

Notices of Intent

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 111—The Louisiana School, District and State Accountability System (LAC 28:LXXXIII.301 and 303)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 111—The Louisiana School, District, and State Accountability System* (LAC Part Number LXXXIII). The proposed changes define/outline/clarify the following: The table in §301.L, School Performance Score Goal, was revised to reflect the use of two years of data as is defined in the text of the policy. The edits to §303.J and K, Calculating the SPS, allow School Performance Scores to be calculated very much as they have been in the past until the Graduation Index is implemented in 2007. Both revisions should allow a more efficient transition to the new system that includes iLEAP and a Graduation Index.

Title 28 EDUCATION

Part LXXXIII. Bulletin 111—The Louisiana School, District, and State Accountability System

Chapter 3. School Performance Score Component

§301. School Performance Score Goal

A. - K. ...

L. 2005-2007 High School Transition

2005-2007 High School Transition			
2005			
	Years of Data	Indicators/Weights	Generates
Growth SPS	2005	GEE(60%), Iowa (30%), Attendance (5%), Drop (5%)	Growth Label, Rewards for 2005
Baseline SPS	2004 & 2005	GEE(60%), Iowa (30%), Attendance (5%), Drop (5%)	Performance Label, SI Status, SPS AYP for 2005
Transition Baseline SPS	2004 & 2005	GEE(90%), Attendance (5%), Drop (5%)	Growth Target, Growth Goal for 2006

2006			
	Years of Data	Indicators/Weights	Generates
Growth SPS	2006	GEE(90%), Attendance (5%), Drop (5%)	Growth Label, Rewards for 2006
Baseline SPS	2005 & 2006	2006 GEE/iLEAP (90%), 2005 & 2006 Attendance (5%), 2005 & 2006 Drop (5%)	Performance Label, SI Status refer to H.3 a. above), SPS AYP for 2006; Growth Target and Goal for 2007

2007			
	Years of Data	Indicators/Weights	Generates
Growth SPS	2007	GEE/iLEAP (90%), Attendance (5%), Drop (5%)	Growth Label, Rewards for 2007
Baseline SPS	2006 & 2007	2006 & 2007 GEE/iLEAP (70%), 2007 Graduation Index (30%)	Performance Label, SI Status, SPS AYP for 2007; Growth Target and Goal for 2008 (refer to I.5.a. above)

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:10.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2737 (December 2003), amended LR 31:1512 (July 2005), LR 32:1017 (June 2006), LR 32:

§303. Calculating the SPS Component

A. - I. ...

J. Beginning with the 2007 baseline SPS, a combination school (a school with a grade configuration that includes a combination from both categories of schools, K-8 and 9-12,) will receive a score from a weighted average of the SPS from the K-8 grades and the SPS from the 9-12 grades.

1. The K-8 SPS will be weighted by the number of students eligible to test during the spring test administration.

2. The 9-12 SPS will be weighted by the sum of:

a. the students eligible to test during the spring test administration; and

b. the number of members of the cohort used as the denominator in the graduation index calculation.

K. For combination schools in 2006, for the baseline SPS only, the 3 accountability indicators shall be combined as follows.

1. The K-8 Assessment Index and the 9-12 Assessment Index shall be combined using a weighted average based on testing units.

2. Attendance and Dropout Indices shall be combined as defined in §511 and §513.

3. The 2007 growth SPS shall be calculated using the same procedures as the 2006 baseline SPS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:10.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2738 (December 2003), amended LR 31:763 (April 2004), LR 32:1020 (June 2006), LR 32:

Family Impact Statement

In accordance with Section 953 and 974 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal or amendment. All Family Impact Statements shall be kept on file in the state board office, which has adopted,

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 111—The Louisiana School, District, and State Accountability System—School Performance Score Goal and Disaster Considerations for the School and District Subgroup Component (LAC 28:LXXXIII.301 and 4527)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 111—The Louisiana School, District, and State Accountability System* (LAC 28, Part Number LXXXIII). The proposed changes occur in §§301 and 4527. The purpose of these revisions is to adjust accountability policy to more effectively address conditions created by the hurricanes of 2005 and the implementation of a new testing program. The revisions made to §301 require a preliminary accountability release during 2006. As proposed, the preliminary accountability release will only include the subgroup component and only for those schools that failed the subgroup component in 2005. Implications for schools identified for school improvement are also detailed. The proposed revision to §4527 adjusts the threshold at which schools could qualify for a waiver offered by the USDE in the wake of the hurricanes of 2005. This change is based upon feedback Louisiana Department of Education staff has received from USDE officials.

Title 28

EDUCATION

Part LXXXIII. Bulletin 111—The Louisiana School, District, and State Accountability System

Chapter 3. School Performance Score Component §301. School Performance Score Goal

A. - D. ...

E. Beginning in 2004, preliminary accountability results issued each summer shall include both preliminary school performance scores and subgroup component analyses for those schools on the academic watch list, or in school Improvement 2 or higher, or who have failed the subgroup component the prior year. Beginning in 2007, preliminary accountability results each summer shall include any schools determined to be entering into or remaining in School Improvement 2 or higher, exiting School Improvement 2 or higher, and who have failed the Subgroup Component the prior year. Final accountability results shall be issued during the fall semester of each year.

1. In 2006, the preliminary accountability results shall include only the subgroup component (calculated using LEAP/GEE scores only) and only for those schools that failed the subgroup component in 2005.

a. Schools identified as entering SI2 as a result of their second year of subgroup component failure must offer school choice prior to the first day of school of the 2006-07 academic year.

amended, or repealed a rule in accordance with the applicable provisions of the law relating to public records.

1. Will the proposed Rule affect the stability of the family? No.

2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.

3. Will the proposed Rule affect the functioning of the family? No.

4. Will the proposed Rule affect family earnings and family budget? No.

5. Will the proposed Rule affect the behavior and personal responsibility of children? No.

6. Is the family or a local government able to perform the function as contained in the proposed Rule? No.

Interested persons may submit comments until 4:30 p.m., September 8, 2006, to Nina Ford, State Board of Elementary and Secondary Education, P. O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Weegie Peabody
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Bulletin 111—The Louisiana School, District and State Accountability System

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no estimated implementation costs (savings) to state governmental units. The proposed changes define/outline/clarify the following: The table in §301-L was revised to reflect the use of two years of data as is defined in the text of the policy. The edits to §303-J and K allow School Performance Scores to be calculated very much as they have been in the past until the Graduation Index is implemented in 2007. Both revisions should allow a more efficient transition to the new system that includes iLEAP and a Graduation Index.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There will be no estimated costs and/or economic benefits to persons or non-governmental groups directly affected.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on competition and employment.

Marlyn J. Langley
Deputy Superintendent
Management and Finance
0607#048

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

b. School Improvement status from the fall release of the 2005 final accountability results shall continue to apply through the first semester of academic year 2006-2007.

c. Schools identified as entering SI2 at the release of the 2006 final accountability results must offer school choice beginning in January and continuing for the remainder of the academic year.

F. - L. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:10.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2737 (December 2003), amended LR 31:1512 (July 2005), LR 32:1017 (June 2006), LR 32:

Chapter 45. Disaster Considerations for School and District Accountability

§4527. Disaster Considerations for the School and District Subgroup Component

A. Schools and districts shall receive a one year exclusion from the subgroup component in accountability if they:

1. reside within the boundaries of parishes declared natural disaster areas by the President of the United States; and

2. were closed due to the declared disaster for 18 consecutive school days.

B. Any school or district with displaced students comprising 10 percent or more of its eligible Subgroup Component testing population on the days of testing in a given academic year, and that fails the Subgroup Component, shall receive a one year exclusion from accountability decisions (refer to §3103) based on the Subgroup Component during the academic year in which the disaster occurred.

C. Any school or district that fails the subgroup component because of the failure of any subgroup that includes displaced students shall be re-evaluated with the displaced students comprising a separate subgroup and excluded from all other subgroups.

1. If, after re-evaluation, no subgroups fail or only the displaced students subgroup fails the subgroup component, the school or district shall:

a. submit a plan for approval to the LDE addressing the needs of displaced students; and

b. implement the plan after receiving LDE approval.

2. The school or district shall not be labeled as failing subgroup AYP, nor enter or advance in school improvement.

3. Schools or districts that, at the beginning of the following academic year, enroll fewer than 50 percent of the students who comprised the displaced students subgroup may request a one year exclusion from the subgroup component.

4. The displaced students shall not be considered a separate subgroup the following academic year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:10.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

Family Impact Statement

In accordance with Section 953 and 974 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal or amendment. All Family Impact Statements shall be kept on file in the State Board Office, which has adopted, amended, or repealed a rule in accordance with the applicable provisions of the law relating to public records.

1. Will the proposed Rule affect the stability of the family? No.

2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.

3. Will the proposed Rule affect the functioning of the family? No.

4. Will the proposed Rule affect family earnings and family budget? No.

5. Will the proposed Rule affect the behavior and personal responsibility of children? No.

6. Is the family or a local government able to perform the function as contained in the proposed Rule? No.

Interested persons may submit comments until 4:30 p.m., September 8, 2006, to: Nina Ford, State Board of Elementary and Secondary Education, P. O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Weegie Peabody
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Bulletin 111—The Louisiana School, District, and State Accountability System—School Performance Score Goal and Disaster Considerations for the School and District Subgroup Component

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no estimated implementation costs (savings) to state governmental units. The proposed changes occur in Section 301 and Section 4527. The purpose of these revisions is to adjust accountability policy to meet conditions created by the hurricanes of 2005 and the implementation of a new testing program. The revisions made to Section 301 require a Preliminary Accountability release during 2006. As proposed, the preliminary accountability release will only include the subgroup component and only for those schools that failed the subgroup component in 2005. Implications for schools identified for school improvement are also detailed. The proposed revision to Section 4527 adjusts the threshold at which schools could qualify for a waiver offered by the United States Department of Education (USDE) in the wake of the hurricanes of 2005. This change is based upon feedback received from USDE officials.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There will be no estimated costs and/or economic benefits to persons or non-governmental groups directly affected.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)

There will be no effect on competition and employment.

Marlyn Langley
Deputy Superintendent
Management and Finance
0607#046

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 123—Adult Education Content Standards
(LAC 28:CXXIX.Chapters 1-11)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement *Bulletin 123—Adult Education Content Standards*. Bulletin 123 will be printed in codified format as LAC 28, Part CXXIX of the Louisiana Administrative Code. The Louisiana Adult Education Content Standards have been developed to raise accountability levels among adult education programs and ensure that similar concepts are taught at appropriate educational levels throughout the state. The intent of the content standards is to provide a resource that will ease the process of developing curriculum frameworks and planning instruction for adult educators throughout Louisiana in both Adult Basic Education (ABE) and Adult Secondary Education (ASE) class settings. The Louisiana Adult Education Content Standards were developed based upon a directive from the U.S. Department of Education, Office of Vocational and Adult Education. The standards will assist the state in complying with the requirements of the Workforce Investment Act of 1998.

**Title 28
EDUCATION**

Part CXXIX. Bulletin 123—Adult Education Content Standards

Chapter 1. General Provisions

§101. Introduction

A. The Workforce Investment Act of 1998, Title II, authorizes adult education in Louisiana. The Adult Education program provides instruction to adults who are 16 years of age and older, not enrolled in the K-12 system, and have less than a high school education. The purposes of adult education programs are to assist adults to:

1. become literate;
2. obtain knowledge and skills for employment and self-sufficiency;
3. obtain the educational skills necessary to become full partners in their children's educational development; or
4. complete their secondary school education.

B. The standards were designed to raise accountability levels among adult education programs and ensure that similar concepts are taught at an educational functioning level throughout the state. The intent of the content standards document is to provide a tool that will ease the processes of developing curriculum frameworks and planning instruction for adult educators throughout Louisiana.

C. The Louisiana Adult Education Content Standards may be used by programs in providing Adult Basic Education (ABE) and Adult Secondary Education (ASE)

instruction to adults. These educational functioning levels (EFLs) of adults were considered in developing the standards. The current educational functioning levels, as approved by the National Reporting System for Adult Education, include:

1. Adult Basic Education

Educational Functioning Level	Grade Level Equivalent
Beginning ABE Literacy	0 to 1.9
Beginning Basic Education	2 to 3.9
Low-Intermediate Basic Education	4 to 5.9
High-Intermediate Basic Education	6 to 8.9

2. Adult Secondary Education

Educational Functioning Level	Grade Level Equivalent
Low Adult Secondary Education	9 to 10.9
High Adult Secondary Education	11 to 12.9

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§103. Content Standards Foundation Skills*

A. The following foundation skills have been identified as essential competencies needed to meet the demands of the classroom and the world beyond. These skills apply to all students in all disciplines. These foundation skills were used throughout the development of the Louisiana Adult Education Content Standards and are embedded throughout the standards.

1. Communication. Communication is a process by which information is exchanged and a concept of "meaning" is being created and shared between individuals through a common system of symbols, signs, or behavior. Students should be able to communicate clearly, fluently, strategically, technologically, critically, and creatively in society and in a variety of workplaces. This process can best be accomplished through use of the following skills:

- a. reading;
- b. writing;
- c. speaking;
- d. listening;
- e. viewing; and
- f. visually representing.

2. Problem Solving. Problem solving is the identifying of an obstacle or challenge and the application of knowledge and thinking processes which include reasoning, decision making, and inquiry in order to reach a solution using multiple pathways, even when no routine path is apparent.

3. Resource Access and Utilization. Resource access and utilization is the process of identifying, locating, selecting, and using resource tools to help in analyzing, synthesizing, and communicating information. The identification and employment of appropriate tools, techniques, and technologies are essential to all learning processes. These resource tools include:

- a. pen;
- b. pencil;
- c. paper;
- d. audio/video material;

- e. word processors;
- f. computers;
- g. interactive devices;
- h. telecommunication; and
- i. other emerging technologies.

4. **Linking and Generating Knowledge.** This is the effective use of cognitive processes to generate and link knowledge across the disciplines and in a variety of contexts. In order to engage in the principles of continual improvement, students must be able to transfer and elaborate on these processes. *Transfer* refers to the ability to apply a strategy or content knowledge effectively in a setting or context other than that in which it was originally learned. *Elaboration* refers to monitoring, adjusting, and expanding strategies into other contexts.

5. **Citizenship.** Citizenship involves the application of the understanding of the ideals, rights, and responsibilities of active participation in a democratic republic that includes:

- a. working respectfully and productively together for the benefit of the individual and the community;
- b. being accountable for one's choices and actions and understanding their impact on oneself and others;
- c. knowing one's civil, constitutional, and statutory rights; and
- d. mentoring others to be productive citizens and lifelong learners.

*Developed by the Louisiana Department of Education, Louisiana Content Standards and Assessment Development Project, 1997.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§105. Interpreting and Using the Adult Education Content Standards

A. This §105 provides definitions for standards-related terms used throughout this Part CXXIX. Following is a hierarchy of the standards-related terms used in this Part.

1. *Strand*—the subject area that is to be taught. There are five strands incorporated in the Louisiana Adult Education Content Standards. The strands include:

- a. language arts—reading;
- b. language arts—writing;
- c. mathematics;
- d. science; and
- e. social studies.

Strand Example: *Social Studies*

2. *Standard*—the overall goal, end result of a learning experience.

- a. A *standard* determines the purpose, aim and rationale of class instruction.
- b. A *standard* is often not immediately measurable; rather, it sets the framework by preparing students for future activities and further knowledge acquisition.
- c. A *standard* expresses a purpose for instruction but does not designate the specific abilities that the learner must possess.

Standard Example: Adult learners use and apply social studies concepts in a variety of situations.

3. *Benchmark*—supports the standard. It defines what a learner must know and be able to do in the lesson. A *benchmark* is brief and written to the point so that it is easy to understand and may be achieved over a well defined time period.

Benchmark Example: Adult learners apply the behavioral science concepts of psychology, sociology and anthropology to personal and community situations.

Describe different family structures and role of moods, emotions, and relationships in a family.

Define bias, prejudice and personal values, and give examples of each.

Explain and give examples of social stratification, race, ethnicity and gender and their effect on individual beliefs, attitudes, and behavior.

Describe the impact of values, and beliefs on specific group behaviors.

Describe selected group values and beliefs and how they influence society.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

Chapter 3. English Language Arts—Reading §301. Standard

A. Adult learners develop and apply reading strategies for the understanding of written material for different purposes.

B. The four components of teaching reading to adult learners include alphabetic (phonemic awareness and word analysis), fluency, vocabulary, and comprehension. The range for introducing, instructing, reinforcing, and mastering each of the four components is:

- 1. Alphabetic—Beginning Literacy to Beginning Basic (0 to 3.9);
- 2. Fluency—Beginning Basic to High Intermediate (2.0 to 8.9);
- 3. Vocabulary—Beginning Basic to High Adult Secondary (2.0 to 12.9);
- 4. Comprehension—Beginning Basic to High Adult Secondary (2.0 to 12.9).

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§303. Benchmark 1—Phonemic Awareness and Word Analysis

A. Adult learners apply phonemic awareness and word analysis skills to make connections between written letters and sounds.

1. Mastery should be evidenced upon completion of the Beginning Basic (2.0-3.9).

B. Phonemic Awareness

1. Apply phonemic awareness skills:

- a. isolation;
- b. identity (written and oral letter recognition);
- c. categorization;
- d. blending;
- e. segmentation;
- f. deletion;
- g. addition;
- h. substitution;
- i. syllabication.

C. Word Analysis

- 1. Apply word analysis (phonetic awareness) skills:
 - a. context clues (i.e., picture clues and sentence clues);
 - b. basic sight words;
 - c. spelling patterns and rules;
 - d. meaning of root words, suffixes and prefixes;
 - e. decoding of unfamiliar or new words.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§305. Benchmark 2—Fluency

A. Adult learners apply fast and accurate decoding skills to read with the proper rhythm, intonation, and expression in order to increase comprehension.

1. Mastery should be evidenced by completion of High Intermediate (6.0-8.9).

a. Group words appropriately into meaningful grammatical units for interpretation.

b. Use punctuation to determine where to place emphasis or pause in order to make sense from written print and non-print text during oral reading.

c. Apply context clues to interpret written print and non-print text.

d. Read at an appropriate pace based upon the level of materials and the purpose for reading.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§307. Benchmark 3—Vocabulary

A. Adult learners apply spoken, oral and written vocabulary skills in order to comprehend and communicate in a variety of contexts.

1. Vocabulary is a skill that is developed through a continuous process at all educational functioning levels.

a. Use context clues to derive meanings of words from spoken, oral, written print and non-print text.

b. Apply the meaning of root words, suffixes and prefixes to derive meaning from new and unfamiliar vocabulary words from a variety of print and non-print texts.

c. Recognize the meaning of word origins (i.e., Greek, Anglo-Saxon, Latin) to understand content area vocabulary words.

d. Recognize basic word patterns, antonyms, and synonyms.

e. Identify and use idioms and the literal and figurative meanings of words in spoken, oral and written language.

f. Identify multiple meanings of words, denotative and connotative meanings of words, and multiple meanings of related words.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§309. Benchmark 4—Comprehension

A. Adult learners apply reading skills (Alphabetics, Fluency, Vocabulary) and strategies to interpret meaning from spoken, oral and written language in a variety of contexts.

1. Comprehension is a skill that is improved through a continuous process at all educational functioning levels.

a. Construct meaning from spoken, oral and written communication:

i. use the conventions of print (read from left to right directionality, from top to bottom, one-to-one matching, sentence framing);

ii. recognize the general structure of sentences and paragraphs;

iii. identify error detection while reading;

iv. locate information from print and non-print text, recalling information, and using information effectively;

v. listening comprehension;

vi. use skimming and scanning strategies.

b. Apply information and ideas from a passage:

i. organize thoughts and ideas according to order and sequence;

ii. summarize;

iii. retell;

iv. generate questions about print and non-print text;

v. state the main idea and supporting details;

vi. read and interpret charts and graphs.

c. Analyze content, style, and structure:

i. make inferences from print and non-print text;

ii. state points of view;

iii. state the author's purpose of print and non-print text;

iv. recognize the literary structure (i.e., cause and effect, compare and contrast, fact and opinion);

v. recognize and describe story elements (i.e., setting, plot, character, theme, point of view, beginnings, middles, endings);

vi. interpret figurative language;

vii. make predictions from print and non-print text.

d. Develop connections between separate sources of information:

i. write about print and non-print text;

ii. integrate information from long print and non-print text;

iii. make predictions from print and non-print text;

iv. describe multiple inferences from an entire passage;

v. integrate information from outside the passage (i.e., life experiences) to reach a new understanding.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

Chapter 5. English Language Arts—Writing

§501. Standard

A. Adult learners write competently using Standard American English for a variety of purposes and audiences.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§503. Benchmark 1—Spelling, Punctuation, and Capitalization

A. Adult learners apply correct spelling, punctuation, and capitalization rules to complete a variety of writing tasks in accordance with the learner's identified educational functional level.

1. Write (print and cursive) upper and lower-case letters of the alphabet.

2. Write and spell words correctly.

3. Apply capitalization rules.

4. Apply punctuation rules to all written text:

a. terminal punctuation;

b. commas;

c. colons and semi-colons;

- d. apostrophes;
 - e. quotation marks.
5. Use a variety of resources to spell unfamiliar words.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§505. Benchmark 2—Grammar, Usage and Conventions of Sentence Structure

A. Adult learners identify and apply correct grammar and usage rules and the conventions of sentence structure to complete a variety of writing tasks in accordance with their identified educational functional level.

1. Identify and use basic parts of speech:
 - a. verbs;
 - b. nouns;
 - c. pronouns;
 - d. adjectives;
 - e. adverbs;
 - f. conjunctions;
 - g. prepositions; and
 - h. interjections.
2. Identify subject and predicate in sentences.
3. Apply standard grammar and usage to subject and verb agreement, simple past, present, and future continuous verb tense.
4. Identify and correct sentence fragments and run-on sentences.
5. Recognize the standard use of homonyms, homophones, and homographs.
6. Use a thesaurus.
7. Apply standard grammar and usage.
 - a. Combine simple sentences into compound and complex sentences.
 - b. Construct conditional clauses.
 - c. Develop parallel structures.
 - d. Use modifiers appropriately.
 - e. Use compound verbs appropriately.
 - f. Create possessive forms of nouns or pronouns with gerunds.
 - g. Use conjunctive adverbs appropriately.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§507. Benchmark 3—Writing Process

A. Adult learners apply writing skills to complete a variety of practical writing tasks in accordance with their identified educational functional level.

1. Apply pre-writing tools to generate topics and/or plan writing tasks (e.g., brainstorming, clustering, outlining, listing, webbing).
2. Write a dialogue of sentences that uses descriptive words and phrases to develop ideas and advance characters.
3. Develop a paragraph on a topic of the learner's own choosing that includes a topic sentence followed by supporting details.
4. Write an essay/composition (i.e., expository, descriptive, persuasive, narrative, comparative) on a given topic that includes a well-developed thesis.

5. Write a letter for a variety of purposes that includes a heading, salutation, and closing.

6. Revise written work by identifying and correcting:
 - a. spelling;
 - b. punctuation;
 - c. capitalization;
 - d. sentence fragments;
 - e. run-on sentences; and
 - f. grammar and usage errors.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

Chapter 7. Mathematics

§701. Standard

A. Adult learners apply reasoning and problem-solving techniques, use numerical intuition to verify solutions, and make connections with life situations for communication of math ideas.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§703. Benchmark 1—Number Sense

A. Adult learners develop and apply number sense to solve a variety of real-life problems and to determine if the results are reasonable.

1. Read, write, and orally express whole numbers as numerals and number words between 0 and 1,000,000.
2. Read, write, and locate whole numbers and fractions on a number line between 0 and 1,000.
3. Round whole numbers to a given place.
4. Round decimals to tenths, hundredths, and thousandths place.
5. Read, write, and orally express a decimal as a part of a whole, expressed in tenths, hundredths, thousandths, etc.
6. Read, write and express a fraction as the relationship between the part (numerator) and the whole (denominator).
7. Read, write and express numbers in their equivalent fractional, decimal, and percent form (e.g., $1/2 = 3/6 = 2/4$, and $0.5 = 50$ percent).
8. Read, write, and order integers.
9. Match whole numbers and fractions (e.g., $1/2$, $1/3$, $1/4$) to pictorial representations and identify these as commonly used fractions.
10. Identify coins and currency and recognize money (e.g., \$ and ¢) symbols.
11. Identify and construct equal relationships of coins and currency (e.g., a quarter equals 2 dimes and 1 nickel).
12. Make change using pennies, nickels, dimes, quarters, half-dollars, and bills up to \$100.
13. Add, subtract, multiply and divide by one, two, three, and four digit numbers.
14. Add, subtract, multiply and divide fractions, decimals, and percents.
15. Use computation and estimation to solve problems involving integers, exponents, and square roots.
16. Use estimation to check the reasonableness of results in word problems with calculator situation.
17. Solve multi-step word problems using whole numbers.

18. Solve word problems involving whole numbers, fractions, decimals, and percents.

19. Represent numbers in various ways:

- a. prime factors;
- b. square roots;
- c. exponents;
- d. absolute value; and
- e. scientific notation.

20. Use estimation to check the reasonableness of results using whole numbers, fractions, decimals, and percents in solving problems.

21. Solve and simplify expressions using order of operations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§705. Benchmark 2—Data Analysis

A. Adult learners apply data collection, data analysis, and probability to interpret, predict, and/or solve real-life problems.

1. Gather data familiar to themselves and their surroundings.

2. Sort, classify, and organize data about objects.

3. Represent data using concrete objects.

4. Represent data using tables and graphs such as:

- a. line graphs;
- b. bar graphs;
- c. circle graphs; or
- d. pictorial graphs and maps.

5. Analyze tables, charts, graphs, diagrams, and maps.

6. Apply basic concepts of probability.

7. Create tables, charts, and diagrams using spreadsheets or other technology.

8. Calculate and interpret the mean, median, mode, and range of a data set.

9. Use data collection, data analysis, and probability to solve word problems.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§707. Benchmark 3—Algebra

A. Adult learners apply algebraic concepts and methods to explore, analyze or solve real-life problems.

1. Describe and extend a variety of patterns using manipulative or objects.

2. Describe and extend numerical patterns (e.g., 2, 4, 6, 8).

3. Identify the missing element in a number sentence involving:

- a. addition;
- b. subtraction;
- c. multiplication; and/or
- d. division with whole numbers.

4. Identify algebraic concepts such as:

- a. variable;
- b. constant;
- c. term;
- d. expression;
- e. equation; and
- f. inequality.

5. Solve one variable linear equation or inequality with one operation. Use substitution to check the answer.

6. Solve one variable linear equation with two or more operations. Use substitution to check the answer.

7. Solve word problems using one and two-step linear equations.

8. Solve proportion problems using algebraic methods.

9. Determine slope and intercept of a linear equation.

10. Create a table of values that satisfy a linear equation.

11. Create a graph using a table of values from a solved equation.

12. Use formulas to solve problems.

13. Write and solve equivalent forms of equations, inequalities, and systems of equations using:

- a. mental math;
- b. paper and pencil; or
- c. technology (e.g., calculator or computer).

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§709. Benchmark 4—Geometry

A. Adult learners use geometric properties, relationships, and methods to identify, analyze and solve real-life problems.

1. Identify basic geometric shapes.

2. Describe basic geometric shapes by naming, building, drawing, comparing, and sorting two and three-dimensional shapes, i.e.,:

- a. cube;
- b. cylinder;
- c. prism;
- d. square;
- e. rhombus;
- f. hexagon;
- g. sphere.

3. Graph ordered pairs on rectangular coordinate plane.

4. Classify angles as right, acute, obtuse, straight, or reflex.

5. Describe geometric figures, e.g.,:

- a. symmetric;
- b. perpendicular;
- c. parallel.

