only Medicaid covered days for inpatient hospital services, which include newborn days and distinct part psychiatric units, are included in this calculation. Inpatient stays covered by Medicare Part A can not be included in the determination of the Medicaid inpatient days utilization rate. Small rural hospitals as defined by the Rural Hospital Preservation Act (R.S. 40:1300.143) shall be excluded from this reimbursement reduction.

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Ben A. Bearden at the 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 for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

0306#002

DECLARATION OF EMERGENCY

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

Private HospitalsC Outpatient Services Reimbursement Reduction

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Emergency Rule under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the 2002-2003 General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a Rule in January of 1996 which established the reimbursement methodology for outpatient hospital services at an interim rate of 60 percent of billed charges and cost settlement adjusted to 83 percent of allowable costs documented in the cost report, except for laboratory services subject to the Medicare Fee Schedule and outpatient surgeries (*Louisiana Register, Volume 22, Number 1*).

As a result of a budgetary shortfall, the bureau adjusted the provisions contained in the January 1996 Rule governing the reimbursement methodology for outpatient hospital services. Reimbursement for those surgical procedures that were not included on the Medicaid outpatient surgery list was set at the highest flat fee in the four Medicaid established outpatient surgery payment groups when the procedure is performed in an outpatient setting. In addition, the interim reimbursement rate for all other outpatient hospital services was changed to a hospital specific cost to charge ratio calculation based on filed cost reports for the period ending in state fiscal year 1997 (*Louisiana Register, Volume 26, Number 12*).

As a result of a budgetary shortfall, the bureau adjusted the interim reimbursement rate for hospital outpatient services in private hospitals to a hospital specific cost to charge ratio calculation based on the latest filed cost reports.

The final reimbursement for these services will continue to be cost settlement at 83 percent of allowable costs (*Louisiana Register, Volume 29, Number 3*). This Emergency Rule is promulgated to continue the provisions of the March 1, 2003 Emergency Rule. This action is necessary in order to avoid a budget deficit in the medical assistance programs.

Emergency Rule

Effective for dates of service June 30, 2003 and after, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the reimbursement methodology for outpatient hospital services to a hospital specific cost to charge ratio calculation based on the latest filed cost report. These cost to charge ratio calculations will be reviewed on an ongoing basis as cost reports are filed and will be adjusted as necessary.

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Ben A. Bearden at the 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 for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

0306#055

DECLARATION OF EMERGENCY

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

Rehabilitation ServicesC Reimbursement Fee Increase

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated 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 final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing provides coverage and reimbursement for rehabilitation services under the Medicaid Program. Rehabilitation services include physical, occupational and speech therapies Reimbursement is available for these services through outpatient hospital, home health, rehabilitation center and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) health services. The bureau adopted a Rule establishing the reimbursement methodology for EPSDT rehabilitation services in April of 1997 (*Louisiana Register, Volume 23, Number 4*). The bureau also adopted a Rule establishing the reimbursement methodology for rehabilitation services rendered in rehabilitation center and outpatient hospital settings in June of 1997 (*Louisiana Register, Volume 23, Number 6*). The bureau adopted a subsequent Rule in May of

2001 to establish the reimbursement methodology for rehabilitation services rendered by home health agencies (*Louisiana Register, Volume 27, Number 5*). Reimbursement for these services is a flat fee established by the bureau minus the amount that any third party coverage would pay.

Act 13 of the 2002 Regular Session of the Louisiana Legislature directed the department to increase the reimbursement for physical therapy, occupational therapy, and speech/language and hearing therapy services provided to children under three years of age. In compliance with the Appropriation Bill and as a result of the allocation of additional funds by the legislature, the bureau increased the reimbursement rates for rehabilitation services provided to Medicaid recipients up to the age of three, regardless of the type of provider performing the services (*Louisiana Register Volume 28, Number 7*).