6. Compare geometric figures using similarity or congruency.

7. Solve problems involving alternate interior, corresponding, complementary, or supplementary angles.

8. Classify triangles by their angles and sides as:

- a. equilateral;
- b. isosceles;
- c. scalene;
- d. acute;
- e. obtuse; and
- f. right.

9. Label and identify the characteristics, (i.e., radius, diameter, base, height) of a:

- a. circle;
- b. cylinder;
- c. parallelogram;
- d. pentagon;

- e. hexagon;
- f. octagon;
- g. decagon;
- h. rhombus;
- i. trapezoid;
- j. cube;
- k. sphere; or
- l. prism.

10. Use the appropriate geometric formula (i.e., area, perimeter, volume, Pythagorean relationship, distance between two points in a plane) to solve problems.

11. Solve problems using similarity and proportion.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§711. Benchmark 5—Measurement

A. Adult learners apply knowledge of standard measurements to real-life situations.

1. Recognize the attributes of length, volume, weight, area, and time.

2. Measure using non-standard (e.g., string, paper clip, toothpicks) and standard (i.e., U.S. Customary and metric system) units.

3. Use common references (e.g., pitcher, paper clip, string) for measurements to make comparisons and estimates.

4. Recognize that units of measurements or approximations can affect differences in precision.

5. Select an appropriate unit and tool to measure an object or event, i.e.,:

- a. ruler;
- b. thermometer;
- c. measuring cup;
- d. scale; and
- e. stop watch.

6. Identify the appropriate U.S. customary units of measurement for an object or event, i.e.,:

- a. length;
- b. capacity;
- c. weight;
- d. area;
- e. volume;
- f. time; and
- g. temperature.

7. Solve real-life problems involving measurement using U.S. customary units.

8. Identify the appropriate metric units of measurement for an object or event, i.e.,:

- a. length;
- b. capacity;
- c. weight;
- d. area;
- e. volume;
- f. time; and
- g. temperature.

9. Solve real-life problems involving measurement using metric units.

10. Apply the appropriate tools and standard units to measure an object or event, i.e.,:

- a. length;
- b. capacity;
- c. weight;

- d. area;
- e. volume;
- f. time; and
- g. temperature.

11. Use appropriate tools and standard units to measure geometric figures, i.e.,:

- a. angles;
- b. circles;
- c. triangles;
- d. squares.

12. Convert measurements to equivalent units within a given system (i.e., U.S. customary or metric system).

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

Chapter 9. Science

§901. Standard

A. Adult learners understand the key concepts and principles of science and use this scientific knowledge and scientific ways of thinking for individual and social purposes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§903. Benchmark 1—History and Nature of Science

A. Adult learners understand the history and nature of science and illustrate different aspects of scientific inquiry and the human aspects of science.

- 1. Develop the ability to engage in scientific inquiry.
- 2. Develop an understanding of the nature of scientific knowledge.
- 3. Develop an understanding of the history of science.
- 4. Recognize the relationship between science and technology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§905. Benchmark 2—Physical Science

A. Adult learners recognize the characteristics and interrelationships of matter and energy in the physical world.

1. Identify the different states of matter, recognizes that matter can be made of one or more materials, and that it can change and exist in one or more states.

- 2. Identify and describe physical properties of objects.
- 3. Identify and describe structure of atoms.
- 4. Identify and describe chemical reactions.
- 5. Identify and describe conservation of energy and matter.

6. Recognize the characteristics of forces and motion and evaluate their interaction.

7. Identify how energy is a property of many substances, occurs in many forms (e.g., heat, light, and electricity), and can be transferred in many ways.

8. Identify and describe interactions of energy and matter.

9. Interpret visual representations in science (e.g., diagrams, formulas).

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§907. Benchmark 3—Life Science

A. Adult learners recognize the characteristics of living organisms, understand their relationship to each other and to their environment, and interpret related scientific data.

1. Recognize the characteristics and basic needs of living things.
2. Recognize and describe the differences between living and non-living things.
3. Describe life cycles.
4. Identify the various systems and functions of the human body.
5. Compare organisms to their environment, e.g.,:
 - a. predator/prey;
 - b. parasite/host;
 - c. food chains; and
 - d. webs.
6. Identify the basic characteristics of the cell.
7. Identify factors affecting heredity.
8. Recognize behavior of organisms.
9. Explore experimental evidence that supports the theory of the origin of life.
10. Interpret visual representations in science (e.g., diagrams, formulas).

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§909. Benchmark 4—Earth and Space Science

A. Adult learners develop an understanding of the composition, processes, and interrelationships of Earth, the solar system, and the universe.

1. Identify the structure and composition of the Earth system.
2. Explain the Earth's relationship to other bodies in the solar system.
3. Recognize evidence for evolution.
4. Describe the energy in the Earth's system.
5. Describe geochemical cycles.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§911. Benchmark 5—Science and Society

A. Adult learners develop an understanding of the importance of environmental quality in the world.

1. Identify ecological systems and their interactions (e.g., air, water, plants).
2. Describe how resources and resource management affect the environment.
3. Recognize the relationships between environmental protection and maintaining quality of life.
4. Recognize how personal choices and responsible actions impact the environment, e.g.,:
 - a. litter;
 - b. irrigation;
 - c. levees; and
 - d. offshore drilling.
5. Recognize personal and community health.
6. Recognize population growth.
7. Recognize risk and benefits.
8. Interpret visual representations of scientific data (i.e., diagrams, charts, and tables).

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

Chapter 11. Social Studies

§1101. Standard

A. Adult learners use and apply social studies concepts in a variety of situations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§1103. Benchmark 1—Behavioral Sciences

A. Adult learners apply the behavioral science concepts of psychology, sociology and anthropology to personal and community situations.

1. Describe different family structures and role of moods, emotions, and relationships in a family.
2. Define *bias*, *prejudice* and *personal values*, and give examples of each.
3. Explain and give examples of social stratification, race, ethnicity and gender and their affect on individual beliefs, attitudes, and behavior.
4. Describe the impact of values, and beliefs on specific group behaviors.
5. Describe selected group values and beliefs and how they influence society.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§1105. Benchmark 2—Economics

A. Adult learners employ basic economic concepts, evaluate problems, and make rational choices as a consumer, worker, and citizen.

1. Recognize that individuals and families with limited resources make economic choices.
2. Define and apply the concept of choice by balancing cost with benefits.
3. Recognize and explain the relationship between producers and consumers (supply and demand).
4. Understand that prices in a market economy are determined by the interaction of supply and demand.
5. Use concepts of money management, e.g., :
 - a. interest;
 - b. credit;
 - c. savings;
 - d. investment;
 - e. budget; and
 - f. debt.
6. Recognize and explain the role of banks and other financial institutions in the economy.
7. Recognize that consumers and producers make economic choices based on supply, demand, access to markets and actions of government.
8. Recognize how international trade links countries around the world.
9. Recognize how nations specialize and become interdependent through trade.
10. Recognize and describe how government policies create free or restricted trade.

11. Use tables, graphs, diagrams, and charts of economic information to explain economic trends and patterns at the local level.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§1107. Benchmark 3—Geography

A. Adult learners demonstrate the use of geographic tools to locate and analyze information about people, places and environments.

1. Define and demonstrate knowledge of directions in their local community and state, as well as, on a world map and globe.

2. Draw simple maps to give directions.

3. Recite address including:

- a. city;
- b. state;
- c. zip code;
- d. parish; and
- e. country.

4. Recognize that maps and globes represent different views of the world.

5. Describe and define natural features such as:

- a. landforms;
- b. bodies of water;
- c. mountains;
- d. deserts; and
- e. natural resources.

6. Locate positions on a map or globe.

7. Interpret and use a map key.

8. Describe the characteristics of maps.

9. Interpret maps, charts, graphs and other geographic information.

10. Define and use longitude and latitude to locate positions on a map or globe.

11. Recognize and locate specific land masses and bodies of water.

12. Describe how people depend on the physical environment and its natural resources to satisfy basic needs.

13. Describe how people can conserve their natural and man-made resources.

14. Describe the purposes of, and differences among, maps, and how maps are both similar to and different from globes and aerial photographs.

15. Describe the cause and effect of selected migrations and world history, as well as, their family's migration history.

16. Describe how people have depended on the physical environment and its natural resources to satisfy their needs and how these needs have an impact on the natural environment.

17. Explain and interpret basic geo-political, population and cultural geography maps, charts, graphs and tables.

18. Describe natural and demographic characteristics of places and use this knowledge to define how regions relate to one another and undergo change.

19. Explain how geographic factors affect human activities.

20. Interpret thematic maps that depict various aspects of the United States and its world trade products, trade routes, and cross-cultural interactions.

21. Identify economic, political, and social patterns that have emerged over the last 50 years.

22. Use geographic knowledge to explain the past, interpret the present, and to anticipate future issues.

23. Explain policies and programs for resource management, including the relationship between environmental quality and economic growth.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§1109. Benchmark 4—History

A. Adult learners develop a historical time and perspective as they study the history of their community, state, nation, and world.

1. Sequence days, months, holidays and personal life events in chronological order.

2. Trace the history of a family (i.e., important events, documents, customs) using primary source materials, i.e.,:

- a. photographs;
- b. artifacts; and
- c. interviews.

3. Describe personal family events from the past your family experienced. Consider cultural changes as well as core values and beliefs.

4. Describe how people lived in earlier centuries then explain how their lives would be different today.

5. Describe examples of honesty, courage, determination, and individual responsibility in United States and world history.

6. Sequence key eras in world history, United States history, and Louisiana history over the last millennium.

7. Describe the positive contributions of selected individuals from world history, United States history and Louisiana history.

8. Describe historical examples of architecture, music, art, religion and sports and how they are viewed in the present.

9. Describe the distinctive economy, symbols, customs and oral traditions of Louisiana.

10. Interpret historical data from graphs, tables, pictures, maps and political cartoons.

11. Recognize and understand the impact of key historical places, events, ideas, decisions, and cultures in United States and world history by describing selected cultures of the ancient and medieval world and identify their contributions to world history.

12. Recognize and understand the impact of historical events, ideas, decisions, and cultures in United States and world history by describing selected events from the fifteenth to the twenty-first century and their impact on world history.

13. Use key documents of United States history to analyze past and present issues.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

§1111. Benchmark 5—Civics

A. Adult learners demonstrate knowledge of the structures, functions and symbols of government and apply these to citizenship.

1. Identify the rights and responsibilities of citizens and gives examples of how citizens use their rights and carry out their responsibilities.
2. Recognize that in order to select effective leaders, citizens have to become informed about candidates' qualifications and the issues they support.
3. Demonstrate how to follow the actions of elected officials and how to communicate with them while in office.
4. Identify the fundamental rights guaranteed in the Bill of Rights and can apply these protections to everyday life.
5. Explain that the United States government is divided into executive, legislative, and judicial branches with specific responsibilities and powers.
6. Demonstrate knowledge of federal, state, and local systems of government by explaining how each system affects their lives.
7. Identify and explain the impact of American democratic idea and actions in selected world events.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:

Family Impact Statement

In accordance with Section 953 and 974 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Family Impact Statement on the Rule proposed for adoption, repeal or amendment. All Family Impact Statements shall be kept on file in the state board office which has adopted, amended, or repealed a rule in accordance with the applicable provisions of the law relating to public records.

1. Will the proposed Rule affect the stability of the family? No.
2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.
3. Will the proposed Rule affect the functioning of the family? No.
4. Will the proposed Rule affect family earnings and family budget? No.
5. Will the proposed Rule affect the behavior and personal responsibility of children? No.
6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Interested persons may submit written comments until 4:30 p.m., September 8, 2006, to Nina A. Ford, Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Weegie Peabody
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Bulletin 123 Adult Education Content Standards

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
The estimated costs to implement Bulletin 123: Adult Education Content Standards will be approximately \$1000,

- which includes printing costs so that the bulletin may be distributed to local adult education programs.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There are no estimated effects on revenue collections for state or local governmental units.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There are no estimated costs and/or economic benefits that will directly affect persons or non-governmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
The Louisiana Adult Education Content Standards will provide a framework for planning instruction in the adult education classroom, which is funded under the Workforce Investment Act of 1998. The aforementioned framework is designed to increase the quality of instruction in the adult education classroom which offers programs to strengthen the skills of the state's workforce.

Marlyn Langley
Deputy Superintendent
Management and Finance
0607#045

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 1196—Louisiana Food and Nutrition Programs,
Policies of Operation—Foodservice Management Company
Contracts (LAC 28:XLIX.111)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 1196—Louisiana Food and Nutrition Programs, Policies of Operation* (LAC 28:XLIX). Bulletin 1196 is the policy manual designed to provide useful guidance and information for the purpose of improving regulatory compliance and to enhance the understanding and operation of the Child Nutrition Programs in Louisiana. This bulletin was developed as a result of the necessity to incorporate all federal and state policy changes which have already been implemented by the sponsors. This revision is an update of state policies.

Title 28 EDUCATION

Part XLIX. Bulletin 1196—Louisiana Food and Nutrition Programs, Policies of Operation Chapter 1. Administration §111. Permanent Agreement between Sponsor and Louisiana State Department of Education

- A. - B. ...
- C. Conditions of the Agreement
 1. - 26.a. ...
 27. Foodservice Management Company Contracts
 - a. School food authorities eligible to contract with a for profit entity must use the state approved prototype Food Service Management Company (FSMC) contract if Child Nutrition Program funds are to be used.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:191-199.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 27:2102 (December 2001), amended LR 29:2022 (October 2003), LR 32:

Family Impact Statement

1. Will the proposed Rule affect the stability of the family? No.
2. Will the proposed Rule affect the authority and rights of parents regarding the education and supervision of their children? No.
3. Will the proposed Rule affect the functioning of the family? No.
4. Will the proposed Rule affect family earnings and family budget? No.
5. Will the proposed Rule affect the behavior and personal responsibility of children? No.
6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Interested persons may submit comments until 4:30 p.m., September 8, 2006, to Nina Ford, State Board of Elementary and Secondary Education, P. O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Weegie Peabody
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Bulletin 1196—Louisiana Food and
Nutrition Programs, Policies of Operation
Foodservice Management Company Contracts**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There is no estimated costs (savings) to state or local governmental units. This is a revision of Bulletin 1196 which has incorporated all Federal and State policy changes which have already been implemented by the sponsors. There will be no costs due to the fact the Bulletin will be on the Website and can be downloaded.
The State Board of Elementary and Secondary Education estimated cost for printing this policy change and first page of the fiscal and economic impact statement in the Louisiana Register is approximately \$34.00. Funds are currently budgeted for this purpose.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There will be no estimated effect on revenue collection of state or local governmental units.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There will be no costs or economic benefits to directly affect persons or non-governmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
There will be no effect on competition and employment.

Marlyn J. Langley
Deputy Superintendent
Management and Finance
0607#047

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

**Student Financial Assistance Commission
Office of Student Financial Assistance**

Scholarship/Grant Programs
(LAC 28:IV.505, 507, 703 and 1301)

The Louisiana Student Financial Assistance Commission (LASFAC) announces its intention to amend its Scholarship/Grant Rules (R.S. 17:3021-3025, R.S. 3041.10-3041.15, R.S. 17:3042.1, and R.S. 17:3048.1).

The proposed Rule has no known impact on family formation, stability, or autonomy, as described in R.S. 49:972. (SG0672NI)

Title 28

EDUCATION

**Part IV. Student Financial Assistance—Higher
Education Scholarship and Grant Programs
Chapter 5. Application; Application Deadlines, and
Proof of Compliance**

**§505. Application Deadlines for High School
Graduates and Home Study Completers of 2004
and Later and Eligible Non-Graduates**

- A. - A.3.
- B. Deadline to Facilitate Timely Payment
- B.1. - C.1. ...
 2. Returning Students
 - a. Beginning with the 2002-2003 through the 2004-2005 academic year (college), in order for a returning student to receive the full benefits of a TOPS award as provided in §701.E, the final deadline for receipt of a student's initial FAFSA or the on-line application is May 1 of the academic year (college) he first enrolls as a full-time student in an eligible college or university.
 - b. Beginning with the 2005-2006 academic year (college), in order for a returning student to receive the full benefits of a TOPS award as provided in §701.E, the final deadline for receipt of the student's initial FAFSA or the on-line application is the July 1 immediately preceding the academic year (college) he first enrolls as a full-time student in an eligible college or university.
 3. - 3.c. ...
 - d. If a returning student graduates in the 2003-2004 academic year (high school) and will be a first-time student in the fall semester of 2006, the student must submit the initial FAFSA or the on-line application no later than July 1, 2007.
 - C.4. - E. ...
 - F. Renewal FAFSA
 - 1.a. Through the 2004-2005 academic year (college), in order to remain eligible for TOPS awards, a student who is eligible for federal grant aid must file a renewal FAFSA so that it is received by May 1 of each academic year (college) after initial eligibility is established.
 - b. Beginning with the 2005-2006 academic year (college), in order to remain eligible for TOPS awards, a student who is eligible for federal grant aid must file a renewal FAFSA so that it is received by the July 1 immediately preceding each academic year (college) after initial eligibility is established.

2. Students who can demonstrate that they do not qualify for federal grant aid because of their family's financial condition are not required to submit a renewal FAFSA.

3.a. In the event of a budgetary shortfall, applicants who do not file a renewal FAFSA or who do not complete all sections of the FAFSA will be the first denied a TOPS award.

b. Students who can demonstrate that they do not qualify for federal grant aid because of their family's financial condition and do not want to be the first denied a TOPS award must file a renewal FAFSA so that it is received by the July 1 immediately preceding each academic year (college) after initial eligibility is established.

F.4. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:338 (May 1996), repromulgated LR 24:635 (April 1998), amended LR 24:1901 (October 1998), repromulgated LR 27:1847 (November 2001), amended LR 30:2017 (September 2004), LR 31:37 (January 2005), LR 32:

§507. Final Deadline for Submitting Documentation of Eligibility

A. LASFAC will continue to process eligibility for both new and renewal applicants during each award year until July 1 after the spring term of that award year.

B.1. Through the 2004-2005 academic year (college), all documentation and certifications necessary to establish student eligibility including, but not limited to, high school and/or college transcripts and certifications, copies of student aid reports, applicant confirmation forms, promissory notes, ACT and/or SAT scores, residency affidavits, proof of citizenship or permanent residency status and other documents that may be utilized in determining eligibility, must be received by LASFAC no later than May 1 of the award year. For example, to receive an award for the 2004-2005 award year, LASFAC must have in its possession all documents relevant to establishing eligibility by May 1, 2005.

2. Beginning with the 2005-2006 academic year (college), all documentation and certifications necessary to establish student initial eligibility including, but not limited to, high school and/or college transcripts and certifications, copies of student aid reports, applicant confirmation forms, promissory notes, ACT and/or SAT scores, residency affidavits, proof of citizenship or permanent residency status and other documents that may be utilized in determining eligibility, must be received by LASFAC no later than the July 1 immediately following the academic year (college) the student enrolls as a first-time, full-time student in an eligible college or university. For example, to receive an award for the 2006-2007 academic year (college), LASFAC must have in its possession all documents relevant to establishing eligibility by July 1, 2007.

C.1. Returning students, who graduated high school during the 2001-2002 academic years (high school) and who enroll in an eligible college or university in the spring semester 2003, must submit documentation that establishes TOPS eligibility no later than May 1, 2004.

2. Returning students, who enroll in an eligible college or university in the fall semester of 2003 through the

spring semester of 2005, must submit documentation that establishes TOPS eligibility no later than May 1 of the academic year (college) the student enrolls in an eligible college or university. For example, a student who seeks to enroll in an eligible college or university in the fall semester of 2003 must submit documentation that establishes TOPS eligibility no later than May 1, 2004.

3. Returning students, who enroll in an eligible college or university in the fall semester of 2005 or later, must submit documentation that establishes TOPS eligibility no later than July 1 immediately following the academic year (college) the student enrolls as a full-time student in an eligible college or university. For example, a student who seeks to enroll in an eligible college or university in the fall semester of 2006 must submit documentation that establishes TOPS eligibility no later than July 1, 2007.

D.1. A student who successfully completed an undergraduate degree prior to or during the 2001-2002 academic year (college) and wishes to receive his remaining award eligibility to attend a postgraduate school must provide the documentation and certifications required to establish student eligibility no later than May 1, 2004.

2. A student who successfully completes an undergraduate degree during the 2002-2003 through the 2004-2005 academic year (college) and wishes to receive his remaining award eligibility to attend a postgraduate school must provide the documentation and certifications required to establish student eligibility no later than May 1 of the academic year (college) the student seeks to receive his remaining award eligibility. For example, to receive the remaining award for the 2003-2004 academic year (college), the student must submit the required documents no later than May 1, 2004.

3. A student who successfully completes an undergraduate degree during the 2005-2006 academic year (college) or later and wishes to receive his remaining award eligibility to attend a postgraduate school must provide the documentation and certifications required to establish student eligibility no later than the July 1 immediately following the academic year (college) the student seeks to receive his remaining award eligibility. For example, to receive the remaining award for the 2006-2007 academic year (college), the student must submit the required documents no later than July 1, 2007.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:338 (May 1996), repromulgated LR 24:635 (April 1998), amended LR 24:1901 (October 1998), repromulgated LR 27:1847 (November 2001), amended LR 28:447 (March 2002), LR 30:1161 (June 2004), LR 30:1471 (July 2004), LR 30:2019 (September 2004), LR 32:

Chapter 7. Tuition Opportunity Program for Students (TOPS) Opportunity, Performance, and Honors Awards

§703. Establishing Eligibility

A. - A.5.a.i.(d). ...

5.a.ii. for purposes of satisfying the requirements of §703.A.5.a.i., above, or §803.A.6.a., the following courses shall be considered equivalent to the identified core courses and may be substituted to satisfy corresponding core courses.

Core Curriculum Course	Equivalent (Substitute) Course
Physical Science	General Science, Integrated Science
Algebra I	Algebra I, Parts I and 2, Integrated Mathematics I
Applied Algebra IA and IB	Applied Mathematics I and II
Algebra I, Algebra II and Geometry	Integrated Mathematics I, II and III
Algebra II	Integrated Mathematics II
Geometry	Integrated Mathematics III
Geometry, Trigonometry, Calculus, or Comparable Advanced Mathematics	Pre-Calculus, Algebra III, Probability and Statistics, Discrete Mathematics, Applied Mathematics III*, Advanced Mathematics I, Advanced Mathematics II
Chemistry	Chemistry Com
Fine Arts Survey	Speech Debate (2 units)
Western Civilization	European History
Civics	AP American Government
	*Applied Mathematics III was formerly referred to as Applied Geometry

A.5.a.iii. - I.8. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3025, R.S. 17:3042.1 and R.S. 17:3048.1.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance LR 22:338 (May 1996), repromulgated LR 24:636 (April 1998), amended LR 24:1902 (October 1998), LR 24:2237 (December 1998), LR 25:257 (February 1999); LR 25:655 (April 1999), LR 25:1794 (October 1999), LR 26:64, 67 (January 2000), LR 26:689 (April 2000), LR 26:1262 (June 2000), LR 26:1602 (August 2000), LR 26:1996, 1999, 2001 (September 2000), LR 26:2268 (October 2000), LR 26:2753 (December 2000), LR 27:36 (January 2001), LR 27:702 (May 2001), LR 27:1219, 1219 (August 2001), repromulgated LR 27:1850 (November 2001), amended LR 28:772 (April 2002), LR 28:2330, 2332 (November 2002), LR 29:125 (February 2003), LR 29:2372 (November 2003), LR 30:1162 (June 2004), LR 30:1471 (July 2004), LR 30:2019 (September 2004), LR 31:37 (January 2005), LR 31:2213 (September 2005), LR 31:3112 (December 2005), LR 32:

Chapter 13. Leveraging Educational Assistance Partnership (LEAP)

§1301. General Provisions

A. - E. ...

F. Reallocation of Funds. Uncommitted institutional allotted funds are reallocated if not committed by the deadline of November 1 for colleges and universities and campuses of Louisiana Technical College and January 1 for proprietary schools. The method of reallocation is dependent upon the amount of funds available for reallocation. If the reallocation amount is less than \$50,000, then only two- and four-year colleges and universities, which have fully committed their original allotment by the appropriate deadline, receive a reallocation. If \$50,000 or more is available for reallocation, it is reallocated to eligible schools of all types, which have fully committed their original allotment by the appropriate deadline.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:338 (May 1996), repromulgated LR 24:641 (April 1998), amended LR 24:1910 (October 1998), LR 25:1458 (August 1999), repromulgated LR 27:1860 (November 2001), amended LR 28:2332 (November 2002), LR 32:

Interested persons may submit written comments on the proposed changes until 4:30 p.m., August 9, 2006, to Jack L.

Guinn, Executive Director, Office of Student Financial Assistance, P.O. Box 91202, Baton Rouge, LA 70821-9202.

George Badge Eldredge
General Counsel

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Scholarship/Grant Programs

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There are no estimated implementation costs or savings to state or local governmental units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Revenue collections of state and local governments will not be affected by the proposed changes.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There are no estimated effects on economic benefits to directly affected persons or non-governmental groups resulting from these measures.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There are no anticipated effects on competition and employment resulting from these measures.

George Badge Eldredge
General Counsel
0607#009

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Tuition Trust Authority Office of Student Financial Assistance

START Savings Program
(LAC 28:VI.107, 305, 311 and 315)

The Louisiana Tuition Trust Authority announces its intention to amend its START Savings Program (R.S. 17:3091 et seq.) Rules.

The proposed Rule has no known impact on family formation, stability, or autonomy, as described in R.S. 49:972. (ST0674NI)

Title 28 EDUCATION

Part VI. Student Financial Assistance—Higher Education Savings

Chapter 1. General Provisions

§107. Applicable Definitions

Variable Earnings—refers to that portion of funds in an ESA, invested in equities, bonds, short-term fixed income investments or a combination of any of the three.

Variable Earnings Transaction Fund—the subaccount established within the Louisiana Education Tuition and Savings Fund to receive funds as directed by rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:712 (June 1997), amended LR 24:1268 (July 1998), LR 25:1794 (October 1999), LR 26:2260 (October 2000), LR 27:37 (January 2001), LR

27:1222 (August 2001), LR 27:1876 (November 2001), LR 28:450 (March 2002), LR 28:777 (April 2002), LR 28:2334 (November 2002), LR 29:556 (April 2003), LR 30:786 (April 2004), LR 30:1169 (June 2004), LR 30:2302 (October 2004), LR 31:639 (March 2005), LR 32:

Chapter 3. Education Savings Account

§305. Deposits to Education Savings Accounts

A. – E.1. ...

2. Deposits for investment options that include variable earnings will be assigned a trade date based on the method of deposit and the date of receipt.

a. Deposits by check will be assigned a trade date three business days after the business day during which they were received.

b. Deposits made by electronic funds transfer through the Automated Clearing House (ACH) Network, or its successor, will be assigned a trade date of three business days after the business day during which they were received.

c. Deposits made by all other means of electronic funds transfer will be assigned a trade date of one business day after the business day during which they were received.

3. Deposits for investment options that include variable earnings, which are received via check or electronic funds transfer through the Automated Clearing House Network, will be deposited into the fixed earnings option until the trade date. Earnings accrued on these deposits prior to the trade date shall be deposited in the Variable Earnings Transaction Fund.

4. Deposits received on weekends and holidays will be considered received on the next business day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:715 (June 1997), amended LR 24:1270 (July 1998), LR 26:2263 (October 2000), LR 27:1880 (November 2001), LR 30:788 (April 2004), LR 30:1169 (June 2004), LR 30:2302 (October 2004), LR 32:

§311. Termination and Refund of an Education Savings Account

A. - C.2.b. ...

c. the deposits to or the current value of an account invested in a variable earnings option, whichever is less, less earning enhancements allocated to the account and earnings thereon if the account has been open for less than 12 months. Any increase in the value of an account invested in a variable earnings option over the amount deposited shall be forfeited by the account owner and deposited in the Variable Earnings Transaction Fund, if the account was invested in a variable earnings option and terminated within 12 months of the date the account was opened;

C.2.d. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:717 (June 1997), amended LR 24:1273 (July 1998), repromulgated LR 26:2265 (October 2000), amended LR 27:38 (January 2001), LR 27:1882 (November 2001), LR 28:779 (April 2002), LR 30:790 (April 2004), LR 31:639 (March 2005), LR 32:

§315. Miscellaneous Provisions

A. - M.2. ...

3. Earnings reported by the state treasurer on deposits made by check or an ACH transfer, which is not honored by the financial institution on which it was drawn subsequent to

the trade date, shall be forfeited by the account owner and deposited into the Variable Earnings Transaction Fund.