This Emergency Rule is being promulgated to continue the provisions contained in the July 6, 2002 Rule. This action is being taken to protect the health and welfare of Medicaid recipients under the age of three and to ensure access to rehabilitation services by encouraging the participation of rehabilitation providers in the Medicaid Program.

Emergency Rule

Effective for dates of services on or after July 4, 2003, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the April 20, 1997, June 20, 1997 and May 20, 2001 Rules governing the reimbursement methodology for rehabilitation services provided by outpatient hospitals, rehabilitation centers, home health agencies and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) health services providers to increase the reimbursement rates for rehabilitation services provided to Medicaid recipients up to the age of three, regardless of the type of provider performing the services. The new reimbursement rates for rehabilitation services rendered to Medicaid recipients up to the use of three are as follows.

Home Health Agencies and Outpatient Hospitals

Procedure Name	New Rate
Initial Sp/Lang Evaluation	\$ 7 0.00
Initial Hearing Evaluation	\$ 70.00
Sp/Lan/Hear Therapy 60 Minutes	\$ 56.00
Visit W/Procedure(S) 45 Minutes	\$ 56.00
Visit W/Procedure(S) 60 Minutes	\$ 74.00
Visit W/Procedures 90 Minutes	\$112.00
Procedures And Modalities 60 Minutes	\$ 74.00
Pt And Rehab Evaluation	\$ 75.00
Initial Ot Evaluation	\$ 70.00
Ot 45 Minutes	\$ 45.00
Ot 60 Minutes	\$ 60.00

Rehabilitation Centers

Procedure Name	New Rate
Group Sp Lang Hear Therapy 1/2 Hour	\$ 26.00
Speech Group Therapy Add 15 Minutes	\$ 13.00
Group Sp Lang Hear Therapy 1 Hour	\$ 51.00
Initial Sp/Lang Evaluation	\$ 70.00
Initial Hearing Evaluation	\$ 70.00
Sp/Lang/Hear Therapy 30 Minutes	\$ 26.00
Sp/Lang/Hear Therapy 45 Minutes	\$ 39.00
Sp/Lang/Hear Therapy 60 Minutes	\$ 52.00
Visit W/Procedure(S) 30 Minutes	\$ 34.00

Visit W/Procedure(S) 45 Minutes	\$ 51.00
Visit W/Procedure(S) 60 Minutes	\$ 68.00
Visit W/Procedure(S) 75 Minutes	\$ 85.00
Visit W/Procedure(S) 90 Minutes	\$102.00
Ctr Visit One/More Modal/Proc 15 Minutes	\$ 17.00
Procedures And Modalities 60 Minutes	\$ 68.00
Pt And Rehab Evaluation	\$ 75.00
Initial Ot Evaluation	\$ 70.00
Ot 30 Minutes	\$ 26.00
Ot 45 Minutes	\$ 39.00
Ot 60 Minutes	\$ 52.00

EPSDT Health Services

Procedure Name	New Rate
Electrical Stimulation	\$ 17.00
Pt-One Area-Therapeutic-30 Minutes	\$ 17.00
Pt-Neuromuscular Reed-30 Minutes	\$ 17.00
Pt-Gait Training-30 Minutes	\$ 34.00
Orthotic Training	\$ 14.00
Kinetic Act One Area-30 Minutes	\$ 14.00
Physical Performance Test	\$ 14.00
Physical Therapy Evaluation/Re-Evaluation	\$ 92.00
Occ Therapy Evaluation/Re-Evaluation	\$ 70.00
Speech/Language Evaluation/Re-Evaluation	\$ 70.00
Speech/Language Therapy 30 Minutes	\$ 26.00
Speech/Language Therapy Add 15 Minutes	\$ 13.00
Group Sp Lang Hear Therapy 1/2 Hour	\$ 26.00
Speech Group Therapy 20 Minutes	\$ 13.00
Speech Group Therapy Add 15 Minutes	\$ 13.00
Group Sp Lang Hear Therapy 1 Hour	\$ 52.00
Speech Lang Hearing Therapy 20 Minutes	\$ 17.00
Sp/Lan/Hear Therapy 60 Minutes	\$ 52.00
Procedures And Modalities 30 Minutes	\$ 34.00
Procedures And Modalities 45 Minutes	\$ 52.00

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services

Interested persons may submit written comments to Ben A. Bearden, at the Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, Louisiana 70821-9030. He is the person responsible for responding to 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

0306#056

DECLARATION OF EMERGENCY

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

Private Inpatient Psychiatric Services
Reimbursement Reduction

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Emergency Rule under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by the

2002-2003 General Appropriation Act, which states: "The secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law". This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., and shall be in effect for the maximum period allowed under the Administrative Procedure Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a Rule which established the prospective reimbursement methodology for inpatient psychiatric hospital services provided in either a free-standing psychiatric hospital or distinct part psychiatric unit of an acute care general hospital (*Louisiana Register, Volume 19, Number 6*). This Rule was subsequently amended to discontinue the practice of automatically applying an inflation adjustment to the reimbursement rates for inpatient psychiatric services in those years when the rates are not rebased (*Louisiana Register, Volume 25, Number 5*).

As a result of a budgetary shortfall, the bureau promulgated an Emergency Rule that reduced the reimbursement paid for private inpatient psychiatric services to 85 percent of the per diem rates (a 15 percent reduction) in effect on March 31, 2003 (*Louisiana Register, Volume 29, Number 4*). Small rural hospitals as defined by the Rural Hospital Preservation Act (R.S. 40:1300.143) were excluded from this reimbursement reduction. Based on comments received in response to the public process notice, the bureau has determined that is necessary to further reduce the reimbursement reduction for private inpatient psychiatric hospital services. This action is being taken in order to avoid a budget deficit in the medical assistance programs. Taking this reduction in per diem rates in state fiscal year 2002-2003 into consideration, the department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that inpatient psychiatric services under the state plan are available at least to the extent that they are available to the general population in the state. It is estimated that implementation of this Emergency Rule will reduce expenditures for private inpatient psychiatric services by approximately \$81,743 for state fiscal year 2002-2003.

Emergency Rule

Effective for dates of service from May 19, 2003 through June 30, 2003, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing reduces the reimbursement paid for private inpatient psychiatric hospital services. The reimbursement shall be 95 percent of the per diem rates (a 5 percent reduction) in effect on March 31, 2003 for private hospitals with a Medicaid utilization rate of 25 percent or greater and 90 percent of the per diem rates (a 10 percent reduction) in effect on March

31, 2003 for private hospitals with a Medicaid utilization rate of less than 25 percent. The Medicaid inpatient days utilization rate shall be calculated based on the filed cost report for the period ending in state fiscal year 2002 and received by the department prior to April 30, 2003. Only Medicaid covered days for inpatient hospital services, which include newborn days and distinct part psychiatric units, are included in this calculation. Inpatient stays covered by Medicare Part A can not be included in the determination of the Medicaid inpatient days utilization rate. Small rural hospitals as defined by the Rural Hospital Preservation Act (R.S. 40:1300.143) shall be excluded from this reimbursement reduction.

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Ben A. Bearden at the 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 for review by interested parties at parish Medicaid offices.

David W. Hood
Secretary

0306#001

DECLARATION OF EMERGENCY

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

Private Intermediate Care Facilities for the Mentally RetardedC Reimbursement Reduction

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq.

Emergency Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing published an Emergency Rule reducing the reimbursement paid to private for profit intermediate care facilities for the mentally retarded (ICF-MR) to 85 percent of the per diem rates (a 15 percent reduction) in effect on March 31, 2003 and to private non-profit intermediate care facilities for the mentally retarded to 92.5 percent of the per diem rates (a 7.5 percent reduction) in effect on March 31, 2003 (*Louisiana Register, Volume 29, Number 4*). The department has now determined that it is necessary to rescind this Emergency Rule and notification is provided to interested persons through this medium.

David W. Hood
Secretary

0306#050