N. - R. ...

S. Variable Earnings Transaction Fund

1. Monies in the Variable Earnings Transaction Fund shall be used to pay any charges assessed to the START Saving Program by a financial institution and any loss of value between the purchase and redemption of units in a variable earnings option that are incurred when a check or ACH transfer is dishonored after the trade date by the financial institution on which it was drawn.

2. After the payment of expenses as provided in Paragraph 1, above, LATTI may declare monies remaining in the Variable Earnings Transaction Fund as surplus. Such surplus shall be appropriated to the Saving Enhancement Fund to be used as earnings enhancements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3091-3099.2.

HISTORICAL NOTE: Promulgated by the Tuition Trust Authority, Office of Student Financial Assistance, LR 23:718 (June 1997), amended LR 24:1274 (July 1998), LR 26:1263 (June 2000), repromulgated LR 26:2267 (October 2000), amended LR 27:1221 (August 2001), LR 27:1884 (November 2001), LR 28:1761 (August 2002), LR 28:2335 (November 2002), LR 29:2038 (October 2003), repromulgated LR 29:2374 (November 2003), amended LR 30:791 (April 2004), LR 30:1472 (July 2004), LR 31:2216 (September 2005), LR 32:

Interested persons may submit written comments on the proposed changes (ST0674NI) until 4:30 p.m., August 9, 2006, to Jack L. Guinn, Executive Director, Office of Student Financial Assistance, P.O. Box 91202, Baton Rouge, LA 70821-9202.

George Badge Eldredge
General Counsel

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: START Savings Program

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Under this change, monies received by ACH Transfer or check for deposit in a START variable earnings investment option will be held for three days before they are invested. Any interest earned on these funds will be used to pay for trading losses due to a dishonored deposit and any surplus will be used to pay for START Earnings Enhancements payments. This will reduce the state's obligation to fund the Earnings Enhancements from State General Fund monies.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The agency self-generated revenues will increase slightly as interest on deposits held for the three-day holding period are earned and placed in the Variable Earnings Transaction Fund.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

It is standard business practice to hold deposits received by check or ACH transfer to allow time for the deposit to clear the depositor's bank. Therefore, the impact on START depositors due to the three-day holding period is considered minimal. In fact, depositors are receiving an increased benefit since the proposed change reduces the current five-day holding period to three days, giving them two additional days of investment.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There are no anticipated effects on competition and employment resulting from these measures.

George Badge Eldredge
General Counsel
0607#008

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Environmental Quality
Office of the Secretary
Legal Affairs Division**

Environmental Quality Regulations—Cleanup Package (LAC 33:I.705 and 909; III.509; V.2299 and 3325; IX.107 and 7107; XI.301; and XV.102 and 399)(OS070)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Environmental Quality regulations, LAC 33:I.705 and 909; III.509; V.2299 and 3325; IX.107 and 7107; XI.301; and XV.102 and 399 (Log #OS070).

Minor changes are being incorporated into LAC 33:Parts I, III, V, IX, XI, and XV. These amendments involve clarification in language and correction of several minor mistakes and omissions. This Rule will address typographical errors, incorrect references, minor mistakes, and inadvertent omissions that have been found in the regulations. The basis and rationale for this proposed Rule are to incorporate necessary corrections into the regulations.

This proposed Rule meets an exception listed in R.S. 30:2019(D)(2) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required. This proposed Rule has no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

Title 33

ENVIRONMENTAL QUALITY

Part I. Office of the Secretary

Subpart 1. Departmental Administrative Procedures

Chapter 7. Penalties

§705. Penalty Determination Method

A. - D. ...

E. The information obtained from the violation-specific and violator-specific factors can be entered into one of the following formulas to obtain a penalty amount (P_n) for each penalty event:

$$P_n = A_n + (B_n \times [C_n - A_n])$$

$$P_n = 2(A_n + [B_n \times (C_n - A_n)]) *$$

where:

P_n = penalty amount for a given penalty event.

A_n = the minimum value of the penalty range for the cell located on the penalty matrix for a given penalty event.

B_n = the sum of percentage adjustments calculated for a given penalty event, where 100 percent ≥ B ≥ -100 percent.

C_n = the maximum value of the penalty range for the cell located on the penalty matrix for a given penalty event.

* [NOTE: For violation of a previous enforcement action the penalty is multiplied by 2. The statutory maximum is \$50,000 in circumstances where the penalty event constitutes a violation of a previous enforcement action as stated in R.S. 30:2025(E)(2).]

F. - J. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2050.3.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of the Secretary, LR 25:658 (April 1999), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:2400 (December 1999), LR 30:421 (March 2004), amended by the Office of Environmental Assessment, LR 30:2802 (December 2004), amended by the Office of the Secretary, Legal Affairs Division, LR 32:

**Chapter 9. Petition for Rulemaking
§909. Processing a Rulemaking Petition**

A. ...

B. Within 90 days of receipt of the petition for rulemaking, the administrative authority shall deny the petition in writing, stating reasons for the denial, or shall initiate rulemaking by providing the petitioner with the necessary, completed form as provided in the department's Policy Number 0003-88, "Rule Development Procedure."

1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of the Secretary, LR 23:298 (March 1997), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2440 (November 2000), amended by the Office of the Secretary, Legal Affairs Division, LR 32:

Part III. Air

**Chapter 5. Permit Procedures
§509. Prevention of Significant Deterioration**

A. - A.4.e. ...

f. Hybrid Test for Projects That Involve Multiple Types of Emissions Units. A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the emissions increases for each emissions unit, using the method specified in Subparagraphs A.4.c-d of this Section as applicable with respect to each emissions unit, for each type of emissions unit equals or exceeds the significant amount for that pollutant, as defined in Subsection B of this Section.

A.5. - AA.15.b....

Figure 1, AQCR, Map of Louisiana. Repealed.

[Editor's Note: Map is located after Section 509, Historical Note.]

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 14:348 (June 1988), LR 16:613 (July 1990), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:478 (May 1991), LR 21:170 (February 1995), LR 22:339 (May 1996), LR 23:1677 (December 1997), LR 24:654 (April 1998), LR 24:1284 (July 1998), repromulgated LR 25:259 (February 1999), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2447 (November 2000), LR 27:2234 (December 2001), amended by the Office of the Secretary, Legal Affairs Division, LR 31:2437 (October 2005), LR 31:3135, 3156 (December 2005), LR 32:

Part V. Hazardous Waste and Hazardous Materials
Subpart 1. Department of Environmental
Quality—Hazardous Waste
Chapter 22. Prohibitions on Land Disposal
Subchapter B. Hazardous Waste Injection Restrictions
§2299. Appendix—Tables 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

Table 2. Treatment Standards for Hazardous Wastes

Waste Code	Waste Description and Treatment/Regulatory Subcategory ¹	Regulated Hazardous Constituent		Wastewaters	Non-Wastewaters
		Common Name	CAS ² Number	Concentration in mg/L ³ ; or Technology Code ⁴	Concentration in mg/kg ⁵ unless noted as "mg/L TCLP" or Technology Code ⁴

[See Prior Text in D001 ⁹ – F028]					
F032	Wastewaters (except those that have not come into contact with process contaminants), process residuals, preservative drippage, and spent formulations from wood preserving processes generated at plants that currently use or have previously used chlorophenolic formulations (except potentially cross-contaminated wastes that have had the F032 waste code deleted in accordance with LAC 33:V.4901.B.3 or potentially cross-contaminated wastes that are otherwise currently regulated as hazardous wastes (i.e., F034 or F035), and where the generator does not resume or initiate use of chlorophenolic formulations). This listing does not include K001 bottom sediment sludge from the treatment of wastewater from wood preserving processes that use creosote and/or pentachlorophenol.	Acenaphthene	83-32-9	0.059	3.4
		Anthracene	120-12-7	0.059	3.4
		Benz(a)anthracene	56-55-3	0.059	3.4
		Benzo(b)fluoranthene (difficult to distinguish from benzo(k)fluoranthene)	205-99-2	0.11	6.8
		Benzo(k)fluoranthene (difficult to distinguish from benzo(b)fluoranthene)	207-08-9	0.11	6.8
		Benzo(a)pyrene	50-32-8	0.061	3.4
		Chrysene	218-01-9	0.059	3.4
		Dibenz(a,h)anthracene	53-70-3	0.055	8.2
		2-4 Dimethylphenol	105-67-9	0.036	14
		Fluorene	86-73-7	0.059	3.4
		Hexachlorodibenzo-p-dioxins	NA	0.000063, or CMBST ¹¹	0.001, or CMBST ¹¹
		Hexachlorodibenzofurans	NA	0.000063, or CMBST ¹¹	0.001, or CMBST ¹¹
		Indeno (1,2,3-c,d) pyrene	193-39-5	0.0055	3.4
		Naphthalene	91-20-3	0.059	5.6
		Pentachlorodibenzo-p-dioxins	NA	0.000063, or CMBST ¹¹	0.001, or CMBST ¹¹
		Pentachlorodibenzofurans	NA	0.000035, or CMBST ¹¹	0.001, or CMBST ¹¹
		Pentachlorophenol	87-86-5	0.089	7.4
		Phenanthrene	85-01-8	0.059	5.6
		Phenol	108-95-2	0.039	6.2
		Pyrene	129-00-0	0.067	8.2
		Tetrachlorodibenzo-p-dioxins	NA	0.000063, or CMBST ¹¹	0.001, or CMBST ¹¹
		Tetrachlorodibenzofurans	NA	0.000063, or CMBST ¹¹	0.001, or CMBST ¹¹
		2,3,4,6- Tetrachlorophenol	58-90-2	0.030	7.4
2,4,6- Trichlorophenol	88-06-2	0.035	7.4		
Arsenic	7440-38-2	1.4	5.0 mg/L TCLP		
Chromium (Total)	7440-47-3	2.77	0.60 mg/L TCLP		
F034	Wastewaters (except those that have not come into contact with process contaminants), process residuals, preservative drippage, and spent formulations from wood preserving processes generated at plants that use creosote formulations. This listing does not include K001 bottom sediment sludge from the treatment of wastewater from wood preserving processes that use creosote and/or pentachlorophenol.	Acenaphthene	83-32-9	0.059	3.4
		Anthracene	120-12-7	0.059	3.4
		Benz(a)anthracene	56-55-3	0.059	3.4
		Benzo(b)fluoranthene (difficult to distinguish from benzo(k)fluoranthene)	205-99-2	0.11	6.8
		Benzo(k)fluoranthene (difficult to distinguish from benzo(b)fluoranthene)	207-08-9	0.11	6.8
		Benzo(a)pyrene	50-32-8	0.061	3.4
		Chrysene	218-01-9	0.059	3.4
		Dibenz(a,h)anthracene	53-70-3	0.055	8.2
		Fluorene	86-73-7	0.059	3.4
		Indeno (1,2,3-c,d) pyrene	193-39-5	0.0055	3.4
		Naphthalene	91-20-3	0.059	5.6
		Phenanthrene	85-01-8	0.059	5.6
		Pyrene	129-00-0	0.067	8.2
		Arsenic	7440-38-2	1.4	5.0 mg/L TCLP
		Chromium (Total)	7440-47-3	2.77	0.60 mg/L TCLP

Table 2. Treatment Standards for Hazardous Wastes

Waste Code	Waste Description and Treatment/Regulatory Subcategory ¹	Regulated Hazardous Constituent		Wastewaters	Non-Wastewaters
		Common Name	CAS ² Number	Concentration in mg/L ³ ; or Technology Code ⁴	Concentration in mg/kg ⁵ unless noted as "mg/L TCLP" or Technology Code ⁴
F035	Wastewaters (except those that have not come into contact with process contaminants), process residuals, preservative drippage, and spent formulations from wood preserving processes generated at plants that use inorganic preservatives containing arsenic or chromium. This listing does not include K001 bottom sediment sludge from the treatment of wastewater from wood preserving processes that use creosote and/or pentachlorophenol.	Arsenic	7440-38-2	1.4	5.0 mg/L TCLP
		Chromium (Total)	7440-47-3	2.77	0.60 mg/L TCLP
F037	Petroleum refinery primary oil/water/solids separation sludge. Any sludge generated from the gravitational separation of oil/water/solids during the storage or treatment of process wastewaters and oily cooling wastewaters from petroleum refineries. Such sludges include, but are not limited to, those generated in: oil/water/solids separators; tanks and impoundments; ditches and other conveyances; sumps; and stormwater units receiving dry weather flow. Sludge generated in stormwater units that do not receive dry weather flow, sludges generated from noncontact once-through cooling waters segregated for treatment from other process or oily cooling waters, sludges generated in aggressive biological treatment units as defined in LAC 33:V.4901.B.2.b. (including sludges generated in one or more additional units after wastewaters have been treated in aggressive biological treatment units) and K051 wastes are not included in this listing. This listing does include residuals generated from processing or recycling oil-bearing hazardous secondary materials excluded under LAC 33:V.105.D.1.1, if those residuals are to be disposed.	Acenaphthene	83-32-9	0.059	NA
		Anthracene	120-12-7	0.059	3.4
		Benzene	71-43-2	0.14	10
		Benzo(a)anthracene	56-55-3	0.059	3.4
		Benzo(a)pyrene	50-32-8	0.061	3.4
		bis(2-Ethylhexyl) phthalate	117-81-7	0.28	28
		Chrysene	218-01-9	0.059	3.4
		Di-n-butyl phthalate	84-74-2	0.057	28
		Ethylbenzene	100-41-4	0.057	10
		Fluorene	86-73-7	0.059	NA
		Naphthalene	91-20-3	0.059	5.6
		Phenanthrene	85-01-8	0.059	5.6
		Phenol	108-95-2	0.039	6.2
		Pyrene	129-00-0	0.067	8.2
		Toluene	108-88-3	0.080	10
		Xylenes-mixed isomers (sum of o-, m-, and p-xylene concentrations)	1330-20-7	0.32	30
		Chromium (Total)	7440-47-3	2.77	0.60 mg/L TCLP
		Cyanides (Total) ⁷	57-12-5	1.2	590
Lead	7439-92-1	0.69	NA		
Nickel	7440-02-0	NA	11mg/L TCLP		
*** [See Prior Text in F038]					
F039	Leachate (liquids that have percolated through land disposed wastes) resulting from the disposal of more than one restricted waste classified as hazardous under LAC 33:V.Subchapter A. (Leachate resulting from the disposal of one or more of the following EPA Hazardous Wastes and no other Hazardous Wastes retains its EPA Hazardous Waste Number(s): F020, F021, F022, F026, F027, and/or F028.)	*** [See Prior Text in Acenaphthylene – Endosulfan II]			
		Endosulfan sulfate	1031-07-8	0.029	0.13
*** [See Prior Text in Endrin – Vanadium]					
K001	Bottom sediment sludge from the treatment of wastewaters from wood preserving processes that use creosote and/or pentachlorophenol.	Naphthalene	91-20-3	0.059	5.6
		Pentachlorophenol	87-86-5	0.089	7.4
		Phenanthrene	85-01-8	0.059	5.6
		Pyrene	129-00-0	0.067	8.2
		Toluene	108-88-3	0.080	10
		Xylenes-mixed isomers (sum of o-, m-, and p-xylene concentrations)	1330-20-7	0.32	30
Lead	7439-92-1	0.69	0.75 mg/L TCLP		
*** [See Prior Text in K002 – K010]					

Table 2. Treatment Standards for Hazardous Wastes

Waste Code	Waste Description and Treatment/Regulatory Subcategory ¹	Regulated Hazardous Constituent		Wastewaters	Non-Wastewaters
		Common Name	CAS ² Number	Concentration in mg/L ³ ; or Technology Code ⁴	Concentration in mg/kg ⁵ unless noted as "mg/L TCLP" or Technology Code ⁴
K011	Bottom stream from the wastewater stripper in the production of acrylonitrile.	Acetonitrile	75-05-8	5.6	38
		Acrylonitrile	107-13-1	0.24	84
		Acrylamide	79-06-1	19	23
		Benzene	71-43-2	0.14	10
		Cyanide (Total)	57-12-5	1.2	590
* * *					
[See Prior Text in K013 – K060]					
K061	Emission control dust/sludge from the primary production of steel in electric furnaces.	Antimony	7440-36-0	NA	1.15 mg/L TCLP
		Arsenic	7440-38-2	NA	5.0 mg/L TCLP
		Barium	7440-39-3	NA	21 mg/L TCLP
		Beryllium	7440-41-7	NA	1.22 mg/L TCLP
		Cadmium	7440-43-9	0.69	0.11 mg/L TCLP
		Chromium (Total)	7440-47-3	2.77	0.60 mg/L TCLP
		Lead	7439-92-1	0.69	0.75 mg/L TCLP
		Mercury	7439-97-6	NA	0.025 mg/L TCLP
		Nickel	7440-02-0	3.98	11 mg/L TCLP
		Selenium	7782-49-2	NA	5.7 mg/L TCLP
		Silver	7440-22-4	NA	0.14 mg/L TCLP
		Thallium	7440-28-0	NA	0.20 mg/L TCLP
		Zinc	7440-66-6	NA	4.3 mg/L TCLP
* * *					
[See Prior Text in K062 – K085]					
K086	Solvent wastes and sludges, caustic washes and sludges, or water washes and sludges from cleaning tubs and equipment used in the formulation of ink from pigments, driers, soaps, and stabilizers containing chromium and lead.	Acetone	67-64-1	0.28	160
		Acetophenone	96-86-2	0.010	9.7
		bis(2-Ethylhexyl) phthalate	117-81-7	0.28	28
		n-Butyl alcohol	71-36-3	5.6	2.6
		Butylbenzyl phthalate	85-68-7	0.017	28
		Cyclohexanone	108-94-1	0.36	NA
		o-Dichlorobenzene	95-50-1	0.088	6.0
		Diethyl phthalate	84-66-2	0.20	28
		Dimethyl phthalate	131-11-3	0.047	28
		Di-n-butyl phthalate	84-74-2	0.057	28
		Di-n-octyl phthalate	117-84-0	0.017	28
		Ethyl acetate	141-78-6	0.34	33
		Ethylbenzene	100-41-4	0.057	10
		Methanol	67-56-1	5.6	NA
		Methyl ethyl ketone	78-93-3	0.28	36
		Methyl isobutyl ketone	108-10-1	0.14	33
		Methylene chloride	75-09-2	0.089	30
		Naphthalene	91-20-3	0.059	5.6
		Nitrobenzene	98-95-3	0.068	14
		Toluene	108-88-3	0.080	10
		1,1,1-Trichloroethane	71-55-6	0.054	6.0
		Trichloroethylene	79-01-6	0.054	6.0
		Xylenes-mixed isomers (sum of o-, m-, and p-xylene concentrations)	1330-20-7	0.32	30
Chromium (Total)	7440-47-3	2.77	0.60 mg/L TCLP		
Cyanides (Total) ⁷	57-12-5	1.2	590		
Lead	7439-92-1	0.69	0.75 mg/L TCLP		
* * *					
[See Prior Text in K087]					
K088	Spent potliners from primary aluminum reduction.	Acenaphthene	83-32-9	0.059	3.4
		Anthracene	120-12-7	0.059	3.4
		Benzo(a)anthracene	56-55-3	0.059	3.4
		Benzo(a)pyrene	50-32-8	0.061	3.4
		Benzo(b)fluoranthene	205-99-2	0.11	6.8
		Benzo(k)fluoranthene	207-08-9	0.11	6.8
		Benzo(g,h,i)perylene	191-24-2	0.0055	1.8
		Chrysene	218-01-9	0.059	3.4
		Dibenz(a,h)anthracene	53-70-3	0.055	8.2
		Fluoranthene	206-44-0	0.068	3.4
		Indeno (1,2,3-c,d)pyrene	193-39-5	0.0055	3.4
		Phenanthrene	85-01-8	0.059	5.6
		Pyrene	129-00-0	0.067	8.2

Table 2. Treatment Standards for Hazardous Wastes

Waste Code	Waste Description and Treatment/Regulatory Subcategory ¹	Regulated Hazardous Constituent		Wastewaters	Non-Wastewaters
		Common Name	CAS ² Number	Concentration in mg/L ³ ; or Technology Code ⁴	Concentration in mg/kg ⁵ unless noted as "mg/L TCLP" or Technology Code ⁴
		Antimony	7440-36-0	1.9	1.15 mg/L TCLP
		Arsenic	7440-38-2	1.4	26.1
		Barium	7440-39-3	1.2	21 mg/L TCLP
		Beryllium	7440-41-7	0.82	1.22 mg/L TCLP
		Cadmium	7440-43-9	0.69	0.11 mg/L TCLP
		Chromium (Total)	7440-47-3	2.77	0.60 mg/L TCLP
		Lead	7439-92-1	0.69	0.75 mg/L TCLP
		Mercury	7439-97-6	0.15	0.025 mg/L TCLP
		Nickel	7440-02-0	3.98	11 mg/L TCLP
		Selenium	7782-49-2	0.82	5.7 mg/L TCLP
		Silver	7440-22-4	0.43	0.14 mg/L TCLP
		Cyanide (Total) ⁷	57-12-5	1.2	590
		Cyanide (Amenable) ⁷	57-12-5	0.86	30
		Fluoride	16984-48-8	35	N/A
* * *					
[See Prior Text in K093 – K161]					
K169	Crude oil tank sediment from petroleum refining operations.	Benz(a)anthracene	56-55-3	0.059	3.4
		Benzene	71-43-2	0.14	10
		Benzo(g,h,i)perylene	191-24-2	0.0055	1.8
		Chrysene	218-01-9	0.059	3.4
		Ethyl Benzene	100-41-4	0.057	10
		Fluorene	86-73-7	0.059	3.4
		Naphthalene	91-20-3	0.059	5.6
		Phenanthrene	81-05-8	0.059	5.6
		Pyrene	129-00-0	0.067	8.2
		Toluene (Methyl Benzene)	108-88-3	0.080	10
		Xylene(s) (Total)	1330-20-7	0.32	30
* * *					
[See Prior Text in K170 – K174]					
K175	Wastewater treatment sludge from the production of vinyl chloride monomer using mercuric chloride catalyst in an acetylene-based process.	Arsenic	7440-36-0	1.4	5.0 mg/L TCLP
		Mercury ¹²	7438-97-6	NA	0.025 mg/L TCLP
		pH ¹²		NA	pH≤6.0
	All K175 wastewaters.	Mercury	7438-97-6	0.15	NA
* * *					
[See Prior Text in K176 – P064]					
P065	Mercury fulminate nonwastewaters, regardless of their total mercury content, that are not incinerator residues or are not residues from RMERC.	Mercury	7439-97-6	NA	IMERC
	Mercury fulminate nonwastewaters that are either incinerator residues or are residues from RMERC; and contain greater than or equal to 260 mg/kg total mercury.	Mercury	7439-97-6	NA	RMERC
	Mercury fulminate nonwastewaters that are residues from RMERC and contain less than 260 mg/kg total mercury.	Mercury	7439-97-6	NA	0.20 mg/L TCLP
	Mercury fulminate nonwastewaters that are incinerator residues and contain less than 260 mg/kg total mercury.	Mercury	7439-97-6	NA	0.025 mg/L TCLP
	All mercury fulminate wastewaters.	Mercury	7439-97-6	0.15	NA
* * *					
[See Prior Text in P066 – P089]					
P092	Phenyl mercuric acetate nonwastewaters, regardless of their total mercury content, that are not incinerator residues or are not residues from RMERC.	Mercury	7439-97-6	NA	IMERC; or RMERC
	Phenyl mercuric acetate nonwastewaters that are either incinerator residues or are residues from RMERC; and still contain greater than or equal to 260 mg/kg total mercury.	Mercury	7439-97-6	NA	RMERC

Table 2. Treatment Standards for Hazardous Wastes					
Waste Code	Waste Description and Treatment/Regulatory Subcategory ¹	Regulated Hazardous Constituent		Wastewaters	Non-Wastewaters
		Common Name	CAS ² Number	Concentration in mg/L ³ ; or Technology Code ⁴	Concentration in mg/kg ⁵ unless noted as "mg/L TCLP" or Technology Code ⁴
	Phenyl mercuric acetate nonwastewaters that are residues from RMERC and contain less than 260 mg/kg total mercury.	Mercury	7439-97-6	NA	0.20 mg/L TCLP
	Phenyl mercuric acetate nonwastewaters that are incinerator residues and contain less than 260 mg/kg total mercury.	Mercury	7439-97-6	NA	0.025 mg/L TCLP
	All phenyl mercuric acetate wastewaters.	Mercury	7439-97-6	0.15	NA
* * *					
[See Prior Text in P093 – U411]					

Footnote 1. - Footnote 12. ...

[Note: NA means Not Applicable.]

Table 3. - Table 12. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2180 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Hazardous Waste Division, LR 16:1057 (December 1990), amended LR 17:658 (July 1991), LR 21:266 (March 1995), LR 22:22 (January 1996), LR 22:834 (September 1996), LR 23:566 (May 1997), LR 24:301 (February 1998), LR 24:670 (April 1998),

LR 24:1732 (September 1998), LR 25:451 (March 1999), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:282 (February 2000), LR 27:295 (March 2001), LR 29:322 (March 2003), LR 30:1682 (August 2004), amended by the Office of the Secretary, Legal Affairs Division, LR 32:828 (May 2006), LR 32:

Chapter 33. Ground Water Protection

§3325. Ground Water Monitoring List

Table 4 lists ground water monitoring constituents.

Table 4. Ground Water Monitoring List ¹		
Common Name ²	CAS RN ³	Chemical Abstracts Service Index Name ⁴
Acenaphthene	83-32-9	Acenaphthylene, 1,2-dihydro-
Acenaphthylene	208-96-8	Acenaphthylene
Acetone	67-64-1	2-Propanone
Acetophenone	98-86-2	Ethanone, 1-phenyl-
Acetonitrile; Methyl cyanide	75-05-8	Acetonitrile
2-Acetylamino-fluorene; 2-AAF	53-96-3	Acetamide, N-9H-fluoren-2-yl-
Acrolein	107-02-8	2-Propenal
Acrylonitrile	107-13-1	2-Propenenitrile
Aldrin	309-00-2	1,4:5,8-Dimethano-naph-thalene, 1,2,3,4,10,10- hexachloro-1,4,4a,5,8, 8a,-hexa-hydro (1 α ,4 α , 4 $\alpha\beta$,5 β ,8 α ,8 $\alpha\beta$)
Allyl chloride	107-05-1	1-Propene, 3-chloro-
4-Amino-biphenyl	92-67-1	[1,1'-Biphenyl]-4-amine
Aniline	62-53-3	Benzenamine
Anthracene	120-12-7	Anthracene
Antimony	(Total)	Antimony
Aramite	140-57-8	Sulfurous acid,2-chloro-ethyl 2-[4-(1,1-di-methylethyl) phenoxy]-1- methyl-ethyl ester
Arsenic	(Total)	Arsenic
Barium	(Total)	Barium
Benzene	71-43-2	Benzene
Benzo[a]anthracene; Benzanthracene	56-55-3	Benzo[a]anthracene
Benzo[b]-fluor-anthene	205-99-2	Benzo[e]acephen-anthry-lene
Benzo[k]-fluor-anthene	207-08-9	Benzo[k]fluoranthene
Benzo[ghi]perylene	191-24-2	Benzo[ghi]perylene
Benzo[a]pyrene	50-32-8	Benzo[a]pyrene
Benzyl alcohol	100-51-6	Benzenemethanol
Beryllium	(Total)	Beryllium
alpha-BHC	319-84-6	Cyclohexane,1,2,3,4,5, 6-hexachloro-, (1 α ,2 α ,3 β ,4 α ,5 β ,6 β)
beta-BHC	319-85-7	Cyclohexane, 1,2,3,4,5, 6-hexachloro-, (1 α ,2 β ,3 α ,4 β ,5 α ,6 β)-
delta-BHC	319-86-8	Cyclohexane, 1,2,3,4,5, 6-hexachloro-, (1 α ,2 α ,3 α , 4 β ,5 α ,6 β)-
gamma-BHC; Lindane	58-89-9	Cyclohexane, 1,2,3,4,5, 6-hexachloro-, (1 α ,2 α ,3 β ,4 α ,5 α ,6 β)
Bis(2-chloroethoxy) methane-	111-91-1	Ethane,1,1'-[methyl- enebis(oxy)]bis[2- chloro-
Bis(2-chloroethyl) ether	111-44-4	Ethane, 1,1'-oxybis[2- chloro-
Bis(2-chloro-1-methylethyl)ether; 2,2'-Dichlorodi- isopropyl ether	108-60-1	Propane, 2,2'-oxybis [1-chloro-
Bis(2-ethyl-hexyl) phthalate	117-81-7	1,2-Benzenedicarboxylic acid,bis(2-ethylhexyl) ester
Bromodichloro- methane	75-27-4	Methane, bromodichloro-

Table 4. Ground Water Monitoring List¹

Common Name ²	CAS RN ³	Chemical Abstracts Service Index Name ⁴
Bromoform;Tri-bromomethane	75-25-2	Methane, tribromo-
4-Bromophenyl-phenyl ether	101-55-3	Benzene,1-bromo-4- phenoxy-
Butyl benzyl phthalate;Benzyl butyl phthalate	85-68-7	1,2-Benzenedicarboxylic acid, butyl phenyl- methyl ester
Cadmium	(Total)	Cadmium
Carbon disulfide	75-15-0	Carbon disulfide
Carbon tetrachloride	56-23-5	Methane, tetrachloro-
Chlordane	57-74-9	4,7-Methano-1H-indene, 1,2,4,5,6,7,8,8-octa-chloro-2,3,3a,4,7,7a-hexahydro-
p-Chloroaniline	106-47-8	Benzenamine, 4 chloro-
Chlorobenzene	108-90-7	Benzene, chloro-
Chloro- benzilate	510-15-6	Benzenaeetic acid, 4-chloro- α -(4-chloro- phenyl)- α -hydroxy-, ethyl ester
p-Chloro- m-cresol	59-50-7	Phenol, 4-chloro-3- methyl-
Chloroethane; Ethyl chloride	75-00-3	Ethane, chloro-
Chloroform	67-66-3	Methane, trichloro-
2-Chloro- naphthalene	91-58-7	Naphthalene, 2-chloro-
2-Chlorophenol	95-57-8	Phenol, 2-chloro-
4-Chlorophenyl phenyl ether	7005-72-3	Benzene, 1-chloro-4- phenoxy-
Chloroprene	126-99-8	1,3-Butadiene, 2-chloro-
Chromium	(Total)	Chromium
Chrysene	218-01-9	Chrysene
Cobalt	(Total)	Cobalt
Copper	(Total)	Copper
m-Cresol	108-39-4	Phenol, 3-methyl-
o-Cresol	95-48-7	Phenol, 2-methyl-
p-Cresol	106-44-5	Phenol, 4-methyl-
Cyanide	57-12-5	Cyanide
2,4-D; 2,4-Di-chlorophenoxy-acetic acid	94-75-7	Acetic acid, (2,4- dichlorophenoxy)-
4,4'-DDD	72-54-8	Benzene, 1,1'-(2,2- dichloroethylidene) bis[4-chloro-
4,4'-DDE	72-55-9	Benzene, 1,1'-(dichloro- ethenylidene) bis[4- chloro-
4,4'-DDT	50-29-3	Benzene, 1,1'-(2,2,2- trichloroethylidene) bis[4-chloro-
Diallate	2303-16-4	Carbamothioic acid, bis(1-methylethyl)-, S-(2,3-dichloro-2-propenyl)ester
Dibenz[a,h] anthracene	53-70-3	Dibenz[a,h]anthracene
Dibenzofuran	132-64-9	Dibenzofuran
Dibromochloro- methane; Chlorodi- bromomethane	124-48-1	Methane, dibromo- chloro-
1,2-Dibromo-3-chloropropane; DBCP	96-12-8	Propane, 1,2-dibromo- 3-chloro-
1,2-Dibromoethane; Ethylene dibromide	106-93-4	Ethane, 1,2-dibromo-
Di-n-butyl phthalate	84-74-2	1,2-Benzenedicarboxylic acid, dibutyl ester
o-Dichlorobenzene	95-50-1	Benzene, 1,2-dichloro-
m-Dichlorobenzene	541-73-1	Benzene, 1,3-dichloro-
p-Dichlorobenzene	106-46-7	Benzene, 1,4-dichloro-
3,3'-Dichloro- benzidine	91-94-1	[1,1'-Biphenyl]4,4'- diamine, 3,3'-dichloro-
trans-1,4- Dichloro-2-butene	110-57-6	2-Butene,1,4- dichloro-, (E)-
Dichlorodifluoro- methane	75-71-8	Methane, dichloro- difluoro-
1,1-Dichloro-ethane	75-34-3	Ethane, 1,1-dichloro-
1,2-Dichloro-ethane; Ethylene dichloride	107-06-2	Ethane, 1,2-dichloro-
1,1-Dichloro- ethylene; Vinylidene chloride	75-35-4	Ethene, 1,1-dichloro-
trans-1,2- Dichloroethylene	156-60-5	Ethene,1,2-dichloro-(E)-
2,4-Dichlorophenol	120-83-2	Phenol, 2,4-dichloro-
2,6-Dichlorophenol	87-65-0	Phenol, 2,6-dichloro-
1,2-Dichloro-propane	78-87-5	Propane, 1,2- dichloro-
cis-1,3- Dichloro- propene	10061-01-5	1-Propene, 1,3- dichloro-,(Z)-
trans-1,3- Dichloropropene	10061-02-6	1-Propene, 1,3- dichloro-, (E)-
Diieldrin	60-57-1	2,7:3,6-Dimethanonaphth [2,3-b]oxirene,3,4,5, 6,9,9- hexachloro-1a,2,2a,3,6,6a,7,7a-octahydro-, (1 α ,2 β ,2 α ,3 β ,6 β ,6 α ,7 β ,7 α)-
Diethyl phthalate	84-66-2	1,2-Benzenedicarboxylic acid, diethyl ester
O,O-Diethyl O-2-pyrazinyl phosphorothioate; Thionazin	297-97-2	Phosphorothioic acid, O,O-diethyl O-pyrazinyl ester
Dimethoate	60-51-5	Phosphorodithioic acid, O,O-dimethyls-[2-(methylamino)-2-oxoethyl] ester
p-(Dimethyl-amino)azobenzene	60-11-7	Benzenamine, N,N-di-methyl-4- (phenylazo)-
7,12-Dimethyl- benz[a] anthracene	57-97-6	Benz[a]anthracene, 7,12-dimethyl-
3,3'-Dimethyl- benzidine	119-93-7	[1,1'-Biphenyl]-4,4'- diamine, 3,3'-dimethyl-
alpha, alpha- Dimethyl- phenethylamine	122-09-8	Benzenethanamine, α , α -dimethyl-
2,4-Dimethyl- phenol	105-67-9	Phenol, 2,4-dimethyl-
Dimethyl phthalate	131-11-3	1,2-Benzenedicarboxylic acid, dimethyl ester
m-Dinitrobenzene	99-65-0	Benzene, 1,3-dinitro-
4,6-Dinitro-o- cresol	534-52-1	Phenol, 2-methyl-4,6- dinitro-
2,4-Dinitrophenol	51-28-5	Phenol, 2,4-dinitro-
2,4-Dinitro- toluene	121-14-2	Benzene, 1-methyl-2, 4-dinitro-
2,6-Dinitro- toluene	606-20-2	Benzene, 2-methyl- 1,3-dinitro-

Table 4. Ground Water Monitoring List¹

Common Name ²	CAS RN ³	Chemical Abstracts Service Index Name ⁴
Dinoseb; DNBP; 2-sec-Butyl- 4,6-dinitrophenol	88-85-7	Phenol, 2-(1-methyl- propyl)-4,6-dinitro-
Di-n-octyl phthalate	117-84-0	1,2-Benzenedicarboxylic acid, dioctyl ester
1,4-Dioxane	123-91-1	1,4-Dioxane
Diphenylamine	122-39-4	Benzenamine, N-phenyl-
Disulfoton	298-04-4	Phosphorodithioic acid, O,O-diethyl S-[2- (ethylthio)ethyl]ester
Endosulfan I	959-98-8	6,9-Methano-2,4,3- benzodioxathiepin 6,7,8, 9,10,10-hexachloro-1,5, 5a,6,9,9a-hexahydro-, 3-oxide, (3 α ,5 α β ,6 α ,9 α ,9 α β)-
Endosulfan II	3213-65-9	6,9-Methano-2,4,3- benzodioxathiepin, 6,7,8,9,10,10-hexa-chloro- 1,5,5a,6,9, 9a-hexahydro-, 3-oxide, (3 α ,5 α ,6 β ,9 α ,9 α β)-
Endosulfan sulfate	1031-07-8	6,9-Methano-2,4,3- benzodioxathiepin, 6,7,8,9,10,10-hexa-chloro- 1,5,5a,6,9,9a- hexahydro-, 3,3-dioxide
Endrin	72-20-8	2,7:3,6-Dimethanonaphth[2,3-b]oxirene,3,4,5,6,9,9-hexachloro- 1a,2,2a,3,6,6a,7,7a-octahydro-, (1 α ,2 β ,2 α β , 3 α ,6 α ,6 α β , 7 β ,7 α)-
Endrin aldehyde	7421-93-4	1,2,4-Methenocyclopenta[cd] pentalene- 5-carboxaldehyde, 2,2a,3,3,4,7- hexachloro-decahydro-,(1 α ,2 β ,2 α β , 4 β ,4 α β ,5 β ,6 α β ,6 β β ,7R*)-
Ethylbenzene	100-41-4	Benzene, ethyl-
Ethyl methacrylate	97-63-2	2-Propenoic acid, 2-methyl-, ethyl ester
Ethyl methane- sulfonate	62-50-0	Methanesulfonic acid, ethyl ester
Famphur	52-85-7	Phosphorothioic acid, O-[4-[(dimethylamino) sulfonyl]phenyl]-O,O-di- methyl ester
Fluoranthene	206-44-0	Fluoranthene
Fluorene	86-73-7	9H-Fluorene
Heptachlor	76-44-8	4,7-Methano-1H-indene, 1,4,5,6,7,8,8-hepta-chloro-3a,4,7,7a- tetrahydro-
Heptachlor epoxide	1024-57-3	2,5-Methano-2H-indeno [1,2-b]oxirene,2,3,4,5, 6,7,7-heptachloro- 1a,1b,5,5a, 6,6a-hexa-hydro-,(1 α ,1 β ,2 α , 5 α ,5 α β ,6 β ,6 α)
Hexachlorobenzene	118-74-1	Benzene, hexachloro-
Hexachlorobutadiene	87-68-3	1,3-Butadiene, 1,1,2,3,4,4- hexachloro-
Hexachloro- cyclopentadiene	77-47-4	1,3-Cyclopentadiene, 1,2,3,4,5,5-hexachloro-
Hexachloroethane	67-72-1	Ethane, hexachloro-
Hexachlorophene	70-30-4	Phenol,2,2'-methyl-enebis [3,4,6- tri-chloro-
Hexachloropropene	1888-71-7	1-Propene,1,1,2,3,3,3-hexachloro
2-Hexanone	591-78-6	2-Hexanone
Indeno(1,2,3- cd) pyrene	193-39-5	Indeno[1,2,3-cd] pyrene
Isobutyl alcohol	78-83-1	1-Propanol, 2-methyl-
Isodrin	465-73-6	1,4,5,8-Dimethano- naphthalene,1,2,3,4,10,10-hexachloro-1,4,4a,5,8,8a- hexahydro- (1 α ,4 α ,4 α β , 5 β ,8 β ,8 α β) -
Isophorone	78-59-1	2-Cyclohexen-1-one,3,5,5-trimethyl-
Isosafrole	120-58-1	1,3-Benzodioxole,5-(1- propenyl)-
Kepone	143-50-0	1,3,4-Metheno-2H-cylo-buta-[cd]pentalen-2- one,1,1a,3,3a,4,5,5,5a,5b,6-decachloroocta-hydro-
Lead	(Total)	Lead
Mercury	(Total)	Mercury
Methacrylonitrile	126-98-7	2-Propenenitrile, 2-methyl-
Methapyrilene	91-80-5	1,2,Ethanediamine, N,N- dimethyl-N'-2-pyridinyl-N'-(2-thienylmethyl)-
Methoxychlor	72-43-5	Benzene,1,1'-(2,2,2, trichloroethylidene) bis[4-methoxy-
Methyl bromide; Bromomethane	74-83-9	Methane, bromo-
Methyl chloride; Chloromethane	74-87-3	Methane, chloro-
3-Methyl-cholanthrene	56-49-5	Benz[j]aceanthrylene, 1,2-dihydro-3-methyl-
Methylene bromide; Dibromomethane	74-95-3	Methane, dibromo-
Methylene chloride; Dichloromethane	75-09-2	Methane, dichloro-
Methyl ethyl ketone; MEK	78-93-3	2-Butanone
Methyl iodide; Iodomethane	74-88-4	Methane, iodo-
Methylmethacrylate	80-62-6	2-Propenoic acid, 2- methyl-, methyl ester
Methyl methanesulfonate	66-27-3	Methanesulfonic acid, methyl ester
2-Methyl-naphthalene	91-57-6	Naphthalene, 2-methyl-
Methyl parathion; Parathion methyl	298-00-0	Phosphorothioic acid, O,O-dimethyl O-(4-nitrophenyl)ester
4-Methyl-2- pentanone; Methylisobutyl ketone	108-10-1	2-Pentanone, 4-methyl
Naphthalene	91-20-3	Naphthalene
1,4-Naphthoquinone	130-15-4	1,4-Naphthalene-dione
1-Naphthylamine	134-32-7	1-Naphthalenamine
2-Naphthylamine	91-59-8	2-Naphthalenamine
Nickel	(Total)	Nickel
o-Nitroaniline	88-74-4	Benzenamine, 2-nitro-
m-Nitroaniline	99-09-2	Benzenamine, 3-nitro-
p-Nitroaniline	100-01-6	Benzenamine, 4-nitro-
Nitrobenzene	98-95-3	Benzene, nitro-
o-Nitrophenol	88-75-5	Phenol, 2-nitro-
p-Nitrophenol	100-02-7	Phenol, 4-nitro-
4-Nitroquinoline, 1-oxide	56-57-5	Quinoline, 4-nitro-, 1-oxide
N-Nitrosodi-n- butylamine	924-16-3	1-Butanamine, N-butyl-N-nitroso

Table 4. Ground Water Monitoring List¹

Common Name ²	CAS RN ³	Chemical Abstracts Service Index Name ⁴
N-Nitroso- diethylamine	55-18-5	Ethanamine, N-ethyl- N-nitroso
N-Nitroso- dimethylamine	62-75-9	Methanamine, N- methyl-N-nitroso-
N-Nitroso- diphenylamine	86-30-6	Benzenamine, N-nitroso-N-phenyl-
N-Nitrosodipropyl-amine;Di-n-propyl-nitrosamine	621-64-7	1-Propanamine, N-nitroso-N-propyl-
N-Nitrosom- ethylethylamine	10595-95-6	Ethanamine, N-methyl- N-nitroso-
N-Nitrosomor- pholine	59-89-2	Morpholine, 4-nitroso-
N-Nitrosopiperi-dine	100-75-4	Piperidine, 1- nitroso-
N-Nitrosopyrroli-dine	930-55-2	Pyrrolidine, 1- nitroso-
5-Nitro-o- toluidine	99-55-8	Benzenamine,2-methyl-5-nitro-
Parathion	56-38-2	Phosphorothioic acid, O,O-diethyl-O-(4-nitro-phenyl) ester
Polychlorinated biphenyls; PCBs	See Note 5	1,1'-Biphenyl, chloro derivatives
Polychlorinated dibenzo-p- dioxins; PCDDs	See Note 6	Dibenzo[b,e][1,4]dioxin, chloro derivatives
Polychlorinated dibenzofurans; PCDFs	See Note 7	Dibenzofuran, chloro derivatives
Pentachlorobenzene	608-93-5	Benzene, pentachloro-
Pentachloroethane	76-01-7	Ethane, pentachloro-
Pentachloro- nitrobenzene	82-68-8	Benzene, pentachloro- nitro-
Pentachlorophenol	87-86-5	Phenol, pentachloro-
Phenacetin	62-44-2	Acetamide, N-(4- ethoxyphenyl)
Phenanthrene	85-01-8	Phenanthrene
Phenol	108-95-2	Phenol
p-Phenylenediamine	106-50-3	1,4- Benzenediamine
Phorate	298-02-2	Phosphorodithioic acid, O,O-diethyl S-[(ethylthio)methyl] ester
2-Picoline	109-06-8	Pyridine, 2-methyl-
Pronamide	23950-58-5	Benzamide, 3,5-dichloro-N-(1,1-dimethyl-2-pro-pynyl)-
Propionitrile; Ethyl cyanide	107-12-0	Propanenitrile
Pyrene	129-00-0	Pyrene
Pyridine	110-86-1	Pyridine
Safrole	94-59-7	1,3-Benzodioxole, 5- (2-propenyl)-
Selenium	(Total)	Selenium
Silver	(Total)	Silver
Silvex; 2,4,5-TP	93-72-1	Propanoic acid,2-(2,4, 5-trichlorophenoxy)-
Styrene	100-42-5	Benzene, ethenyl-
Sulfide	18496-25-8	Sulfide
2,4,5-T; 2,4,5-, Trichlorophenoxy-acetic acid	93-76-5	Acetic acid, (2,4,5- trichlorophenoxy)-
2,3,7,8-TCDD; 2,3,7,8-Tetra-chlorodibenzo-p- dioxin	1746-01-6	Dibenzo[b,e][1,4]dioxin 2,3,7,8-tetrachloro-
1,2,4,5-Tetra- chlorobenzene	95-94-3	Benzene, 1,2,4,5-tetrachloro-
1,1,1,2-Tetra- chloroethane	630-20-6	Ethane, 1,1,1,2- tetrachloro-
1,1,2,2-Tetra- chloroethane	79-34-5	Ethane, 1,1,2,2- tetrachloro-
Tetrachloro- ethylene; Perchloroethylene; Tetrachloroethene	127-18-4	Ethene, tetrachloro-
2,3,4,6-Tetra- chlorophenol	58-90-2	Phenol, 2,3,4,6- tetrachloro-
Tetraethyl dithio-pyrophosphate; Sulfotepp	3689-24-5	Thiodiphosphoric acid ((HO) ₂ P(S) ₂ O), tetraethyl ester
Thallium	(Total)	Thallium
Tin	(Total)	Tin
Toluene	108-88-3	Benzene, methyl-
o-Toluidine	95-53-4	Benzenamine, 2-methyl-
Toxaphene	8001-35-2	Toxaphene
1,2,4-Tri- chlorobenzene	120-82-1	Benzene, 1,2,4-trichloro-
1,1,1-Tri- chloroethane; Methylchloroform	71-55-6	Ethane, 1,1,1-trichloro-
1,1,2-Tri- chloroethane	79-00-5	Ethane, 1,1,2-trichloro-
Trichloro- ethylene; Trichloroethene	79-01-6	Ethene, trichloro-
Trichlorofluoro-methane	75-69-4	Methane, trichlorofluoro-
2,4,5-Tri- chlorophenol	95-95-4	Phenol, 2,4,5-trichloro-
2,4,6-Tri- chlorophenol	88-06-2	Phenol, 2,4,6-trichloro-
1,2,3-Tri- chloropropane	96-18-4	Propane, 1,2,3-tri-chloro-
O,O,O-Triethyl phosphorothioate	126-68-1	Phosphorothioic acid, O,O,O-triethyl ester
sym-Trinitro- benzene	99-35-4	Benzene, 1,3,5- trinitro
Vanadium	(Total)	Vanadium
Vinyl acetate	108-05-4	Acetic acid, ethenyl ester
Vinyl chloride	75-01-4	Ethene, chloro-
Xylene (total)	1330-20-7	Benzene, dimethyl-
Zinc	(Total)	Zinc

¹The regulatory requirements pertain only to the list of substances.

²Common names are those widely used in government regulations, scientific publications, and commerce; synonyms exist for many chemicals.

³Chemical Abstracts Service registry number. Where "Total" is entered, all species in the ground water that contain this element are included.

⁴CAS index names are those used in the ninth Cumulative Index.

⁵Polychlorinated biphenyls (CAS RN 1336-36-3); this category contains congener chemicals, including constituents of Aroclor-1016 (CAS RN 12674-11-2), Aroclor-1221 (CAS RN 11104-28-2), Aroclor-1232 (CAS RN 11141-16-5), Aroclor-1242 (CAS RN 53469-21-9), Aroclor-1248 (CAS RN 12672-29-6), Aroclor-1254 (CAS RN 11097-69-1), and Aroclor-1260 (CAS RN 11096-82-5).

⁶This category contains congener chemicals, including tetrachlorodibenzo-p-dioxins (see also 2,3,7,8-TCDD), pentachlorodibenzo-p-dioxins, and hexachlorodibenzo-p-dioxins.

⁷This category contains congener chemicals, including tetrachlorodibenzofurans, pentachlorodibenzofurans, and hexachlorodibenzofurans.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2180 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Hazardous Waste Division, LR 16:399 (May 1990), amended LR 18:1256 (November 1992), amended by the Office of Waste Services, Hazardous Waste Division, LR 24:1742 (September 1998), amended by the Office of the Secretary, Legal Affairs Division, LR 32:

Part IX. Water Quality

Subpart 1. Water Pollution Control

Chapter 1. General Provisions

§107. Definitions

Designated Water Use—repealed.

Primary Contact—repealed.

Secondary Contact—repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 11:1066 (November 1985), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2538 (November 2000), LR 30:1473 (July 2004), amended by the Office of the Secretary, Legal Affairs Division, LR 32:

Subpart 2. The Louisiana Pollutant Discharge Elimination System (LPDES) Program

Chapter 71. Appendices

§7107. Appendix D—Permit Application Testing Requirements (LAC 33:IX.2501)

Table I. Testing Requirements for Organic Toxic Pollutants by Industrial Category for Existing Dischargers				
Industrial Category	GC/MS Fraction ⁽¹⁾			
	Volatile	Acid	Base/Neutral	Pesticides

[See Prior Text in Adhesives and Sealants – Petroleum Refining]				
Pharmaceutical Preparations	*	*	*	

[See Prior Text in Photographic Equipment and Supplies – Timber Products Processing]				

⁽¹⁾The toxic pollutants in each fraction are listed in Table II.

* Testing required.

Table II. – Table V. Editorial Note. ...

For the duration of the suspensions, therefore, Table I effectively reads:

Table I. Testing Requirements for Organic Toxic Pollutants by Industry Category				
Industrial Category	GC/MS Fraction ⁽¹⁾			
	Volatile	Acid	Base/Neutral	Pesticides

[See Prior Text in Adhesives and Sealants - Foundries]				
Gum and Wood (All Subparts except D and F)	*	*		
Subpart D—tall oil rosin	*	*	*	
Subpart F—rosin-based derivatives	*	*	*	
Inorganic Chemicals Manufacturing	*	*	*	

[See Prior Text in Iron and Steel Manufacturing - Petroleum Refining]				
Pharmaceutical Preparations	*	*	*	
Photographic Equipment and Supplies	*	*	*	

[See Prior Text in Plastic and Synthetic Materials Manufacturing - Timber Products Processing]				

⁽¹⁾The pollutants in each fraction are listed in Item V-C in the NPDES permit application.

*Testing required.

Table I.A. – Footnote †. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), repromulgated by the Office of Environmental Assessment, Environmental Planning Division, LR 30:233 (February 2004), amended by the Office of the Secretary, Legal Affairs Division, LR 32:

Part XI. Underground Storage Tanks

Chapter 3. Registration Requirements, Standards, and Fee Schedule

§301. Registration Requirements

A. - B.1. ...

a. tank and piping installation in accordance with LAC 33:XI.303.B.4;

b. cathodic protection of steel tanks and piping in accordance with LAC 33:XI.303.B.1-2;

B.1.c. - C.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Solid and Hazardous Waste, Underground Storage Tank Division, LR 11:1139 (December 1985), amended LR 16:614 (July 1990), LR 17:658 (July 1991), LR 18:727 (July 1992), LR 20:294 (March 1994), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2558 (November 2000), LR 28:475 (March 2002),

amended by the Office of Environmental Assessment, LR 31:1066 (May 2005), amended by the Office of the Secretary, Legal Affairs Division, LR 31:2520 (October 2005), repromulgated LR 32:393 (March 2006), amended LR 32:

Part XV. Radiation Protection

Chapter 1. General Provisions

§102. Definitions and Abbreviations

As used in these regulations, these terms have the definitions set forth below. Additional definitions used only in a certain chapter may be found in that chapter.

* * *

Byproduct Material—

1. ...

2. the tailings or wastes produced by the extraction or concentration of uranium or thorium (R.S. 30:2103) from ore processed primarily for its source material content, including discrete surface wastes resulting from uranium or thorium solution extraction processes. Underground ore bodies depleted by these solution extraction operations do not constitute byproduct material within this definition.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Nuclear Energy Division, LR 13:569 (October 1987), amended by Office of Air Quality and Radiation Protection, Radiation Protection Division, LR 18:34 (January 1992), LR 19:1421 (November 1993), LR 20:650 (June 1994), LR 22:967 (October 1996), LR 24:2089 (November 1998), repromulgated LR 24:2242 (December 1998), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2563 (November 2000), LR 26:2767 (December 2000), LR 30:1171, 1188 (June 2004), amended by the Office of Environmental Assessment, LR 31:44 (January 2005), LR 31:1064 (May 2005), amended by the Office of the Secretary, Legal Affairs Division, LR 32:811 (May 2006), LR 32:

Chapter 3. Licensing of Radioactive Material

Subchapter Z. Appendices

§399. Schedules A and B, and Appendices A, B, C, D, E, and F

Schedule A. - Note 4. ...

Schedule B Exempt Quantities	
Byproduct Material	Microcuries
Antimony 122 (Sb 122)	100
Antimony 124 (Sb 124)	10
Antimony 125 (Sb 125)	10
Arsenic 73 (As 73)	100
Arsenic 74 (As 74)	10
Arsenic 76 (As 76)	10
Arsenic 77 (As 77)	100
Barium 131 (Ba 131)	10
Barium 133 (Ba 133)	10
Barium 140 (Ba 140)	10
Bismuth 210 (Bi 210)	1
Bromine 82 (Br 82)	10
Cadmium 109 (Cd 109)	10
Cadmium 115m (Cd 115m)	10
Cadmium 115 (Cd 115)	100
Calcium 45 (Ca 45)	10
Calcium 47 (Ca 47)	10
Carbon 14 (C 14)	100
Cerium 141 (Ce 141)	100
Cerium 143 (Ce 143)	100
Cerium 144 (Ce 144)	1
Cesium 131 (Cs 131)	1,000
Cesium 134m (Cs 134m)	100

Schedule B Exempt Quantities	
Byproduct Material	Microcuries
Cesium 134 (Cs 134)	1
Cesium 135 (Cs 135)	10
Cesium 136 (Cs 136)	10
Cesium 137 (Cs 137)	10
Chlorine 36 (Cl 36)	10
Chlorine 38 (Cl 38)	10
Chromium 51 (Cr 51)	1,000
Cobalt 58m (Co 58m)	10
Cobalt 58 (Co 58)	10
Cobalt 60 (Co 60)	1
Copper 64 (Cu 64)	100
Dysprosium 165 (Dy 165)	10
Dysprosium 166 (Dy 166)	100
Erbium 169 (Er 169)	100
Erbium 171 (Er 171)	100
Europium 152 9.2h (Eu 152 9.2h)	100
Europium 152 13 yr (Eu 152 13 yr)	1
Europium 154 (Eu 154)	1
Europium 155 (Eu 155)	10
Fluorine 18 (F 18)	1,000
Gadolinium 153 (Gd 153)	10
Gadolinium 159 (Gd 159)	100
Gallium 67 (Ga 67)	100
Gallium 72 (Ga 72)	10
Germanium 71 (Ge 71)	100
Gold 198 (Au 198)	100
Gold 199 (Au 199)	100
Hafnium 181 (Hf 181)	10
Holmium 166 (Ho 166)	100
Hydrogen 3 (H 3)	1,000
Indium 113m (In 113m)	100
Indium 114m (In 114m)	10
Indium 115m (In 115m)	100
Indium 115 (In 115)	10
Iodine 125 (I 125)	1
Iodine 126 (I 126)	1
Iodine 129 (I 129)	0.1
Iodine 131 (I 131)	1
Iodine 132 (I 132)	10
Iodine 133 (I 133)	1
Iodine 134 (I 134)	10
Iodine 135 (I 135)	10
Iridium 192 (Ir 192)	10
Iridium 194 (Ir 194)	100
Iron 55 (Fe 55)	100
Iron 59 (Fe 59)	10
Krypton 85 (Kr 85)	100
Krypton 87 (Kr 87)	10
Lanthanum 40 (La 140)	10
Lutetium 177 (Lu 177)	100
Manganese 52 (Mn 52)	10
Manganese 54 (Mn 54)	10
Manganese 56 (Mn 56)	10
Mercury 197m (Hg 197m)	100
Mercury 197 (Hg 197)	100
Mercury 203 (Hg 203)	10
Molybdenum 99 (Mo 99)	100
Neodymium 147 (Nd 147)	100
Neodymium 149 (Nd 149)	100
Nickel 59 (Ni 59)	100
Nickel 63 (Ni 63)	10
Nickel 65 (Ni 65)	100
Niobium 93m (Nb 93m)	10
Niobium 95 (Nb 95)	10
Niobium 97 (Nb 97)	10
Osmium 185 (Os 185)	10
Osmium 191m (Os 191m)	100
Osmium 191 (Os 191)	100
Osmium 193 (Os 193)	100

Schedule B Exempt Quantities	
Byproduct Material	Microcuries
Palladium 103 (Pd 103)	100
Palladium 109 (Pd 109)	100
Phosphorus 32 (P 32)	10
Platinum 191 (Pt 191)	100
Platinum 193m (Pt 193m)	100
Platinum 193 (Pt 193)	100
Platinum 197m (Pt 197m)	100
Platinum 97 (Pt 197)	100
Polonium 210 (P 210)	0.1
Potassium 42 (K 42)	10
Praseodymium 142 (Pr 142)	100
Praseodymium 143 (Pr 143)	100
Promethium 147 (Pm 147)	10
Promethium 149 (Pm 149)	10
Rhenium 186 (Re 186)	100
Rhenium 188 (Re 188)	100
Rhodium 103m (Rh 103m)	100
Rhodium 105 (Rh 105)	100
Rubidium 86 (Rb 86)	10
Rubidium 87 (Rb 87)	10
Ruthenium 97 (Ru 97)	100
Ruthenium 103 (Ru 103)	10
Ruthenium 105 (Ru 105)	10
Ruthenium 106 (Ru 106)	1
Samarium 151 (Sm 151)	10
Samarium 153 (Sm 153)	100
Scandium 46 (Sc 46)	10
Scandium 47 (Sc 47)	100
Scandium 48 (Sc 48)	10
Selenium 75 (Se 75)	10
Silicon 31 (Si 31)	100
Silver 105 (Ag 105)	10
Silver 110m (Ag 110m)	1
Silver 111 (Ag 111)	100
Sodium 24 (Na 24)	10
Strontium 85 (Sr 85)	10
Strontium 89 (Sr 89)	1
Strontium 90 (Sr 90)	0.1
Strontium 91 (Sr 91)	10
Strontium 92 (Sr 92)	10
Sulfur 35 (S 35)	100
Tantalum 182 (Ta 182)	10
Technetium 96 (Tc 96)	10
Technetium 97m (Tc 97m)	100
Technetium 97 (Tc 97)	100
Technetium 99m (Tc 99m)	100
Technetium 99 (Tc 99)	10
Tellurium 125m (Te 125m)	10
Tellurium 127m (Te 127m)	10
Tellurium 127 (Te 127)	100
Tellurium 129m (Te 129m)	10
Tellurium 129 (Te 129)	100
Tellurium 131m (Te 131m)	10
Tellurium 132 (Te 132)	10
Terbium 60 (Tb 160)	10
Thallium 200 (Tl 200)	100
Thallium 201 (Tl 201)	100
Thallium 202 (Tl 202)	100
Thallium 204 (Tl 204)	10
Thulium 170 (Tm 170)	10
Thulium 171 (Tm 171)	10
Tin 113 (Sn 113)	10
Tin 125 (Sn 125)	10
Tungsten 181 (W 181)	10
Tungsten 185 (W 185)	10
Tungsten 187 (W 187)	100
Vanadium 48 (V 48)	10
Xenon 131m (Xe 131m)	1,000
Xenon 133 (Xe 133)	100

Schedule B Exempt Quantities	
Byproduct Material	Microcuries
Xenon 135 (Xe 135)	100
Ytterbium 175 (Yb 175)	100
Yttrium 90 (Y 90)	Section 399
Yttrium 91 (Y 91)	10
Yttrium 92 (Y 92)	100
Yttrium 93 (Y 93)	100
Zinc 65 (Zn 65)	10
Zinc 69m (Zn 69m)	100
Zinc 69 (Zn 69)	1,000
Zirconium 93 (Zr 93)	10
Zirconium 95 (Zr 95)	10
Zirconium 97 (Zr 97)	10
Any byproduct material not listed above other than alpha-emitting byproduct material.	0.1

Appendix A. - Appendix F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Nuclear Energy Division, LR 13:569 (October 1987), amended by the Office of Air Quality and Radiation Protection, Radiation Protection Division, LR 18:34 (January 1992), LR 20:180 (February 1994), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2574 (November 2000), LR 27:1228 (August 2001), amended by the Office of Environmental Assessment, LR 31:46 (January 2005), LR 31:1580 (July 2005), amended by the Office of the Secretary, Legal Affairs Division, LR 31:2528 (October 2005), LR 32:820 (May 2006), LR 32:

A public hearing will be held on August 24, 2006, at 1:30 p.m. in the Galvez Building, Oliver Pollock Conference Room, 602 N. Fifth Street, Baton Rouge, LA 70802. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Judith A. Schuerman, Ph.D., at the address given below or at (225) 219-3550. Free parking is available in the Galvez Garage with a validated parking ticket.

All interested persons are invited to submit written comments on the proposed regulation. Persons commenting should reference this proposed regulation by OS070. Such comments must be received no later than August 31, 2006, at 4:30 p.m., and should be sent to Judith A. Schuerman, Ph.D., Office of the Secretary, Legal Affairs Division, Box 4302, Baton Rouge, LA 70821-4302 or to fax (225) 219-3582 or by e-mail to judith.schuerman@la.gov. Copies of this proposed regulation can be purchased by contacting the DEQ Public Records Center at (225) 219-3168. Check or money order is required in advance for each copy of OS070. This regulation is available on the Internet at www.deq.louisiana.gov under Rules and Regulations.

This proposed regulation is available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 602 N. Fifth Street, Baton Rouge, LA 70802; 1823 Highway 546, West Monroe, LA 71292; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 1301 Gadwall Street, Lake Charles, LA 70615; 111 New Center Drive, Lafayette, LA 70508; 110 Barataria Street, Lockport, LA 70374; 645 N. Lotus Drive, Suite C, Mandeville, LA 70471.

Herman Robinson, CPM
Executive Counsel

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Cleanup Package

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
There are no expected implementation costs or savings to state or local governmental units as a result of the proposed rule.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
There is no estimated effect on revenue collections of state or local governmental units as a result of the proposed rule.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There are no estimated costs and/or economic benefits to directly affected persons or non-governmental groups as a result of the proposed rule.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
There is no estimated effect on competition or employment as a result of the proposed rule.

Herman Robinson, CPM
Executive Counsel
0607#030

Robert E. Hosse
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Environmental Quality
Office of the Secretary
Legal Affairs Division**

**Oil and Gas Construction Activities Storm Water Waiver
(LAC 33:IX.2511)(WQ069ft)**

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary gives notice that rulemaking procedures have been initiated to amend the Water Quality regulations, LAC 33:IX.2511 (Log #WQ069ft).

This proposed Rule is identical to federal regulations found in 71 FR 33628-33640 (June 12, 2006), which are applicable in Louisiana. For more information regarding the federal requirement, contact the Regulation Development Section at (225) 219-3550 or Box 4302, Baton Rouge, LA 70821-4302. No fiscal or economic impact will result from the proposed Rule; therefore, the Rule will be promulgated in accordance with R.S. 49:953(F)(3) and (4).

This Rule implements the June 12, 2006, revision to 40 CFR 122 (71 FR 33628-33640), which modifies the National Pollutant Discharge Elimination System (NPDES) regulations to provide that certain storm water discharges from field activities or operations, including construction, associated with oil and gas exploration, production, processing, or treatment operations or transmission facilities are exempt from NPDES permit requirements. The Department of Environmental Quality, Office of Environmental Services, became the NPDES permit issuing authority for the State of Louisiana on August 27, 1996. This rule is necessary in order to comply with federal regulations that require the LPDES program to be consistent with the

EPA NPDES program. The basis and rationale for this rule are to mirror the federal regulations.

This proposed Rule meets an exception listed in R.S. 30:2019(D)(2) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required. This proposed Rule has no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

**Title 33
ENVIRONMENTAL QUALITY**

Part IX. Water Quality

**Subpart 2. The Louisiana Pollutant Discharge
Elimination System (LPDES) Program**

**Chapter 25. Permit Application and Special LPDES
Program Requirements**

§2511. Storm Water Discharges

A. - A.1.e.iv. ...

2. The state administrative authority may not require a permit for discharges of storm water runoff from the following:

a. mining operations composed entirely of flows that are from conveyances or systems of conveyances (including but not limited to pipes, conduits, ditches, and channels) used for collecting and conveying precipitation runoff and that are not contaminated by contact with, or that have not come into contact with, any overburden, raw material, intermediate products, finished product, byproduct, or waste products located on the site of such operations, except in accordance with Subparagraph C.1.d of this Section; and

b. all field activities or operations associated with oil and gas exploration, production, processing, or treatment operations or transmission facilities, including activities necessary to prepare a site for drilling and for the movement and placement of drilling equipment, whether or not such field activities or operations may be considered to be construction activities, except in accordance with Subparagraph C.1.c of this Section. Discharges of sediment from construction activities associated with oil and gas exploration, production, processing, or treatment operations or transmission facilities are not subject to the provisions of Clause C.1.c.iii of this Section.

[Note to Subparagraph A.2.b: The department encourages operators of oil and gas field activities or operations to implement and maintain Best Management Practices (BMPs) to minimize discharges of pollutants, including sediment, in storm water both during and after construction activities to help ensure protection of surface water quality during storm events. Appropriate controls would be those suitable to the site conditions and consistent with generally accepted engineering design criteria and manufacturer specifications. Selection of BMPs could also be affected by seasonal or climate conditions.]

A.3. - E.7.c. ...

8. Any storm water discharge associated with small construction activities identified in Subparagraph B.15.a of this Section requires permit authorization by March 10, 2003, unless designated for coverage before then.

E.9. - G.4.d, certification. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2001 et seq., and in particular Section 2074(B)(3) and (B)(4).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 21:945 (September 1995), amended LR 23:957 (August 1997), amended by the Office of Environmental Assessment, Environmental

Planning Division, LR 26:2273 (October 2000), LR 26:2552 (November 2000), repromulgated LR 27:40 (January 2001), amended LR 28:467 (March 2002), LR 29:701 (May 2003), repromulgated LR 30:230 (February 2004), amended by the Office of Environmental Assessment, LR 31:1321 (June 2005), amended by the Office of the Secretary, Legal Affairs Division, LR 31:2510 (October 2005), LR 32:

A public hearing will be held on August 24, 2006, at 1:30 p.m. in the Galvez Building, Oliver Pollock Conference Room, 602 N. Fifth Street, Baton Rouge, LA 70802. Interested persons are invited to attend and submit oral comments on the proposed amendments. Should individuals with a disability need an accommodation in order to participate, contact Judith A. Schuerman, Ph.D., at the address given below or at (225) 219-3550. Parking in the Galvez Garage is free with a validated parking ticket.

All interested persons are invited to submit written comments on the proposed regulation. Persons commenting should reference this proposed regulation by WQ069ft. Such comments must be received no later than August 24, 2006, at 4:30 p.m., and should be sent to Judith A. Schuerman, Ph.D., Office of the Secretary, Legal Affairs Division, Box 4302, Baton Rouge, LA 70821-4302 or to fax (225) 219-3582 or by e-mail to judith.schuerman@la.gov. The comment period for this rule ends on the same date as the public hearing. Copies of this proposed regulation can be purchased by contacting the DEQ Public Records Center at (225) 219-3168. Check or money order is required in advance for each copy of WQ069ft. This regulation is available on the Internet at www.deq.louisiana.gov under Rules and Regulations.

This proposed regulation is available for inspection at the following DEQ office locations from 8 a.m. until 4:30 p.m.: 602 N. Fifth Street, Baton Rouge, LA 70802; 1823 Highway 546, West Monroe, LA 71292; State Office Building, 1525 Fairfield Avenue, Shreveport, LA 71101; 1301 Gadwall Street, Lake Charles, LA 70615; 111 New Center Drive, Lafayette, LA 70508; 110 Barataria Street, Lockport, LA 70374; 645 N. Lotus Drive, Suite C, Mandeville, LA 70471.

Herman Robinson, CPM
Executive Counsel

0607#031

NOTICE OF INTENT

Office of the Governor Division of Administration Office of Group Benefits

EPO Plan of Benefits
(LAC 32:V.Chapters 1-7)

In accordance with the applicable provisions of R.S. 49:950 et seq., the Administrative Procedure Act, and pursuant to the authority granted by R.S. 42:801(C) and 802(B)(1), as amended and reenacted by Act 1178 of 2001, 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 finds that it is necessary to revise and amend provisions of the EPO Plan Document. The reason for this action is to

enhance member clarification and enable fair and effective administration health care benefits effectively for the program and members.

Accordingly, OGB hereby gives Notice of Intent to adopt the following Rule to become effective upon promulgation.

Title 32

EMPLOYEE BENEFITS

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

Chapter 1. Eligibility

§101. Persons to Be Covered

Eligibility requirements apply to all participants in the Program, including the PPO plan, the EPO plan, the MCO plan, an HMO plan, or the life insurance plan.

A. - A.2. ...

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

a. If employment begins on the first day of the month, coverage is effective on the first day of the following month (For example, if hired on July 1, coverage will begin on August 1).

b. If employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (For example, if hired on July 15, coverage will begin on September 1).

c. Employee coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. If completed after 30 days following the date of employment, the Employee will be considered an overdue applicant.

d. An Employee who transfers employment to another Participating Employer must complete a Transfer Form within 30 days following the date of transfer to maintain coverage without interruption. If completed after 30 days following the date of transfer, the Employee will be considered an overdue applicant.

4. Re-Enrollment, Previous Employment for Health Benefits and Life Insurance

A.4.a. - B.1.a. ...

b. An Employee retired from a Participant Employer may not be covered as an Employee.

c. Retirees are not eligible for coverage as overdue applicants.

2. Effective Date of Coverage

a. Retiree coverage will be effective on the first day of the month following the date of retirement if the Retiree and Participant Employer have agreed to make and are making the required contributions (For example, if retired July 15, coverage will begin August 1).

C. - C.2. ...

a. Dependents of Employees. Coverage will be effective on the date the Employee becomes eligible for Dependent Coverage.

C.2.b. - D. ...

1. The terms of the following paragraphs apply to all eligible Employees who apply for coverage after 30 days from the date the Employee became eligible for coverage and to all eligible Dependents of Employees and Retirees for whom the application for coverage was not completed within 30 days from the Date Acquired.

D.2. - E.2. ...

a. A special enrollment application must be made within 30 days of either the termination date of the prior coverage or the date the new Dependent is acquired. If it is made more than 30 days after eligibility, they will be considered overdue applicants subject to a pre-existing condition limitation.

b. ...

i. For loss of other coverage or marriage, the first day of the month following the date the Program receives all required forms for enrollment;

ii. - iii. ...

c. Special enrollment applicants must complete the "Acknowledgment of Pre-existing Condition" form and "Statement of Physical Condition" form.

E.2.d. - G.3. ...

H. Medicare+Choice/Medicare Advantage Option for Retirees (effective July 1, 1999). Retirees who are eligible to participate in a Medicare+Choice/Medicare Advantage plan who cancel coverage with the Program upon enrollment in a Medicare+Choice/Medicare Advantage plan may re-enroll in the Program upon withdrawal from or termination of coverage in the Medicare+Choice/Medicare Advantage plan, at the earlier of the following:

1. - 2. ...

I. Tricare for Life Option for Military Retirees. Retirees eligible to participate in the Tricare for Life (TFL) option on and after October 1, 2001 who cancel coverage with the Program upon enrollment in TFL may re-enroll in the Program in the event that the TFL option is discontinued or its benefits significantly reduced.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1804 (October 1999), amended LR 27:718 (May 2001), LR 28:2339 (November 2002), LR 29:336,338 (March 2003), LR 32:

§103. Continued Coverage

A. ...

1. Leave of Absence without Pay, Employer Contributions to Premiums

a. A participating employee who is granted leave of absence without pay due to a service related injury may continue coverage and the participating employer shall continue to pay its portion of health plan premiums for up to twelve months.

b. A participating employee who suffers a service related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the participating employer shall continue to pay its portion of the premiums until the employee becomes gainfully employed or is placed on state disability retirement.

c. A participating employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (F.M.L.A.) may continue coverage during the time of such leave and the participating employer may continue to pay its portion of premiums.

2. Leave of Absence without Pay; No Employer Contributions to Premiums. An employee granted leave of absence without pay for reasons other than those stated in Paragraph A, may continue to participate in an Office of

Group Benefits benefit plan for a period up to twelve months upon the employee's payment of the full premiums due.

B. - B.2. ...

C. Surviving Dependents/Spouse

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.

a. The surviving legal spouse of an Employee or Retiree may continue coverage unless or until the surviving spouse is or becomes eligible for coverage in a Group Health Plan other than Medicare.

b. The surviving never married Dependent Child of an Employee or Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a Group Health Plan other than Medicare, or until attainment of the termination age for Children, whichever occurs first.

c. Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees and Retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits.

d. Coverage provided by the Civilian Health and Medical Program for the Uniformed Service (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or a Dependent Child.

2. A surviving spouse or Dependent Child cannot add new Dependents to continued coverage other than a Child of the deceased Employee born after the Employee's death.

3. Participant Employer/Dependent Responsibilities

a. It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Program within 60 days of the death of the Employee or Retiree.

b. The Program will notify the surviving Dependents of their right to continue coverage.

c. Application for continued coverage must be made in writing to the Program within 60 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.

d. Coverage for the surviving spouse under this section will continue until the earliest of the following:

i. failure to pay the applicable premium timely;

ii. eligibility of the surviving spouse for coverage under a Group Health Plan other than Medicare.

e. Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:

i. failure to pay the applicable premium timely;

ii. eligibility of the surviving Dependent Child for coverage under any Group Health Plan other than Medicare.

iii. the attainment of the termination age for Children.

4. The provisions of paragraphs 1 through 3 this subsection are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following

the death of an Employee or Retiree. Continued coverage for surviving Dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

D. - D.3. ...

E. Military Service. Members of the National Guard or of the United States military reserves who are called to active military duty, and who are OGB participating Employees or covered Dependents will have access to continued coverage under OGB's health and life plans.

1. Health Plan Participation. When called to active military duty, participating employees and covered dependents may:

a. continue participation in the OGB health plan during the period of active military service, in which case the participating employer may continue to pay its portion of premiums; or

b. cancel participation in the OGB health plan during the period of active military service, in which case such plan participants may apply for reinstatement of OGB coverage within 30 days of:

i. the date of the Employee's reemployment with a participating employer,

ii. the Dependent's date of discharge from active military duty, or

iii. the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select;

iv. plan participants who elect this option and timely apply for reinstatement of OGB coverage will not be subject to a pre-existing condition (PEC) limitation, and the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and the corresponding Rules promulgated by OGB.

2. Life Insurance. When called to active military duty, Employees with OGB life insurance coverage may:

a. continue participation in the OGB life insurance during the period of active military service, however, the Accidental Death and Dismemberment coverage will not be in effect during the period of active military duty; or

b. cancel participation in the OGB life insurance during the period of active military service, in which case such Employee may apply for reinstatement of OGB life insurance within 30 days of the date of the Employee's reemployment with a participating employer; Employees who elect this option and timely apply for reinstatement of OGB life insurance will not be required to provide evidence of insurability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1806 (October 1999), amended LR 30:1190 (June 2004), LR 32:

§105. COBRA

A. Employees

1. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage

under a Leave of Absence has expired, unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.

2. It is the responsibility of the Participant Employer to notify the Program within 30 days of the date coverage would have terminated because of any of the foregoing events, and the Program will notify the Employee within 14 days of his or her right to continue coverage.

3. Application for continued coverage must be made in writing to the Program within 60 days of the date of the election notification and premium payment must be made within 45 days of the date the Employee elects continued coverage, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage under this section will continue until the earliest of the following:

a. failure to pay the applicable premium timely;

b. 18 months from the date coverage would have otherwise terminated;

c. entitlement to Medicare;

d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or

e. the Employer ceases to provide any group health plan for its employees.

5. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or a Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered spouse and/or covered Dependent Children may elect to continue coverage at his/her/their own expense. The elected coverage will be subject to the above-stated notification and termination provisions.

B. Surviving Dependents

1. Coverage under this Plan for covered surviving Dependents of an Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at his/her own expense.

2. It is the responsibility of the Participant Employer or surviving covered Dependents to notify the Program within 30 days of the death of the Employee or Retiree. The Program will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of the date of the election notification.

3. Premium payment must be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for the surviving Dependents under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the Employer ceases to provide any group health plan for its employees.

C. Divorced Spouse

1. Coverage under this Plan for an Employee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the Employee or Retiree, unless the covered divorced spouse elects to continue coverage at his or her own expense.

2. It is the responsibility of the divorced spouse to notify the Program within 60 days from the date of divorce and the Program will notify the divorced spouse within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of the election notification.

3. Premium payment must be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for the divorced spouse under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the Employer ceases to provide any group health plan for its employees.

D. Dependent Children

1. Coverage under this Plan for a covered Dependent Child of a covered Employee or Retiree will terminate on the last day of the month during which the Dependent Child no longer meets the definition of an eligible covered Dependent, unless the Dependent elects to continue coverage at his or her own expense.

2. It is the responsibility of the Dependent to notify the Program within 60 days of the date coverage would have terminated and the Program will notify the Dependent within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of receipt of the election notification.

3. Premium payment must be made within 45 days of the date the continued coverage is elected, for coverage

retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for Children under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the Employer ceases to provide any group health plan for its employees.

E. Dependents of COBRA Participants

1.a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered spouse or a covered Dependent Child becomes ineligible for coverage due to:

- i. death of the employee;
- ii. divorce from the employee; or
- iii. a dependent child no longer meets the definition of an eligible covered Dependent;

b. Then, the spouse and/or Dependent Child may elect to continue COBRA coverage at his/her own expense. Coverage will not be continued beyond 36 months from the date coverage would have otherwise terminated.

2. It is the responsibility of the spouse and/or the Dependent Child to notify the Program within 60 days of the date COBRA coverage would have terminated.

3. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for Children under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the employer ceases to provide any group health plan for its employees.

F. Disability COBRA

1. If a Covered Employee or Covered Dependent is determined by the Social Security Administration or by the Program staff (in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment), to have been totally disabled on the date the Covered Person became eligible for continued coverage or within the initial 18 months of coverage, coverage under this Plan for the Covered Person who is totally disabled may be extended at his or her own expense

up to a maximum of 29 months from the date coverage would have otherwise terminated.

2. To qualify the Covered Person must:

a. submit a copy of his or her Social Security Administration's disability determination to the Program before the initial 18-month continued coverage period expires and within 60 days after the latest of:

i. the date of issuance of the Social Security Administration's disability determination; and

ii. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours.

b. In the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment, submit proof of total Disability to the Program before the initial 18-month continued coverage period expires. The staff and medical director of the Program will make the determination of total Disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history, and other relevant evidence presented by the applicant.

3. For purposes of eligibility for continued coverage under this section, total Disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of 12 months. To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

4. Monthly payments for each month of extended COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

5. Coverage under this section will continue until the earliest of the following:

a. failure to pay the applicable premium timely;

b. 29 months from the date coverage would have otherwise terminated;

c. entitlement to Medicare;

d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied;

e. the Employer ceases to provide any group health plan for its employees; or

f. 30 days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Program within 30 days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment, 30 days after the month in which the Program determines that the Covered Person is no longer disabled.

G. Medicare COBRA

1. If an Employee becomes entitled to Medicare less than 18 months before the date the Employee's eligibility for

benefits under this Plan terminates, the period of continued coverage available for the Employee's covered Dependents will continue until the earliest of the following:

a. failure to pay the applicable premium timely;

b. 36 months from the date of the Employee's Medicare entitlement;

c. entitlement to Medicare;

d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or

e. the Employer ceases to provide any group health plan for its employees.

2. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

H. Miscellaneous Provisions. During the period of continuation, benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Employees and Retirees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1807 (October 1999), amended LR 32:

§107. Change of Classification

A. Adding or Deleting Dependents. The Plan Member must notify the Program when a Dependent is added to or deleted from the Plan Member's coverage that results in a change in the class of coverage. Notice must be provided within 30 days of the addition or deletion.

B. Change in Coverage

1. When there is a change in family status (e.g., marriage, birth of child) that affects the class of coverage, the change in classification will be effective on the date of the event. Application for the change must be made within 30 days of the date of the event.

2. When the addition of a Dependent changes the class of coverage, the additional premium will be charged for the entire month if the date of change occurs before the 15th day of the month. If the date of change occurs on or after the 15th day of the month, an additional premium will not be charged until the first day of the following month.

C. Notification of Change. It is the Employee's responsibility to notify the Program of any change in classification of coverage that affects the Employee's contribution amount. If failure to notify is later determined, it will be corrected on the first day of the following month.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1809 (October 1999), amended LR 32:

Chapter 2. Termination of Coverage

§201. Active Employee and Retired Employee Coverage

A. ...

1. the date the Program terminates;

2. the date the group or agency employing the covered Employee terminates or withdraws from the Program;

3. the date contribution is due if the group or agency fails to pay the required contribution for the covered Employee;

4. the date contribution is due if the Covered Person fails to make any contribution which is required for the continuation of coverage;

5. the last day of the month of the covered Employee's death;

6. the last day of the month in which the covered Employee ceases to be eligible.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1809 (October 1999), amended LR 32:

§203. Dependent Coverage

A. ...

1. the last day of the month the Employee ceases to be covered;

2. the last day of the month in which the Dependent, as defined in this Plan, ceases to be an eligible Dependent of the covered Employee;

3. - 4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1)

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1809 (October 1999), amended LR 32:

Chapter 3. Medical Benefits

§301. Eligible Expenses

A. Eligible Expenses are the charges incurred for the following services, drugs, supplies, and devices, when performed, prescribed, or ordered by a Physician and Medically Necessary for the Treatment of a Covered Person. All charges are subject to applicable deductibles, copayments, and/or coinsurance amounts (unless otherwise specifically provided), Fee Schedule limitations, Schedule of Benefits, exclusions, and other provisions of the Plan. A charge is incurred on the date that the service, drug, supply, or device is performed or furnished.

1. - 3. ...

4. anesthesia and its administration when ordered by the operating Physician and administered by an appropriately licensed nurse anesthetist or Physician in conjunction with a covered surgical service;

5. - 6. ...

7. Blood, blood derivatives, and blood processing, when not replaced;

8. - 8.c. ...

d. Ostomy Supplies, except supplies for nutritional and/or enteral feeding;

e. - 1. ...

9. Services of a licensed speech therapist when pre-approved through Outpatient Procedure Certification (§309, below) for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injury, or other similar structural or neurological disease, limited to 26 visits per Plan Year;

10. ...

11. Services rendered by a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) for the

Treatment of Accidental Injury to a Covered Person's natural teeth, under the following conditions:

a. Coverage was in effect with respect to the individual at the time of the accident;

b. Treatment commences within 90 days from the date of the accident and is completed within two years from the date of the accident;

c. Coverage remains continuously in effect with respect to the Covered Person during the course of the Treatment;

d. Eligible Expenses are limited to the cost of Treatment as estimated at the time of initial Treatment;

e. Eligible Expenses may include dental braces and orthodontic appliances, upon review and approval by the Program's Dental Consultant, and only under the following circumstances:

i. to return the alveolar alignment to its former state prior to a covered dental accident. The Program will allow benefits for orthopedic correction to establish reasonable occlusal function;

ii. a covered surgery that requires the use of braces for stabilization;

iii. severe skeletal deformity (i.e., cleft palate). The Program will allow benefits for orthopedic correction to establish reasonable occlusal function;

f. As used herein Accidental Injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force, and with respect to injuries to teeth, the act of chewing does not constitute an external force.

12. Durable Medical Equipment subject to the lifetime maximum payment limitation as listed in the Schedule of Benefits. The Program will require written certification by the treating Physician to substantiate the Medical Necessity for the equipment and the length of time that it will be used. The purchase of Durable Medical Equipment will be considered an Eligible Expense only upon a showing that the rental cost would exceed the purchase price. Under no circumstances may the Eligible Expense for an item of Durable Medical Equipment exceed the purchase price of such item;

13. - 17. ...

18. Orthopedic shoes prescribed by a Physician and completely custom built, limit one pair per plan year;

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

20. - 20.d. ...

21. Services of a Physical Therapist or Occupational Therapist licensed in the state in which the services are rendered, under the following conditions:

a. services are prescribed by a licensed Physician and rendered in an individual setting;

b. restorative potential exists;

c. services meet the generally accepted standards for medical practice;

d. services are reasonable and Medically Necessary for Treatment of a disease, illness, accident, injury, or post-operative condition;

e. services are approved through Case Management when rendered in the home;

f. services are limited to 50 visits per Plan Year. Additional visits subject to approval by Utilization Management.

22. Cardiac Rehabilitation when:

a. Rendered at a medical facility under the supervision of a licensed Physician;

b. - c. ...

NOTE: Charges incurred for dietary instruction, educational services, behavior modification literature, biofeedback, health club membership, exercise equipment, preventive programs, and any other items excluded by the Plan are not covered, unless provided for under Paragraph 30 of this subsection.

23. Preventive care consisting of routine physical examinations, lab work, and immunizations (including a yearly influenza vaccination) as follows:

a. Well Baby Care expenses subject to the annual deductible and co-payments:

i. newborn facility and professional charges;

ii. birth to age 1—all office visits for scheduled immunizations and screening;

b. Well Child Care expenses subject to the annual deductible and co-payments:

i. age 1 until age 3—three office visits per year for scheduled immunizations and screening;

ii. age 3 until age 15—one office visit per year for scheduled immunizations and screening;

c. Well Adult Care expenses, not subject to the annual deductible, but limited to a maximum benefit of \$200.00:

i. age 16 until age 40—once during a 3-year period;

ii. age 40 until age 50—once during a 2-year period;

iii. age 50 and over—once during a 1-year period.

NOTE: Benefits for Well Baby Care, Well Child Care and routine physical examinations for Well Adult Care, including immunizations, are based on the U.S. Preventive Services Task Force guidelines and recommendations of the National Immunization Program of the Centers for Disease Control and Prevention. All services must be rendered on an outpatient basis to monitor and maintain health and to prevent illness.

24. Specialized, age-appropriate wellness care, not subject to the annual deductible, as follows:

a. One Pap test for cervical cancer per Plan Year;

b. Mammographic examinations performed according to the following schedule:

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

ii. one mammogram every two Plan Years for any person who is 40-49 years of age;

iii. one mammogram every 12 months for any person who is 50 years of age or older;

c. Testing for detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing, once every 12 months for men over the age of 50 years;

25. - 26. ...

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

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

b. Physician Assistants and Registered Nurse Practitioners;

28. - 30.c. ...

31. Testing of sleep disorders only when the tests are performed at either:

a. a facility accredited by the American Academy of Sleep Medicine or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

b. a sleep study facility located within a healthcare facility accredited by JCAHO. No benefits are payable for surgical treatment of sleep disorders (including LAUP) except following demonstrated failure of non-surgical treatment and upon approval by the Program;

32. - 33.c. ...

34. Treatment provided in accordance with a clinical trial for cancer, including costs of investigational treatments and of associated protocol-related patient care if all of the following criteria are met:

a. treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer;

b. treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer;

c. treatment is being provided in accordance with a clinical trial approved by one of the following entities:

i. one of the United States National Institutes of Health;

ii. a cooperative group funded by one of the United States National Institutes of Health;

iii. the FDA in the form of an investigational new drug application;

iv. the United States Department of Veterans Affairs;

v. the United States Department of Defense;

vi. a federally funded general clinical research center;

vii. the Coalition of National Cancer Cooperative Groups.

d. the proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks;

e. the facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

f. there is no clearly superior, non-investigational approach;

g. the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and

h. the patient has signed an institutional review board-approved consent form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1)

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1810 (October 1999), amended LR 28:478 (March 2002), LR 29:334, 338 (March 2003), LR 30:1190 (June 2004), LR 31:440 (February 2005), LR 32:

§303. Fee Schedule

A. The Fee Schedule establishes the maximum allowable charges for Eligible Expenses. The Fee Schedule applies to both contracted (EPO) health care providers, who have entered into agreements with OGB regarding reimbursement under this plan, and to non-contracted (non-EPO) health care providers who have not entered into such agreements.

B. Plan Members may be subject to greater financial responsibility for services, drugs, supplies, and devices provided by non-contracted health care providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1811 (October 1999), amended LR 32:

§305. Automated Claims Adjusting

A. OGB utilizes commercially licensed software that applies all claims against its medical logic program to identify improperly billed charges and charges for which this Plan provides no benefits. Any claim with diagnosis or procedure codes deemed inadequate or inappropriate will be automatically reduced or denied. Providers accepting assignment of benefits cannot bill the Plan Member for the differential on the denial amount, in whole or in part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1811 (October 1999), amended LR 32:

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

A. - A.2. ...

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

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1812 (October 1999), amended LR 32:

§309. Outpatient Procedure Certification (OPC)

A. The purpose of OPC is for the Plan to certify that particular outpatient procedures and therapies are Medically Necessary. If OPC is not obtained when required, no benefits are payable under this Plan.

A.1. - B. ...

1. Speech therapy, subject to the limitations set forth in §301.A.9 of this Part.

2. - 7.d. repealed.

C. - C.2. ...

D. repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1812 (October 1999), amended LR 32:

§311. Case Management

A. - D.3.b. ...

E. repealed.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1812 (October 1999), amended LR 32:

§313. Dental Surgical Benefits

A. ...

B. If a Covered Person requires dental treatment in a hospital setting that is otherwise an Eligible Expense, the Plan will provide benefits for anesthesia rendered in the hospital and associated hospital charges. Prior authorization for hospitalization for dental treatment is required in the same manner as prior authorization is required for other covered medical services.

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

D. The provisions of this section shall not apply to Treatment rendered for Temporomandibular joint (TMJ) diseases or disorders.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1813 (October 1999), amended LR 32:

§315. Medicare Reduction

A. ...

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1813 (October 1999), amended LR 32:

§317. Exceptions and Exclusions

A. No benefits are provided under this Plan for the following:

1. injury compensable under any worker's compensation program, regardless of whether the patient has filed a claim for benefits. This applies to compensation provided on an expense-incurred basis or blanket settlements for past and future losses;

2. maintenance therapy consisting of convalescent, skilled nursing, sanitarium, custodial care, assisted living facilities, or rest cures designed to assist in daily living activities, maintain present physical and/or mental condition, or provide a structured or safe environment;

3. expenses for elective, non-therapeutic voluntary abortions (abortions performed for reasons other than to save the life of the mother);

4. injuries sustained by a Covered Person while in an aggressor role;

5. expenses incurred as a result of a Covered Person's commission or attempted commission of an illegal act;

6. services, supplies, or treatment for cosmetic purposes, including cosmetic surgery and any cosmetic complications of cosmetic surgery, unless necessary for the immediate repair of a deformity caused by a disease and/or injury that occurs while coverage is in force. No payment will be made for expenses incurred in connection with the treatment of any body part not affected by the disease and/or injury;

7. shoes and related items, such as wedges, cookies, and arch supports;

8. dental and orthodontic services, appliances, supplies, and devices, including, but not limited to the following:

a. dental braces and orthodontic appliances, except as specifically provided in §301.A.11.e of this Part;

b. treatment of periodontal disease;

c. dentures, dental implants, and any surgery for their use, except if needed as the result of an accident that meets the Program's requirements;

d. treatment for Temporomandibular Joint (TMJ) diseases or disorders, except as specifically provided in §301.A.28 of this Part;

e. expenses incurred for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, as specifically set forth herein, dental procedures which fall under the guidelines of treatment of accidental injury, procedures necessitated as a result of or secondary to cancer, or oral and maxillofacial surgeries which are shown to the satisfaction of the Program to be Medically Necessary, non-dental, non-cosmetic procedures;

9. medical services, supplies, treatments, and prescription drugs provided without charge to the Covered Person or for which the Covered Person is not legally obligated to pay;

10. maternity expenses incurred by any person other than the Employee or the Employee's legal Spouse;

11. personal convenience items including, but not limited to, admit kits, bedside kits, telephone, television, guest meals, and beds, and charges for luxury accommodations in any hospital or allied health facility provided primarily for the patient's convenience which are not deemed Medically Necessary by the Program;

12. charges for services, supplies, treatment, drugs, and devices which are in excess of the maximum allowable under the Medical Fee Schedule, Outpatient Surgical Facility Fee Schedule, or any other limitations of the Plan;

13. services, supplies, treatment, drugs, devices, and deluxe medical equipment which are not deemed Medically Necessary by the Program;

14. services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, pain rehabilitation control and/or therapy, and dietary or educational instruction for all diseases and/or illnesses, except diabetes;

15. services and supplies for the treatment of and/or related to gender dysphoria or reverse sterilization;

16. artificial organ implants, penile implants, transplantation of non-human organs, and any surgery and

other treatment, services, or supplies, related to such procedures, or to complications related to such procedures;

17. expenses subsequent to the initial diagnosis for infertility and complications, including but not limited to, services, drugs, procedures, or devices to achieve fertility, in-vitro fertilization, low tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, donor eggs, and reversal of sterilization procedures;

18. non-medical supplies such as air conditioners and/or filters, dehumidifiers, air purifiers, wigs or toupees, heating pads, cold devices, home enema equipment, rubber gloves, swimming pools, saunas, whirlpool baths, home pregnancy tests, lift chairs, devices or kits to stimulate the penis, exercise equipment, any other items not normally considered medical supplies, and any items the Program determines are not medical supplies;

19. administrative fees, interest, penalties, or sales tax;

20. marriage counseling, family relations counseling, divorce counseling, parental counseling, job counseling, and career counseling;

21. charges for Physician services rendered to a Covered Person over the telephone or in a non-face-to-face setting;

22. radial keratotomy, laser surgery, and any other procedures, services, or supplies for the correction of refractive errors of the eyes;

23. services, supplies, surgeries, and treatments for excess body fat, resection of excess skin and/or fat following weight loss or pregnancy, and/or obesity, and morbid obesity.

24. hearing aids and any examination to determine the fitting or necessity of hearing aids, except as specifically provided for in §301(A)(33) of this Part;

25. hair plugs and/or transplants;

26. routine physical examinations and/or immunizations not provided for under Eligible Expenses;

27. eye examinations, glasses, and contact lenses, except as specifically provided for as an Eligible Expense in §301.A.15 of this Part;

28. diagnostic or treatment measures that are not recognized as generally accepted medical practice;

29. medical supplies not listed under Eligible Expenses;

30. treatment or services for mental health and substance abuse provided outside the treatment plan developed by the Program's managed care contractor or by therapists with whom or at facilities with which the Program's managed care contractor does not have a contract;

31. genetic testing, except when determined to be Medically Necessary during a covered pregnancy;

32. services rendered by a private-duty Registered Nurse (R.N.) or by a private-duty Licensed Practical Nurse (L.P.N.);

33. services rendered by a Physician or other health care Provider related to the patient by blood, adoption, or marriage;

34. expenses for services rendered by a Physician or other health care Provider who is not licensed in the state where such services are rendered or in any facility not

holding a valid license in the state and for the services rendered;

35. facility fees for services rendered in a Physician's office or in any facility not approved by the federal Health Care Finance Administration for Medicare reimbursement;

36. glucometers;

37. augmentative communication devices;

38. charges to obtain medical records or any other information needed and/or required to adjudicate a claim;

39. charges greater than the global allowance for any laboratory, pathology, or radiological procedure;

40. speech therapy or the services of a speech therapist except as specifically provided in §301.A.9.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1813 (October 1999), amended LR 26:487 (March 2000), LR 27:717 (May 2001), LR 28:2340 (November 2002), LR 31:440 (February 2005), LR 32:

§321. Exclusive Provider Program

A. The Program may implement Exclusive Provider Organization (EPO) arrangements or other agreements to discount payable fees. The Program reserves the right to negotiate the amount of discounts, incentives offered to Plan Members, and all other provisions which are a part of any discount fee arrangement. To be eligible, the Program must be the primary carrier at the time services are rendered.

1. If a Covered Person obtains medical services or hospital services from an eligible provider who has agreed to provide the services at a mutually agreed upon discount from the maximum medical Fee Schedule or at a per diem or discounted rate from a hospital, the Program will pay, after applicable copays, as specified in the Schedule of Benefits. There is a contractual assignment to all EPO providers

2. If a Covered Person receives services from a non-EPO Provider, the Program will pay, after satisfaction of applicable deductibles, as specified in the Schedule of Benefits. Eligible Expenses of non-EPO Providers are based upon the OGB's Fee Schedule.

NOTE: Both EPO and non-EPO services are subject to the applicable co-pays or deductibles, limitations, and exclusions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1835 (October 1999), amended LR 27:722 (May 2001), LR 29:339 (March 2003), LR 32:

§325. Prescription Drug Benefits

A. This Plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription and are dispensed by a licensed pharmacist or pharmaceutical company.

1. These include and shall not be limited to:

a. Insulin;

b. Retin-A dispensed for covered persons under the age of 27;

c. Vitamin B-12 injections;

d. prescription Potassium Chloride; and

e. over-the-counter diabetic supplies including, but not limited to, strips, lancets, and swabs.

2. In addition, this Plan allows benefits limited to \$200 per month for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are Medically Necessary and are obtained from a source approved by the OGB. Such expenses shall be subject to coinsurance and co-payments relating to prescription drug benefits. In connection with this benefit, the following words shall have the following meanings:

a. *Inherited Metabolic Disease*—a disease caused by an inherited abnormality of body chemistry and shall be limited to:

i. Phenylketonuria (PKU),

ii. Maple Syrup Urine Disease (MSUD),

iii. Methylmalonic Acidemia (MMA),

iv. Isovaleric Acidemia (IVA),

v. Propionic Acidemia,

vi. Glutaric Acidemia,

vii. Urea Cycle Defects, or

viii. Tyrosinemia

b. *Low Protein Food Products*—food products that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include natural foods that are naturally low in protein.

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

1. appetite suppressant drugs;

2. dietary supplements;

3. topical forms of Minoxidil;

4. Retin-A dispensed for a covered person over age 26;

5. amphetamines dispensed for diagnoses other than Attention Deficit Disorder or Narcolepsy;

6. nicotine, gum, patches, or other products, services, or programs intended to assist an individual to reduce or cease smoking, or other use of tobacco products;

7. nutritional or parenteral therapy;

8. vitamins and minerals;

9. drugs available over the counter;

10. serostim dispensed for any diagnoses or therapeutic purposes other than AIDS wasting;

11. drugs prescribed for the treatment of impotence, except following the surgical removal of the prostate gland; and

12. glucometers.

C. - C.7 ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1815 (October 1999), amended LR 27:717,718 (May 2001), LR 27:1886 (November 2001), LR 28:2340 (November 2002), LR 29:337 (March 2003), LR 32:

Chapter 4. Uniform Provisions

§401. Statement of Contractual Agreement

A. This Plan, as amended, including the Schedule of Benefits, together with the Application for Coverage and any related documents executed by or on behalf of the covered Employee, constitute the entire agreement between the parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1816 (October 1999), amended LR 32:

§403. Properly Submitted Claim

A. For Plan reimbursement, a claim must include:

1. - 4. ...
5. type of services rendered, with diagnosis and/or procedure codes that are valid and current for the date of service;
6. date and place of service;
7. - 10. ...

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1816 (October 1999), amended LR 32:

§405. When Claims Must Be Filed

A. - B. ...

C. Requests for review of payment or corrected bills must be submitted within 18 months of receipt date of the original claim. Requests for review of payment or corrected bills received after that time will not be considered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1816 (October 1999), amended LR 28:476 (March 2002), LR 32:

§407. Right to Receive and Release Information

A. Without notice or consent the Program may release to or obtain from any company, organization, or person, any information regarding any person which the Program deems necessary to carry out the provisions of this Plan, or to determine how, or if, they apply. Any claimant under the Plan must furnish the Program with any information necessary to implement this provision. OGB retains information for the minimum period of time required by law. After such time, information may no longer be available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1816 (October 1999), amended LR 32:

§409. Legal Limitations

A. ...

B. Information provided by the Program or any of its employees or agents to Plan Members does not modify or override the terms and provisions of the Plan. In the event of any conflict between the written provisions of this Plan and any information provided, the written provisions of this Plan shall supercede and control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1816 (October 1999), amended LR 28:477 (March 2002), LR 32:

§413. Recovery of Overpayments

A. If an overpayment occurs, the Program retains the right to recover the overpayment. The Covered Person, institution, or Provider receiving the overpayment must return the overpayment. At the Plan's discretion, the overpayment may be deducted from future claims. Should legal action be required as a result of fraudulent statements or deliberate omissions on the application for coverage or a claim for benefits, the defendant will be responsible for attorney fees of 25 percent of the overpayment or \$1,000, whichever is greater. The defendant will also be responsible for court costs and legal interest from the date of judicial demand until paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1816 (October 1999), amended LR 32:

§415. Subrogation and Reimbursement

A. Upon payment of any eligible benefits covered under this Plan, the Office of Group Benefits shall succeed and be subrogated to all rights of recovery of the covered Employee, his Dependents or other Covered Persons, or their heirs or assigns, for whose benefit payment is made, and they shall execute and deliver instruments and papers and do whatever is necessary to secure such rights, and shall do nothing after loss to prejudice such rights.

B. The Office of Group Benefits shall be entitled, to the extent of any payment made to a covered Employee, his Dependents or other Covered Persons, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a covered Employee, his Dependents or other Covered Persons, against any person or entity legally responsible for the disease, illness, accident or injury for which said payment was made. To this end, covered Employees, their Dependents, or other Covered Persons agree to immediately notify the Office of Group Benefits of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident or injury.

C. These subrogation and reimbursement rights also apply when a Covered Person recovers under, but not limited to, an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1817 (October 1999), amended LR 32:

§417. Employer Responsibility

A. It is the responsibility of the Participant Employer to submit enrollment and change forms and all other necessary documentation to the Program on behalf of its Employees. Employees of a Participant Employer will not, by virtue of furnishing any documentation to the Program, 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 OGB when 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 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. A Participant Employer that receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the OGB MSP Adjuster within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a covered Employee. If not timely forwarded, OGB will assume responsibility only for Covered Plan benefits due to Medicare for a covered Employee. The Participant Employer will be responsible for interest, fines, and penalties due.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1817 (October 1999), amended LR 29:1819 (September 2003), LR 32:

§419. Program Responsibility

A. OGB will administer the Plan in accordance with its terms, state and federal law, the OGB's established policies, interpretations, practices, and procedures. OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding eligibility for benefits and to decide disputes which may arise relative to a Covered Person's rights.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1817 (October 1999), amended LR 32:

§423. Amendments to or Termination of the Plan and/or Contract

A. OGB has the statutory responsibility of providing health and accident and death benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any Employee, whether active or retired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1818 (October 1999), amended LR 32:

Chapter 6. Definitions

§601. Definitions

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

Appeal—a request by a Plan Member for and a formal review of a medical claim for benefits or an eligibility determination.

Benefit Payment—payment of Eligible Expenses due or owing by a Covered Person, after applicable deductibles, co-payments, and coinsurance, and subject to all limitations and

exclusions, at the rate shown under Percentage Payable in the Schedule of Benefits.

Board of Trustees—repealed.

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

Calendar Year—repealed.

* * *

Child or Children includes—

1. A legitimate, duly acknowledged, and/or legally adopted Child of the Employee and/or the Employee's legal spouse's who is dependent upon the Employee for support;

2. A Child in the process of being adopted by the Employee through an agency adoption, who is living in the household of the Employee, and is or will be included as a Dependent on the Employee's federal income tax return for the current or following tax year (if filing is required);

3. A Child in the legal custody of the Employee, who lives in the household of the Employee and is or will be included as a Dependent on the Employee's federal income tax return for the current or following tax year (if filing is required);

4. A Grandchild of the Employee that is not in the legal custody of the Employee, who is dependent upon the Employee for support and whose parent is a covered Dependent. If the Employee seeking to cover a Grandchild is a paternal grandparent, the Program will require that the biological father, i.e. the covered son of the Employee, execute an acknowledgement of paternity.

NOTE: If the Employee Dependent parent becomes ineligible for coverage under the Program, the Employee's Grandchild will also be ineligible for coverage, unless the Employee has legal custody of his/her Grandchild.

COBRA—the federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Committee—repealed.

Convalescent, Maintenance Care, or Rest Cures—treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by oneself, family, or other caregivers who are not eligible Providers. The services are primarily designed to help the patient with daily living activities, maintain the patient's present physical and mental condition, and/or provide a structured or safe environment.

Covered Person—an active or retired Employee, his/her eligible Dependent, or any other individual eligible for coverage for whom the necessary application forms have been completed and for whom the required contribution is made.

Covered Services—to those health care services for which a Plan Member is entitled to receive Benefit Payments in accordance with the terms of this Plan.

Custodial Care—

1. Care designed to assist an individual in the performance of daily living activities (i.e. services which constitute personal care such as walking, getting in and out of bed, bathing, dressing, eating, and using the toilet) that does not require admission to a hospital or other institution for the treatment of a disease, illness, accident, or injury, or for the performance of surgery;

2. Care primarily intended to provide room and board to an individual with or without routine nursing care, training in personal hygiene, or other forms of self-care;

3. Supervisory care provided by a Physician whose patient who is mentally or physically incapacitated and is not under specific medical, surgical, or psychiatric treatment, when such care is intended to reduce the patient's incapacity to the extent necessary to enable the patient to live outside of an institution providing medical care, or when, despite treatment, there is not reasonable a likelihood that the incapacity will be reduced.

Date Acquired—the date a Dependent of a covered Employee is acquired in the following instances and on the following dates only:

1. legal spouse—the date of marriage;
2. child or children—
 - a. natural child—the date of birth;
 - b. child in the process of being adopted;
 - c. agency adoption—the date the adoption contract was executed between the employee and the adoption agency;
 - d. private adoption—the date the Act of Voluntary Surrender is executed in favor of the Employee. The Program must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date it Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;
 - e. child who lives in the household of the covered Employee and is currently or will be included as a Dependent on the Employee's federal income tax return—the date of the court order granting legal custody;
 - f. grandchild of the Employee that is not in the legal custody of the Employee, but who is dependent upon the Employee for support and whose parent is a covered Dependent:
 - i. the date of birth of the Grandchild, if all of the above requirements are met at the time of birth; or
 - ii. the date on which the coverage becomes effective for the covered Dependent, if all of the above requirements are not met at the time of birth.

Deductible—the dollar amount that a Covered Person must pay as shown in the Schedule of Benefits before benefits will be paid in a Plan Year.

Dependent—any of the following persons who are enrolled for coverage as Dependents, if they are not also covered as an Employee:

1. the covered Employee's legal Spouse;
2. a never married Child from date of birth up to 21 years of age and dependent upon the Employee for support ;
3. a never married Child who is a fulltime student under 24 years of age and financially dependent upon the Employee for support;
4. a never married Child of any age who meets the criteria set forth in §103.D, above;

Durable Medical Equipment (DME)—equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of a illness or injury, and is appropriate for use in the home. DME includes, but is not limited to, items such as wheelchairs, hospital beds, respirators, braces (non-dental), custom orthotics which must be specially made and not available at retail stores.

Emergency Medical Condition—a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or with respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Room Services—medical services eligible for reimbursement that are necessary to screen, evaluate, and stabilize an Emergency Medical Condition and are provided at a hospital Emergency Room and billed by a hospital.

Employee—a full-time Employee as defined by a Participant Employer and in accordance with state law.

Family Unit Limit—each of three covered members of a family unit have met the dollar amount shown in the Schedule of Benefits as Plan Year deductible for an individual. Once the Family Unit Limit is met, the deductibles of all other covered members of the family unit will be considered satisfied for that Plan Year.

Fee Schedule—the maximum allowable charges for professional or hospital services adopted by the OGB that may be considered as an Eligible Expense.

Future Medical Recovery—repealed.

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

Group Health Plan—a plan (including a self-insured plan) offered or contributed to, by an employer (including a self-employed person) or employee organization to provide health care to employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, and/or their families.

Health Insurance Coverage—benefits consisting of medical care offered by a health insurance issuer under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract.

HIPAA—the Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and Federal Regulations promulgated pursuant thereto.

Hospital—an institution that is currently licensed as a hospital by the state in which services are rendered and is not primarily an institution for rest, the aged, the treatment of pulmonary tuberculosis, a nursing home, extended care facility, remedial training institution, or a facility primarily for the treatment of conduct and behavior disorders.

Incurred Date—the date when a particular service or supply is rendered or obtained. When a single charge is made for a series of services, each service will bear a prorated share of the charge.

Lifetime Maximum Benefit—the maximum amount of benefits that will be paid under the Plan for all Eligible Expenses incurred by a Covered Person.

Medically Necessary—a service, treatment, procedure, equipment, drug, device, item, or supply, which, in the judgment of the Program:

1. is appropriate and consistent with a Covered Person's diagnosis and treatment as well as with nationally accepted medical standards; and

2. is not primarily for personal comfort or convenience or Custodial Care.

Medicare—the health insurance available through Medicare laws enacted by the Congress of the United States.

* * *

Occupational Therapy—the application of any activity one engages in for the purposes of evaluation, interpretation, treatment planning, and treatment of problems interfering with functional performance in persons impaired by physical illness or injury in order to significantly improve functioning.

* * *

Participating Provider—an EPO, as defined herein.

Physical Therapy means the evaluation of physical status as related to functional abilities and treatment procedures as indicated by that evaluation. And licensed for the state where services are rendered.

Physician—

1. *Physician* means the following persons, appropriately licensed to practice their respective professional skills at the time and place the service is rendered:

- a. a Doctor of Medicine (M.D.);
- b. a Doctor of Dental Surgery (D.D.S.);
- c. a Doctor of Dental Medicine (D.M.D.);
- d. a Doctor of Osteopathy (D.O.);
- e. a Doctor of Podiatric Medicine (D.P.M.);
- f. a Doctor of Chiropractic (D.C.);
- g. a Doctor of Optometry (O.D.);
- h. a Psychologist meeting the requirements of the National Register of Health Service Providers in Psychology;
- i. a mental health counselor;
- j. a substance abuse counselor;
- k. an Audiologist.

2. The term *Physician* does not include a medical doctor in the capacity of supervising interns, residents, senior residents, or fellows enrolled in a training program who does not personally provide medical Treatment or perform a surgical procedure for the Covered Person.

Plan—coverage offered by the Office of Group Benefits under this contract including EPO benefits, prescription drug benefits, mental health and substance abuse benefits, and comprehensive medical benefits. The term Plan as defined herein is used interchangeably with the term Program as defined below.

* * *

Plan Year—the period from July 1, or the date the Covered Person first becomes covered under the Plan, through the next following June 30. Each successive Plan Year will be the twelve month period from July 1 through the next following June 30.

PPO—repealed.

Program—the Office of Group Benefits and/or the Plan.

Provider—one or more entities which offer health care services and shall include but not be limited to individuals,

or groups of physicians, individuals or groups of psychologists, nurse midwives, ambulance service companies, hospitals, and other health care entities that provide Covered Services to Covered Individuals.

Recovery—with respect to Subrogation and Reimbursement (§413) recovery means any and all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for losses allegedly caused by injury or sickness, whether or not the losses reflect medical or dental charges covered by the Program.

Referee—repealed.

Rehabilitation and Rehabilitation Therapy—care concerned with the management and functional ability of patients disabled by disease, illness, accident, or injury.

Reimbursement—repayment to the Program for Benefits Payments made by the Program.

Retiree—

1. *Retiree* means an individual who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

- a. immediately received retirement benefits from an approved state or governmental agency defined benefit plan;
- b. was not eligible for participation in such plan or legally opted not to participate in such plan; and either:
 - i. began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65; or
 - ii. began employment after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or
 - iii. was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or
 - iv. maintained continuous coverage with the Program as an eligible Dependent until he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan;
- c. immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.

2. *Retiree* also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of Subparagraphs a., b., and c above.

Room and Board—all expenses necessary to maintain and sustain a Covered Person upon admittance to a hospital and during a hospital confinement. This can include, but is not limited to, facility charges for the maintenance of the Covered Person's hospital room, dietary and food services,

nursing services performed by nurses employed by or under contract with the hospital, and housekeeping services.

* * *

Utilization Management—the process of evaluating the necessity, appropriateness, and efficiency of health care services against established guidelines and criteria.

Utilization Review Organization (URO)—an entity that has established one or more utilization review programs which evaluates the medical necessity, appropriateness, and efficiency of the uses of health care services, procedures, and facilities.

Well Adult Care—covered persons age 16 and older and means a routine physical examination by a physician that may include an influenza vaccination, lab work, and x-rays performed as part of the exam in that physician's office, when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedures and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as *Well Adult Care*.

Well Baby Care—covered persons from birth until age 1 and means routine care to a well, newborn infant that may include physical examinations and active immunizations provided by a physician when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedures and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as *Well Baby Care*.

Well Child Care—covered persons from age 1 through age 15 and means routine physical examinations and active immunizations provided by a physician, when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedure and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as *Well Child Care*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1)

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1820 (October 1999), amended LR 29:335 (March 2003), LR 32:

Chapter 7. Schedule of Benefits—EPO
§701. Comprehensive Medical Benefits

A. Eligible Expenses for professional medical services are reimbursed on a fee schedule of maximum allowable charges. All eligible expenses are determined in accordance with plan limitations and exclusions.

Lifetime maximum for all benefits, except outpatient prescription drug benefits, per person	\$2,000,000
Lifetime maximum for outpatient prescription drug benefits, per person	\$250,000

1. ...

2. Percentage Payable, Member Co-Payments

A.2.a. - C.3. ...

²Participating providers are reimbursed at 100% of Eligible Expenses up to the maximum benefit; Non-Participating providers are reimbursed at 70% of Eligible Expenses up to the maximum benefit

Services include screenings to detect illness or health risks during a Physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history.

Specialized age appropriate wellness (not subject to deductible). For a complete list of benefits, see §301(A)24 of this Part.

D. Pre-Natal and Postpartum Maternity. See Percentage payable after member co-payment and satisfaction of applicable deductibles (§701.A.2.a above). \$90 one-time member copay to include physician delivery charge, all pre-natal, and one post-partum visit.

E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1823 (October 1999), amended LR 26: 487 (March 2000), LR 27:717,719 (May 2001), LR 27:1886 (November 2001), LR 28:476 (March 2002), LR 28:2342,2343 (November 2002), LR 28:2509 (December 2002), LR 29:335, 337, 338 (March 2003), LR 30:1190 (June 2004), LR 32:

Family Impact Statement

The proposed Rule has no known impact on family formation, stability, or autonomy.

Interested persons may present their views, in writing, to Tommy D. Teague, Chief Executive Officer, Office of Group Benefits, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Monday, August 21, 2006.

Tommy D. Teague
 Chief Executive Officer

**FISCAL AND ECONOMIC IMPACT STATEMENT
 FOR ADMINISTRATIVE RULES
 RULE TITLE: EPO Plan of Benefits**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

This rule change is to clarify the current EPO Plan of Benefits and make certain technical amendments to the document. The reason for this action is to enhance member clarification and be able to administer health care benefits effectively for the Program and the member. It is anticipated \$3,000 in expenses will be incurred with the publishing of this rule in FY 06/07.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Revenue collections of State or Local Governmental units should not be affected by this rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This rule modifies and updates the EPO Plan of Benefits for the clarification of the members and effectiveness of the Program. This rule contains numerous amendments that incorporates the current administrative practices of the Office of Group Benefits.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Competition and employment will not be affected.

Tommy D. Teague
 Chief Executive Officer
 0607#051

H. Gordon Monk
 Legislative Fiscal Officer
 Legislative Fiscal Office

NOTICE OF INTENT

Office of the Governor Division of Administration Office of Group Benefits

MCO Plan of Benefits
(LAC 32:IX.Chapters 1-6)

In accordance with the applicable provisions of R.S. 49:950, et seq., the Administrative Procedure Act, and pursuant to the authority granted by R.S. 42:801(C) and 802(B)(1), as amended and reenacted by Act 1178 of 2001, 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 finds that it is necessary to revise and amend provisions of the MCO Plan Document. The reason for this action is to enhance member clarification and be able to administer health care benefits effectively for the program and member.

Accordingly, OGB hereby gives Notice of Intent to adopt the following Rule to become effective upon promulgation.

Title 32

EMPLOYEE BENEFITS

Part IX. Managed Care Option (MCO) Plan of Benefits

Chapter 1. Eligibility

§101. Persons to Be Covered

NOTE: Eligibility requirements apply to all participants in the Program, including the PPO plan, the MCO plan, the MCO plan, an HMO plan, or the life insurance plan.

A. - A.2. ...

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

a. If employment begins on the first day of the month, coverage is effective on the first day of the following month (for example, if hired on July 1, coverage will begin on August 1).

b. If employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (for example, if hired on July 15, coverage will begin on September 1).

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

d. An employee who transfers employment to another participating employer must complete a transfer form within 30 days following the date of transfer to maintain coverage without interruption. If completed after 30 days following the date of transfer, the employee will be considered an overdue applicant.

4. Re-Enrollment, Previous Employment for Health Benefits and Life Insurance

A.4.a. - B.1.a. ...

b. An employee retired from a participant employer may not be covered as an employee.

c. Retirees are not eligible for coverage as overdue applicants.

2. Effective Date of Coverage

a. Retiree coverage will be effective on the first day of the month following the date of retirement if the retiree and participant employer have agreed to make and are making the required contributions (For example, if retired July 15, coverage will begin August 1).

C. - C.2. ...

a. Dependents of Employees. Coverage will be effective on the date the employee becomes eligible for dependent coverage.

C.2.b. - D. ...

1. The terms of the following paragraphs apply to all eligible employees who apply for coverage after 30 days from the date the employee became eligible for coverage and to all eligible dependents of employees and retirees for whom the application for coverage was not completed within 30 days from the date acquired.

D.2.-E.1.c. ...

2. After Acquired Dependents. Special enrollment will be permitted for employees or dependents for whom the option to enroll for coverage was previously declined when the employee acquires a new dependent by marriage, birth, adoption, or placement for adoption.

a. A special enrollment application must be made within 30 days of either the termination date of the prior coverage or the date the new dependent is acquired. If it is made more than 30 days after eligibility, they will be considered overdue applicants subject to a pre-existing condition limitation.

b. ...

i. for loss of other coverage or marriage, the first day of the month following the date the program receives all required forms for enrollment;

ii. - iii. ...

c. Special enrollment applicants must complete the "Acknowledgment of Pre-existing Condition" form and "Statement of Physical Condition" form.

E.2.d. - G.3. ...

H. Medicare+Choice/Medicare Advantage Option for Retirees (effective July 1, 1999). Retirees who are eligible to participate in a Medicare+Choice/Medicare Advantage plan who cancel coverage with the program upon enrollment in a Medicare+Choice/Medicare Advantage plan may re-enroll in the program upon withdrawal from or termination of coverage in the Medicare+Choice/Medicare Advantage plan, at the earlier of the following:

H.1. - I. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:883 (June 2003), amended LR 32:

§103. Continued Coverage

A. ...

1. Leave of Absence without Pay, Employer Contributions to Premiums

a. A participating employee who is granted leave of absence without pay due to a service related injury may continue coverage and the participating employer shall

continue to pay its portion of health plan premiums for up to 12 months.

b. A participating employee who suffers a service related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the participating employer shall continue to pay its portion of the premiums until the employee becomes gainfully employed or is placed on state disability retirement.

c. A participating employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (F.M.L.A.) may continue coverage during the time of such leave and the participating employer may continue to pay its portion of premiums.

2. Leave of Absence without Pay; No Employer Contributions to Premiums. An employee granted leave of absence without pay for reasons other than those stated in Paragraph A, may continue to participate in an Office of Group Benefits benefit plan for a period up to 12 months upon the employee's payment of the full premiums due.

B. - B.2. ...

C. Surviving Dependents/Spouse

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

a. The surviving legal spouse of an employee or retiree may continue coverage unless or until the surviving spouse is or becomes eligible for coverage in a Group Health Plan other than Medicare.

b. The surviving never married dependent child of an employee or retiree may continue coverage unless or until such dependent child is or becomes eligible for coverage under a Group Health Plan other than Medicare, or until attainment of the termination age for children, whichever occurs first.

c. Surviving dependents will be entitled to receive the same participant employer premium contributions as employees and retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits.

d. Coverage provided by the Civilian Health and Medical Program for the Uniformed Service (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or a dependent child.

2. A surviving spouse or dependent child cannot add new dependents to continued coverage other than a child of the deceased employee born after the employee's death.

3. Participant Employer/Dependent Responsibilities

a. It is the responsibility of the participant employer and surviving covered dependent to notify the program within 60 days of the death of the employee or retiree.

b. The program will notify the surviving dependents of their right to continue coverage.

c. Application for continued coverage must be made in writing to the program within 60 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage

retroactive to the date coverage would have otherwise terminated.

d. Coverage for the surviving spouse under this Section will continue until the earliest of the following:

i. failure to pay the applicable premium timely;

ii. eligibility of the surviving spouse for coverage under a Group Health Plan other than Medicare.

e. Coverage for a surviving dependent child under this section will continue until the earliest of the following events:

i. failure to pay the applicable premium timely;

ii. eligibility of the surviving dependent child for coverage under any Group Health Plan other than Medicare;

iii. the attainment of the termination age for children.

4. The provisions of Paragraphs 1 through 3 this Subsection are applicable to surviving dependents who, on or after July 1, 1999, elect to continue coverage following the death of an employee or retiree. Continued coverage for surviving dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

D. - D.3. ...

E. Military Service. Members of the National Guard or of the United States military reserves who are called to active military duty, and who are OGB participating employees or covered dependents will have access to continued coverage under OGB's health and life plans.

1. Health Plan Participation. When called to active military duty, participating employees and covered dependents may:

a. continue participation in the OGB health plan during the period of active military service, in which case the participating employer may continue to pay its portion of premiums; or

b. cancel participation in the OGB health plan during the period of active military service, in which case such plan participants may apply for reinstatement of OGB coverage within 30 days of:

i. the date of the employee's reemployment with a participating employer;

ii. the dependent's date of discharge from active military duty; or

iii. the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select;

iv. plan participants who elect this option and timely apply for reinstatement of OGB coverage will not be subject to a pre-existing condition (PEC) limitation, and the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in R.S. 42:851(E) and the corresponding rules promulgated by OGB.

2. Life Insurance. When called to active military duty, employees with OGB life insurance coverage may:

a. continue participation in the OGB life insurance during the period of active military service, however, the accidental death and dismemberment coverage will not be in effect during the period of active military duty; or

b. cancel participation in the OGB life insurance during the period of active military service, in which case such employee may apply for reinstatement of OGB life

insurance within 30 days of the date of the employee's reemployment with a participating employer; employees who elect this option and timely apply for reinstatement of OGB life insurance will not be required to provide evidence of insurability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:885 (June 2003), amended LR 30:1191 (June 2004), LR 32:

§105. COBRA

A. Employees

1. Coverage under this plan for a covered employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the employee no longer meets the definition of an employee, or coverage under a leave of absence has expired, unless the covered employee elects to continue coverage at the employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.

2. It is the responsibility of the participant employer to notify the program within 30 days of the date coverage would have terminated because of any of the foregoing events, and the program will notify the employee within 14 days of his or her right to continue coverage.

3. Application for continued coverage must be made in writing to the program within 60 days of the date of the election notification and premium payment must be made within 45 days of the date the employee elects continued coverage, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 18 months from the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the employer ceases to provide any group health plan for its employees.

5. If employment for a covered employee is terminated (voluntarily or involuntarily) or significantly reduced, the employee no longer meets the definition of an employee, or a leave of absence has expired, and the employee has not elected to continue coverage, the covered spouse and/or covered dependent children may elect to continue coverage at his/her/their own expense. The elected coverage will be subject to the above-stated notification and termination provisions.

B. Surviving Dependents

1. Coverage under this plan for covered surviving dependents of an employee or retiree will terminate on the last day of the month in which the employee's or retiree's

death occurs, unless the surviving covered dependents elect to continue coverage at his/her own expense.

2. It is the responsibility of the participant employer or surviving covered dependents to notify the program within 30 days of the death of the employee or retiree. The program will notify the surviving dependents of their right to continue coverage. Application for continued coverage must be made in writing to the program within 60 days of the date of the election notification.

3. Premium payment must be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for the surviving dependents under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the employer ceases to provide any group health plan for its employees.

C. Divorced Spouse

1. Coverage under this plan for an employee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the employee or retiree, unless the covered divorced spouse elects to continue coverage at his or her own expense.

2. It is the responsibility of the divorced spouse to notify the program within 60 days from the date of divorce and the program will notify the divorced spouse within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the program within 60 days of the election notification.

3. Premium payment must be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for the divorced spouse under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or

e. the employer ceases to provide any group health plan for its employees.

D. Dependent Children

1. Coverage under this plan for a covered dependent child of a covered employee or retiree will terminate on the last day of the month during which the dependent child no longer meets the definition of an eligible covered dependent, unless the dependent elects to continue coverage at his or her own expense.

2. It is the responsibility of the dependent to notify the program within 60 days of the date coverage would have terminated and the program will notify the dependent within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the program within 60 days of receipt of the election notification.

3. Premium payment must be made within 45 days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for children under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the employer ceases to provide any group health plan for its employees.

E. Dependents of COBRA Participants

1. If a covered terminated employee has elected to continue coverage and if during the period of continued coverage the covered spouse or a covered dependent child becomes ineligible for coverage due to:

- a. death of the employee;
- b. divorce from the employee; or
- c. a dependent child no longer meets the definition of an eligible covered dependent; then, the spouse and/or dependent child may elect to continue COBRA coverage at his/her own expense. Coverage will not be continued beyond 36 months from the date coverage would have otherwise terminated.

2. It is the responsibility of the spouse and/or the dependent child to notify the program within 60 days of the date COBRA coverage would have terminated.

3. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for children under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;

b. 36 months beyond the date coverage would have otherwise terminated;

c. entitlement to Medicare;

d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or

e. the employer ceases to provide any group health plan for its employees.

F. Disability COBRA

1. If a covered employee or covered dependent is determined by the Social Security Administration or by the program staff (in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment), to have been totally disabled on the date the covered person became eligible for continued coverage or within the initial 18 months of coverage, coverage under this plan for the covered person who is totally disabled may be extended at his or her own expense up to a maximum of 29 months from the date coverage would have otherwise terminated.

2. To qualify the covered person must:

a. submit a copy of his or her Social Security Administration's disability determination to the program before the initial 18-month continued coverage period expires and within 60 days after the latest of:

- i. the date of issuance of the Social Security Administration's disability determination; and
- ii. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the covered employee's termination or reduction of hours;

b. in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment, submit proof of total disability to the program before the initial 18-month continued coverage period expires. The staff and medical director of the program will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history, and other relevant evidence presented by the applicant.

3. For purposes of eligibility for continued coverage under this Section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of 12 months. To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

4. Monthly payments for each month of extended COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

5. Coverage under this Section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 29 months from the date coverage would have otherwise terminated;

- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied;
- e. the employer ceases to provide any group health plan for its employees; or
- f. 30 days after the month in which the Social Security Administration determines that the covered person is no longer disabled. (The covered person must report the determination to the program within 30 days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment, 30 days after the month in which the program determines that the covered person is no longer disabled.

G. Medicare COBRA

1. If an employee becomes entitled to Medicare less than 18 months before the date the employee's eligibility for benefits under this plan terminates, the period of continued coverage available for the employee's covered dependents will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months from the date of the employee's Medicare entitlement;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the employer ceases to provide any group health plan for its employees.

2. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

H. Miscellaneous Provisions. During the period of continuation, benefits will be identical to those provided to others enrolled in this plan under its standard eligibility provisions for employees and retirees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:886 (June 2003), amended LR 32:

§107. Change of Classification

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

B. Change in Coverage

1. When there is a change in family status (e.g., marriage, birth of child) that affects the class of coverage, the change in classification will be effective on the date of the event. Application for the change must be made within 30 days of the date of the event.

2. When the addition of a dependent changes the class of coverage, the additional premium will be charged for the entire month if the date of change occurs before the fifteenth day of the month. If the date of change occurs on or after the

fifteenth day of the month, an additional premium will not be charged until the first day of the following month.

C. Notification of Change. It is the employee's responsibility to notify the program of any change in classification of coverage that affects the employee's contribution amount. If failure to notify is later determined, it will be corrected on the first day of the following month.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:887 (June 2003), amended LR 32:

Chapter 2. Termination of Coverage

§201. Active Employee and Retired Employee Coverage

A. ...

- 1. the date the program terminates;
- 2. the date the group or agency employing the covered employee terminates or withdraws from the program;
- 3. the date contribution is due if the group or agency fails to pay the required contribution for the covered employee;
- 4. the date contribution is due if the covered person fails to make any contribution which is required for the continuation of coverage;
- 5. the last day of the month of the covered employee's death;
- 6. the last day of the month in which the covered employee ceases to be eligible.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:888 (June 2003), amended LR 32:

§203. Dependent Coverage

A. ...

- 1. the last day of the month the employee ceases to be covered;
- 2. the last day of the month in which the dependent, as defined in this plan, ceases to be an eligible dependent of the covered employee;
- 3. - 4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1)

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:888 (June 2003), amended LR 32:

Chapter 3. Medical Benefits

§301. Eligible Expenses

A. Eligible expenses are the charges incurred for the following services, drugs, supplies, and devices, when performed, prescribed, or ordered by a physician and medically necessary for the treatment of a covered person. All charges are subject to applicable deductibles, copayments, and/or coinsurance amounts (unless otherwise specifically provided), Fee Schedule limitations, Schedule of Benefits, exclusions, and other provisions of the plan. A charge is incurred on the date that the service, drug, supply, or device is performed or furnished.

1. - 3. ...

4. anesthesia and its administration when ordered by the operating physician and administered by an appropriately licensed nurse anesthetist or physician in conjunction with a covered surgical service;

- 5. - 6. ...
- 7. blood, blood derivatives, and blood processing, when not replaced;
- 8. - 8.c. ...
 - d. ostomy supplies, except supplies for nutritional and/or enteral feeding;
 - e. - l. ...
- 9. services of a licensed speech therapist when pre-approved through Outpatient Procedure Certification (§309, below) for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injury, or other similar structural or neurological disease, limited to 26 visits per plan year;
- 10. ...
- 11. services rendered by a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) for the treatment of accidental injury to a covered person's natural teeth, under the following conditions:
 - a. coverage was in effect with respect to the individual at the time of the accident;
 - b. treatment commences within 90 days from the date of the accident and is completed within two years from the date of the accident;
 - c. coverage remains continuously in effect with respect to the covered person during the course of the treatment;
 - d. eligible expenses are limited to the cost of treatment as estimated at the time of initial treatment;
 - e. eligible expenses may include dental braces and orthodontic appliances, upon review and approval by the program's dental consultant, and only under the following circumstances:
 - i. to return the alveolar alignment to its former state prior to a covered dental accident. The program will allow benefits for orthopedic correction to establish reasonable occlusal function;
 - ii. a covered surgery that requires the use of braces for stabilization;
 - iii. severe skeletal deformity (i.e., cleft palate). The program will allow benefits for orthopedic correction to establish reasonable occlusal function;
 - f. as used herein accidental injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force, and with respect to injuries to teeth, the act of chewing does not constitute an external force;
- 12. durable medical equipment subject to the lifetime maximum payment limitation as listed in the Schedule of Benefits. The program will require written certification by the treating physician to substantiate the medical necessity for the equipment and the length of time that it will be used. The purchase of durable medical equipment will be considered an eligible expense only upon a showing that the rental cost would exceed the purchase price. Under no circumstances may the eligible expense for an item of durable medical equipment exceed the purchase price of such item;
- 13. - 17. ...
- 18. orthopedic shoes prescribed by a physician and completely custom built, limit one pair per plan year;

- 19. acupuncture when rendered by a medical doctor licensed in the state in which the services are rendered;
- 20. - 20.d. ...
- 21. services of a physical therapist or occupational therapist licensed in the state in which the services are rendered, under the following conditions:
 - a. services are prescribed by a licensed physician and rendered in an individual setting;
 - b. restorative potential exists;
 - c. services meet the generally accepted standards for medical practice;
 - d. services are reasonable and medically necessary for treatment of a disease, illness, accident, injury, or post-operative condition;
 - e. services are approved through case management when rendered in the home;
 - f. services are limited to 50 visits per plan year. Additional visits subject to approval by utilization management;
- 22. cardiac rehabilitation when:
 - a. rendered at a medical facility under the supervision of a licensed physician;
 - b. - c. ...

NOTE: Charges incurred for dietary instruction, educational services, behavior modification literature, biofeedback, health club membership, exercise equipment, preventive programs, and any other items excluded by the plan are not covered, unless provided for under Paragraph 30 of this Subsection.
- 23. preventive care consisting of routine physical examinations, lab work, and immunizations (including a yearly influenza vaccination) as follows:
 - a. well baby care expenses subject to the annual deductible and co-payments:
 - i. newborn facility and professional charges;
 - ii. birth to age 1—all office visits for scheduled immunizations and screening;
 - b. well child care expenses subject to the annual deductible and co-payments:
 - i. age 1 until age 3—three office visits per year for scheduled immunizations and screening;
 - ii. age 3 until age 15—one office visit per year for scheduled immunizations and screening;
 - c. well adult care expenses, not subject to the annual deductible, but limited to a maximum benefit of \$200.00:
 - i. age 16 until age 40—once during a 3-year period;
 - ii. age 40 until age 50—once during a 2-year period;
 - iii. age 50 and over—once during a 1-year period.

NOTE: Benefits for well baby care, well child care and routine physical examinations for well adult care, including immunizations, are based on the U.S. Preventive Services Task Force guidelines and recommendations of the National Immunization Program of the Centers for Disease Control and Prevention. All services must be rendered on an outpatient basis to monitor and maintain health and to prevent illness.
- 24. specialized, age-appropriate wellness care, not subject to the annual deductible, as follows:
 - a. one Pap test for cervical cancer per plan year;
 - b. mammographic examinations performed according to the following schedule:
 - i. one mammogram during the five-year period a person is 35-39 years of age;

- ii. one mammogram every two plan years for any person who is 40-49 years of age;
- iii. one mammogram every 12 months for any person who is 50 years of age or older;
- c. testing for detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing, once every 12 months for men over the age of 50 years;
- 25. - 26. ...
- 27. services rendered by the following, when billed by the supervising physician:
 - a. perfusionists and registered nurse assistants assisting in the operating room;
 - b. physician assistants and registered nurse practitioners;
- 28. - 30.c. ...
- 31. testing of sleep disorders only when the tests are performed at either:
 - a. a facility accredited by the American Academy of Sleep Medicine or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or
 - b. a sleep study facility located within a healthcare facility accredited by JCAHO. No benefits are payable for surgical treatment of sleep disorders (including LAUP) except following demonstrated failure of non-surgical treatment and upon approval by the program;
- 32. - 33.c. ...
- 34. treatment provided in accordance with a clinical trial for cancer, including costs of investigational treatments and of associated protocol-related patient care if all of the following criteria are met:
 - a. treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer;
 - b. treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer;
 - c. treatment is being provided in accordance with a clinical trial approved by one of the following entities:
 - i. one of the United States National Institutes of Health;
 - ii. a cooperative group funded by one of the United States National Institutes of Health;
 - iii. the FDA in the form of an investigational new drug application;
 - iv. the United States Department of Veterans Affairs;
 - v. the United States Department of Defense;
 - vi. a federally funded general clinical research center;
 - vii. the Coalition of National Cancer Cooperative Groups;
 - d. the proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks;
 - e. the facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

- f. there is no clearly superior, non-investigational approach;
- g. the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and
- h. the patient has signed an institutional review board-approved consent form.

B. Emergency Services. Subject to all applicable terms of the plan, emergency services will be considered eligible expenses whether rendered by a participating provider or non-participating provider, as follows.

1. Emergency services provided to a covered person who is later determined not to have required emergency services will be considered eligible expenses except:

a. when the covered person's medical condition would not have led a prudent lay person, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to health, serious impairment to bodily functions, or serious dysfunction of any bodily organ, unless the covered person was referred for emergency services by a participating provider or by an agent of OGB; or

b. when there was material misrepresentation, fraud, omission, or clerical error.

2. If a covered person requires hospitalization at a non-participating provider medically necessary inpatient services rendered by the non-participating provider will be considered eligible expenses until the covered person can be transferred to a participating provider.

3. OGB must be notified of the emergency services within 48 hours following commencement of treatment or admission, or as soon as medical circumstances permit. See also §307.C regarding the requirement for pre-admission certification (PAC) for emergency admissions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:888 (June 2003), amended LR 30:1191 (June 2004), LR 31:440 (February 2005), LR 32:

§303. Fee Schedule

A. The fee schedule establishes the maximum allowable charges for eligible expenses. The fee schedule applies to both contracted (MCO) health care providers, who have entered into agreements with OGB regarding reimbursement under this plan, and to non-contracted (non-MCO) health care providers who have not entered into such agreements.

B. Plan members may be subject to greater financial responsibility for services, drugs, supplies, and devices provided by non-contracted health care providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:890 (June 2003), amended LR 32:

§305. Automated Claims Adjusting

A. OGB utilizes commercially licensed software that applies all claims against its medical logic program to identify improperly billed charges and charges for which this plan provides no benefits. Any claim with diagnosis or procedure codes deemed inadequate or inappropriate will be automatically reduced or denied. Providers accepting

assignment of benefits cannot bill the plan member for the differential on the denial amount, in whole or in part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:890 (June 2003), LR 32:

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

A. ...

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

C. - C.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:890 (June 2003), amended LR 32:

§309. Outpatient Procedure Certification (OPC)

A. The purpose of OPC is for the plan to certify that particular outpatient procedures and therapies are medically necessary. If OPC is not obtained when required, no benefits are payable under this plan.

B. OPC is required on the following procedures:

1. - 3. ...

4. all PET scans and MRI's, as follows:

- a. brain/head;
- b. upper extremity;
- c. lower extremity;
- d. spine;

5. - 7.d. ...

8. 23 hour observation;

9. hyperbaric treatment.

C. - C.2. ...

~~D. - Repealed.~~

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:891 (June 2003), amended LR 32:

§311. Case Management

A. - D.3.b. ...

E. - E.8. Repealed.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:891 (June 2003), amended LR 32:

§313. Dental Surgical Benefits

A. ...

B. If a covered person requires dental treatment in a hospital setting that is otherwise an eligible expense, the plan will provide benefits for anesthesia rendered in the hospital and associated hospital charges. Prior authorization

for hospitalization for dental treatment is required in the same manner as prior authorization is required for other covered medical services.

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

D. The provisions of this section shall not apply to treatment rendered for Temporomandibular Joint (TMJ) diseases or disorders.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:891 (June 2003), amended LR 32:

§315. Medicare Reduction

A. ...

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:891 (June 2003), amended LR 32:

§317. Exceptions and Exclusions

A. No benefits are provided under this plan for the following:

1. injury compensable under any worker's compensation program, regardless of whether the patient has filed a claim for benefits. This applies to compensation provided on an expense-incurred basis or blanket settlements for past and future losses;

2. maintenance therapy consisting of convalescent, skilled nursing, sanitarium, custodial care, assisted living facilities, or rest cures designed to assist in daily living activities, maintain present physical and/or mental condition, or provide a structured or safe environment;

3. expenses for elective, non-therapeutic voluntary abortions (abortions performed for reasons other than to save the life of the mother);

4. injuries sustained by a covered person while in an aggressor role;

5. expenses incurred as a result of a covered person's commission or attempted commission of an illegal act;

6. services, supplies, or treatment for cosmetic purposes, including cosmetic surgery and any cosmetic complications of cosmetic surgery, unless necessary for the immediate repair of a deformity caused by a disease and/or injury that occurs while coverage is in force. No payment will be made for expenses incurred in connection with the treatment of any body part not affected by the disease and/or injury;

7. shoes and related items, such as wedges, cookies, and arch supports;

8. dental and orthodontic services, appliances, supplies, and devices, including, but not limited to the following:

- a. dental braces and orthodontic appliances, except as specifically provided in §301.A.11.e of this Part;
 - b. treatment of periodontal disease;
 - c. dentures, dental implants, and any surgery for their use, except if needed as the result of an accident that meets the program's requirements;
 - d. treatment for Temporomandibular Joint (TMJ) diseases or disorders, except as specifically provided in §301.A.28 of this Part;
 - e. expenses incurred for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, as specifically set forth herein, dental procedures which fall under the guidelines of treatment of accidental injury, procedures necessitated as a result of or secondary to cancer, or oral and maxillofacial surgeries which are shown to the satisfaction of the program to be medically necessary, non-dental, non-cosmetic procedures;
9. medical services, supplies, treatments, and prescription drugs provided without charge to the covered person or for which the covered person is not legally obligated to pay;
 10. maternity expenses incurred by any person other than the employee or the employee's legal spouse;
 11. personal convenience items including, but not limited to, admit kits, bedside kits, telephone, television, guest meals, and beds, and charges for luxury accommodations in any hospital or allied health facility provided primarily for the patient's convenience which are not deemed medically necessary by the program;
 12. charges for services, supplies, treatment, drugs, and devices which are in excess of the maximum allowable under the Medical Fee Schedule, Outpatient Surgical Facility Fee Schedule, or any other limitations of the plan;
 13. services, supplies, treatment, drugs, devices, and deluxe medical equipment which are not deemed medically necessary by the program;
 14. services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, pain rehabilitation control and/or therapy, and dietary or educational instruction for all diseases and/or illnesses, except diabetes;
 15. services and supplies for the treatment of and/or related to gender dysphoria or reverse sterilization;
 16. artificial organ implants, penile implants, transplantation of non-human organs, and any surgery and other treatment, services, or supplies, related to such procedures, or to complications related to such procedures;
 17. expenses subsequent to the initial diagnosis for infertility and complications, including but not limited to, services, drugs, procedures, or devices to achieve fertility, in-vitro fertilization, low tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, donor eggs, and reversal of sterilization procedures;
 18. non-medical supplies such as air conditioners and/or filters, dehumidifiers, air purifiers, wigs or toupees, heating pads, cold devices, home enema equipment, rubber gloves, swimming pools, saunas, whirlpool baths, home pregnancy tests, lift chairs, devices or kits to stimulate the penis, exercise equipment, any other items not normally

- considered medical supplies, and any items the program determines are not medical supplies;
19. administrative fees, interest, penalties, or sales tax;
 20. marriage counseling, family relations counseling, divorce counseling, parental counseling, job counseling, and career counseling;
 21. charges for physician services rendered to a covered person over the telephone or in a non-face-to-face setting;
 22. radial keratotomy, laser surgery, and any other procedures, services, or supplies for the correction of refractive errors of the eyes;
 23. services, supplies, surgeries, and treatments for excess body fat, resection of excess skin and/or fat following weight loss or pregnancy, and/or obesity, and morbid obesity;
 24. hearing aids and any examination to determine the fitting or necessity of hearing aids, except as specifically provided for in §301.A.33 of this Part;
 25. hair plugs and/or transplants;
 26. routine physical examinations and/or immunizations not provided for under eligible expenses;
 27. eye examinations, glasses, and contact lenses, except as specifically provided for as an eligible expense in §301.A.15 of this Part;
 28. diagnostic or treatment measures that are not recognized as generally accepted medical practice;
 29. medical supplies not listed under eligible expenses;
 30. treatment or services for mental health and substance abuse provided outside the treatment plan developed by the program's managed care contractor or by therapists with whom or at facilities with which the program's managed care contractor does not have a contract;
 31. genetic testing, except when determined to be medically necessary during a covered pregnancy;
 32. services rendered by a private-duty Registered Nurse (R.N.) or by a private-duty Licensed Practical Nurse (L.P.N.);
 33. services rendered by a physician or other health care provider related to the patient by blood, adoption, or marriage;
 34. expenses for services rendered by a physician or other health care provider who is not licensed in the state where such services are rendered or in any facility not holding a valid license in the state and for the services rendered;
 35. facility fees for services rendered in a physician's office or in any facility not approved by the federal Health Care Finance Administration for Medicare reimbursement;
 36. glucometers;
 37. augmentative communication devices;
 38. charges to obtain medical records or any other information needed and/or required to adjudicate a claim;
 39. charges greater than the global allowance for any laboratory, pathology, or radiological procedure;
 40. speech therapy or the services of a speech therapist except as specifically provided in §301.A.9.
- AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).
- HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1834 (October 1999), amended LR 26:488 (March 2000),

§323. Prescription Drug Benefits

A. This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription and are dispensed by a licensed pharmacist or pharmaceutical company.

1. These include and shall not be limited to:
 - a. insulin;
 - b. Retin-A dispensed for covered persons under the age of 27;
 - c. Vitamin B12 injections;
 - d. prescription potassium chloride; and
 - e. over-the-counter diabetic supplies including, but not limited to, strips, lancets, and swabs.

2. In addition, this plan allows benefits limited to \$200 per month for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are medically necessary and are obtained from a source approved by the OGB. Such expenses shall be subject to coinsurance and co-payments relating to prescription drug benefits. In connection with this benefit, the following words shall have the following meanings:

a. "inherited metabolic disease" shall mean a disease caused by an inherited abnormality of body chemistry and shall be limited to:

- i. Phenylketonuria (PKU);
- ii. Maple Syrup Urine Disease (MSUD);
- iii. Methylmalonic Acidemia (MMA);
- iv. Isovaleric Acidemia (IVA);
- v. Propionic Acidemia;
- vi. Glutaric Acidemia;
- vii. Urea Cycle Defects; or
- viii. Tyrosinemia;

b. "low protein food products" mean food products that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include natural foods that are naturally low in protein.

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

1. appetite suppressant drugs;
2. dietary supplements;
3. topical forms of Minoxidil;
4. Retin-A dispensed for a covered person over age 26;
5. amphetamines dispensed for diagnoses other than Attention Deficit Disorder or Narcolepsy;
6. nicotine, gum, patches, or other products, services, or programs intended to assist an individual to reduce or cease smoking, or other use of tobacco products;
7. nutritional or parenteral therapy;
8. vitamins and minerals;
9. drugs available over the counter;
10. serostim dispensed for any diagnoses or therapeutic purposes other than AIDS wasting;
11. drugs prescribed for the treatment of impotence, except following the surgical removal of the prostate gland; and
12. glucometers.

C. - C.7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:893 (June 2003), amended LR 32:

Chapter 4. Uniform Provisions

§401. Statement of Contractual Agreement

A. This plan, as amended, including the Schedule of Benefits, together with the application for coverage and any related documents executed by or on behalf of the covered employee, constitute the entire agreement between the parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:894 (June 2003), amended LR 32:

§403. Properly Submitted Claim

A. For plan reimbursement, a claim must include:

1. - 4. ...
5. type of services rendered, with diagnosis and/or procedure codes that are valid and current for the date of service;
6. date and place of service;
7. - 10. ...

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:894 (June 2003), amended LR 32:

§405. When Claims Must Be Filed

A. - B. ...

C. Requests for review of payment or corrected bills must be submitted within 18 months of receipt date of the original claim. Requests for review of payment or corrected bills received after that time will not be considered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), amended LR 32:

§407. Right to Receive and Release Information

A. Without notice or consent the program may release to or obtain from any company, organization, or person, any information regarding any person which the program deems necessary to carry out the provisions of this plan, or to determine how, or if, they apply. Any claimant under the plan must furnish the program with any information necessary to implement this provision. OGB retains information for the minimum period of time required by law. After such time, information may no longer be available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), amended LR 32:

§409. Legal Limitations

A. ...

B. Information provided by the program or any of its employees or agents to plan members does not modify or override the terms and provisions of the plan. In the event of any conflict between the written provisions of this plan and any information provided, the written provisions of this plan shall supersede and control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), amended LR 32:

§413. Recovery of Overpayments

A. If an overpayment occurs, the program retains the right to recover the overpayment. The covered person, institution, or provider receiving the overpayment must return the overpayment. At the plan's discretion, the overpayment may be deducted from future claims. Should legal action be required as a result of fraudulent statements or deliberate omissions on the application for coverage or a claim for benefits, the defendant will be responsible for attorney fees of 25 percent of the overpayment or \$1,000, whichever is greater. The defendant will also be responsible for court costs and legal interest from the date of judicial demand until paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), amended LR 32:

§415. Subrogation and Reimbursement

A. Upon payment of any eligible benefits covered under this plan, the Office of Group Benefits shall succeed and be subrogated to all rights of recovery of the covered employee, his dependents or other covered persons, or their heirs or assigns, for whose benefit payment is made, and they shall execute and deliver instruments and papers and do whatever is necessary to secure such rights, and shall do nothing after loss to prejudice such rights.

B. The Office of Group Benefits shall be entitled, to the extent of any payment made to a covered employee, his dependents or other covered persons, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a covered employee, his dependents or other covered persons, against any person or entity legally responsible for the disease, illness, accident or injury for which said payment was made. To this end, covered employees, their dependents, or other covered persons agree to immediately notify the Office of Group Benefits of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident or injury.

C. These subrogation and reimbursement rights also apply when a covered person recovers under, but not limited to, an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), amended LR 32:

§417. Employer Responsibility

A. It is the responsibility of the participant employer to submit enrollment and change forms and all other necessary

documentation to the program on behalf of its employees. Employees of a participant employer will not, by virtue of furnishing any documentation to the program, 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 OGB when 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 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. A participant employer that receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the OGB MSP Adjuster within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a covered employee. If not timely forwarded, OGB will assume responsibility only for covered plan benefits due to Medicare for a covered employee. The participant employer will be responsible for interest, fines, and penalties due.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:896 (June 2003), amended LR 32:

§419. Program Responsibility

A. OGB will administer the plan in accordance with its terms, state and federal law, the OGB's established policies, interpretations, practices, and procedures. OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the plan, to make determinations regarding eligibility for benefits and to decide disputes which may arise relative to a covered person's rights.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:896 (June 2003), amended LR 32:

§423. Amendments to or Termination of the Plan and/or Contract

A. OGB has the statutory responsibility of providing health and accident and death benefits to covered persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any employee, whether active or retired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:896 (June 2003), amended LR 32:

Chapter 6. Definitions

§601. Definitions

Accidental Injury—a condition occurring as a direct result of a traumatic bodily injury sustained solely through

accidental means from an external force. With respect to injuries to teeth, the act of chewing does not constitute an external force.

Appeal—a request by a plan member for and a formal review of a medical claim for benefits or an eligibility determination.

Benefit Payment—payment of eligible expenses due or owing by a covered person, after applicable deductibles, co-payments, and coinsurance, and subject to all limitations and exclusions, at the rate shown under percentage payable in the Schedule of Benefits.

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

Child or Children includes—

1. a legitimate, duly acknowledged, and/or legally adopted child of the employee and/or the employee's legal spouse's who is dependent upon the employee for support;

2. a child in the process of being adopted by the employee through an agency adoption, who is living in the household of the employee, and is or will be included as a dependent on the employee's federal income tax return for the current or following tax year (if filing is required);

3. a child in the legal custody of the employee, who lives in the household of the employee and is or will be included as a dependent on the employee's federal income tax return for the current or following tax year (if filing is required);

4. a grandchild of the employee that is not in the legal custody of the employee, who is dependent upon the employee for support and whose parent is a covered dependent. If the employee seeking to cover a grandchild is a paternal grandparent, the program will require that the biological father, i.e., the covered son of the employee, execute an acknowledgement of paternity.

NOTE: If the employee dependent parent becomes ineligible for coverage under the program, the employee's grandchild will also be ineligible for coverage, unless the employee has legal custody of his/her grandchild.

COBRA—the federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Committee—Repealed.

Convalescent, Maintenance Care, or Rest Cures—treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by oneself, family, or other caregivers who are not eligible providers. The services are primarily designed to help the patient with daily living activities, maintain the patient's present physical and mental condition, and/or provide a structured or safe environment.

Covered Person—an active or retired employee, his/her eligible dependent, or any other individual eligible for coverage for whom the necessary application forms have been completed and for whom the required contribution is made.

Covered Services—those health care services for which a plan member is entitled to receive benefit payments in accordance with the terms of this plan.

Custodial Care—

1. care designed to assist an individual in the performance of daily living activities (i.e., services which constitute personal care such as walking, getting in and out

of bed, bathing, dressing, eating, and using the toilet) that does not require admission to a hospital or other institution for the treatment of a disease, illness, accident, or injury, or for the performance of surgery;

2. care primarily intended to provide room and board to an individual with or without routine nursing care, training in personal hygiene, or other forms of self-care;

3. supervisory care provided by a physician whose patient who is mentally or physically incapacitated and is not under specific medical, surgical, or psychiatric treatment, when such care is intended to reduce the patient's incapacity to the extent necessary to enable the patient to live outside of an institution providing medical care, or when, despite treatment, there is not reasonable a likelihood that the incapacity will be reduced.

Date Acquired—the date a dependent of a covered employee is acquired in the following instances and on the following dates only:

1. legal spouse—the date of marriage;

2. child or children □

a. natural child—the date of birth;

b. child in the process of being adopted;

c. agency adoption—the date the adoption contract was executed between the employee and the adoption agency;

d. private adoption—the date the Act of Voluntary Surrender is executed in favor of the employee. The program must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date it Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;

e. child who lives in the household of the covered employee and is currently or will be included as a dependent on the employee's federal income tax return—the date of the court order granting legal custody;

f. grandchild of the employee that is not in the legal custody of the employee, but who is dependent upon the employee for support and whose parent is a covered dependent:

i. the date of birth of the grandchild, if all of the above requirements are met at the time of birth; or

ii. the date on which the coverage becomes effective for the covered dependent, if all of the above requirements are not met at the time of birth.

Deductible—the dollar amount that a covered person must pay as shown in the Schedule of Benefits before benefits will be paid in a plan year.

Dependent—any of the following persons who are enrolled for coverage as dependents, if they are not also covered as an employee:

1. the covered employee's legal spouse;

2. a never married child from date of birth up to 21 years of age and dependent upon the employee for support;

3. a never married child who is a fulltime student under 24 years of age and financially dependent upon the employee for support;

4. a never married child of any age who meets the criteria set forth in §103.D, above;

Durable Medical Equipment (DME)—equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a

person in the absence of a illness or injury, and is appropriate for use in the home. DME includes, but is not limited to, items such as wheelchairs, hospital beds, respirators, braces (non-dental), custom orthotics which must be specially made and not available at retail stores.

Employee—a full-time *employee* as defined by a participant employer and in accordance with state law.

Family Unit Limit—that each of three covered members of a family unit have met the dollar amount shown in the Schedule of Benefits as plan year deductible for an individual. Once the family unit limit is met, the deductibles of all other covered members of the family unit will be considered satisfied for that plan year.

Fee Schedule—the maximum allowable charges for professional or hospital services adopted by the OGB that may be considered as an eligible expense.

Future Medical Recovery—Repealed.

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

Group Health Plan—a plan (including a self-insured plan) offered or contributed to, by an employer (including a self-employed person) or employee organization to provide health care to employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, and/or their families.

Health Insurance Coverage—benefits consisting of medical care offered by a health insurance issuer under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract.

HIPAA—the Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and Federal Regulations promulgated pursuant thereto.

Hospital—an institution that is currently licensed as a hospital by the state in which services are rendered and is not primarily an institution for rest, the aged, the treatment of pulmonary tuberculosis, a nursing home, extended care facility, remedial training institution, or a facility primarily for the treatment of conduct and behavior disorders.

Incurred Date—the date when a particular service or supply is rendered or obtained. When a single charge is made for a series of services, each service will bear a prorated share of the charge.

Lifetime Maximum Benefit—the maximum amount of benefits that will be paid under the plan for all eligible expenses incurred by a covered person.

Medically Necessary—a service, treatment, procedure, equipment, drug, device, item, or supply, which, in the judgment of the program:

1. is appropriate and consistent with a covered person's diagnosis and treatment as well as with nationally accepted medical standards; and

2. is not primarily for personal comfort or convenience or custodial care.

Medicare—the health insurance available through Medicare laws enacted by the Congress of the United States.

Occupational Therapy—the application of any activity one engages in for the purposes of evaluation, interpretation,

treatment planning, and treatment of problems interfering with functional performance in persons impaired by physical illness or injury in order to significantly improve functioning.

Physical Therapy—the evaluation of physical status as related to functional abilities and treatment procedures as indicated by that evaluation. And licensed for the state where services are rendered.

Physician—

1. the following persons, appropriately licensed to practice their respective professional skills at the time and place the service is rendered:

- a. a Doctor of Medicine (M.D.);
- b. a Doctor of Dental Surgery (D.D.S.);
- c. a Doctor of Dental Medicine (D.M.D.);
- d. a Doctor of Osteopathy (D.O.);
- e. a Doctor of Podiatric Medicine (D.P.M.);
- f. a Doctor of Chiropractic (D.C.);
- g. a Doctor of Optometry (O.D.);
- h. a Psychologist meeting the requirements of the National Register of Health Service Providers in Psychology;
- i. a mental health counselor;
- j. a substance abuse counselor;
- k. an Audiologist.

2. does not include a medical doctor in the capacity of supervising interns, residents, senior residents, or fellows enrolled in a training program who does not personally provide medical treatment or perform a surgical procedure for the covered person.

Plan—coverage offered by the Office of Group Benefits under this contract including MCO benefits, prescription drug benefits, mental health and substance abuse benefits, and comprehensive medical benefits. The term *plan* as defined herein is used interchangeably with the term *program* as defined below.

Plan Year—the period from July 1, or the date the covered person first becomes covered under the plan, through the next following June 30. Each successive plan year will be the 12 month period from July 1 through the next following June 30.

Program—the Office of Group Benefits and/or the plan.

Provider—one or more entities which offer health care services and shall include but not be limited to individuals, or groups of physicians, individuals or groups of psychologists, nurse midwives, ambulance service companies, hospitals, and other health care entities that provide covered services to covered individuals.

Recovery—with respect to Subrogation and Reimbursement (§415) recovery means any and all monies paid to the covered person by way of judgment, settlement, or otherwise to compensate for losses allegedly caused by injury or sickness, whether or not the losses reflect medical or dental charges covered by the program.

Referee—Repealed.

Rehabilitation and Rehabilitation Therapy—care concerned with the management and functional ability of patients disabled by disease, illness, accident, or injury.

Reimbursement—repayment to the program for benefits payments made by the program.

Retiree—

1. an individual who was a covered employee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

a. immediately received retirement benefits from an approved state or governmental agency defined benefit plan;

b. was not eligible for participation in such plan or legally opted not to participate in such plan; and either:

i. began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65; or

ii. began employment after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or

iii. was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or

iv. maintained continuous coverage with the program as an eligible dependent until he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan;

b. immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits;

2. also means an individual who was a covered employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of Paragraphs 1, 2, or 3 above.

Room and Board—all expenses necessary to maintain and sustain a covered person upon admittance to a hospital and during a hospital confinement. This can include, but is not limited to, facility charges for the maintenance of the covered person's hospital room, dietary and food services, nursing services performed by nurses employed by or under contract with the hospital, and housekeeping services.

Utilization Management—the process of evaluating the necessity, appropriateness, and efficiency of health care services against established guidelines and criteria.

Utilization Review Organization (URO)—an entity that has established one or more utilization review programs which evaluates the medical necessity, appropriateness, and efficiency of the uses of health care services, procedures, and facilities.

Well Adult Care—applies to covered persons age 16 and older and means a routine physical examination by a physician that may include an influenza vaccination, lab work, and X-rays performed as part of the exam in that physician's office, when such services are billed by that physician with wellness procedure and diagnosis codes.

Other health care services billed with wellness procedures and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as well adult care.

Well Baby Care—applies to covered persons from birth until age 1 and means routine care to a well, newborn infant that may include physical examinations and active immunizations provided by a physician when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedures and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as well baby care.

Well Child Care—applies to covered persons from age 1 through age 15 and means routine physical examinations and active immunizations provided by a physician, when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedure and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as well child care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1)

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:898 (June 2003), amended LR 32:

Family Impact Statement

The proposed Rule has no known impact on family formation, stability, or autonomy.

Interested persons may present their views, in writing, to Tommy D. Teague, Chief Executive Officer, Office of Group Benefits, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Monday, August 21, 2006.

Tommy D. Teague
Chief Executive Officer

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: MCO Plan of Benefits

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

This rule change is being made to add clarification to the MCO plan document language and bring it into line with current interpretation and practice. The rule: 1) clarifies the eligibility provision regarding continued coverage for disabled dependent children, 2) clarifies the coverage for physical and occupational therapy, and 3) modifies the coverage provision for sleep disorders to reflect the name of the accrediting organization. It is anticipated \$3,000 in expenses will be incurred with the publishing of this rule in FY 06/07.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Revenue collections of state and local governmental units will not be affected.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This rule should not directly impact any person or non-governmental group as it only serves to clarify plan document language contained in the MCO plan document to bring it into line with current interpretation and application. There should be no cost impact associated with this rule change.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)

Competition and employment will not be affected.

Tommy D. Teague
Chief Executive Officer
0607#053

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

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

**PPO, EPO, and MCO Plans of Benefits—Colorectal
Screening (LAC 32:III.301, V.301, IX.301)**

In accordance with the applicable provisions of R.S. 49:950, et seq., the Administrative Procedure Act, and pursuant to the authority granted by R.S. 42:801(C) and 802(B)(2), as amended and reenacted by Act 1178 of 2001, 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 finds that it is necessary to revise and amend provisions of the PPO, EPO, and MCO plan documents to authorize benefits for routine colorectal screening. This action is necessary to comply with the provisions of R.S. 22:215.12.

Accordingly, OGB hereby gives notice of intent to adopt the following Rule to become effective upon promulgation.

Title 32

EMPLOYEE BENEFITS

**Part III. Preferred Provider Organization (PPO)—Plan
of Benefits**

Chapter 3. Medical Benefits

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

A. - A.33.c. ...

34. treatment provided in accordance with a clinical trial for cancer, including costs of investigational treatments and of associated protocol-related patient care if all of the following criteria are met:

a. treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer;

b. treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer;

c. treatment is being provided in accordance with a clinical trial approved by one of the following entities:

i. one of the United States National Institutes of Health;

ii. a cooperative group funded by one of the United States National Institutes of Health;

iii. the FDA in the form of an investigational new drug application;

iv. the United States Department of Veterans Affairs;

v. the United States Department of Defense;

vi. a federally funded general clinical research center;

vii. the Coalition of National Cancer Cooperative Groups;

d. the proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks;

e. the facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

f. there is no clearly superior, non-investigational approach;

g. the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and

h. the patient has signed an institutional review board-approved consent form;

35. routine colorectal cancer screening provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations, including:

a. fecal occult blood test;

b. flexible sigmoidoscopy; or

c. colonoscopy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1830 (October 1999), amended LR 28:480 (March 2002), LR 29:339, 343 (March 2003), LR 30:1192 (June 2004), LR 31:441 (February 2005), LR 32:

**Part V. Exclusive Provider Organization (EPO)—Plan
of Benefits**

Chapter 3. Medical Benefits

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

A. - A.33.c. ...

34. treatment provided in accordance with a clinical trial for cancer, including costs of investigational treatments and of associated protocol-related patient care if all of the following criteria are met:

a. treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer;

b. treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer;

c. treatment is being provided in accordance with a clinical trial approved by one of the following entities:

i. one of the United States National Institutes of Health;

ii. a cooperative group funded by one of the United States National Institutes of Health;

iii. the FDA in the form of an investigational new drug application;

iv. the United States Department of Veterans Affairs;

v. the United States Department of Defense;

vi. a federally funded general clinical research center;

vii. the Coalition of National Cancer Cooperative Groups;

d. the proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks;

e. the facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

f. there is no clearly superior, non-investigational approach;

g. the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and

h. the patient has signed an institutional review board-approved consent form;

35. routine colorectal cancer screening provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations, including:

- a. fecal occult blood test;
- b. flexible sigmoidoscopy; or
- c. colonoscopy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1810 (October 1999), amended LR 28:478 (March 2002), LR 29:334, 338 (March 2003), LR 30:1190 (June 2004), LR 31:440 (February 2005), LR 32:

Part IX. Managed Care Option (MCO)—Plan of Benefits

Chapter 3. Medical Benefits

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

A. - A.33.c. ...

34. treatment provided in accordance with a clinical trial for cancer, including costs of investigational treatments and of associated protocol-related patient care if all of the following criteria are met:

a. treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer;

b. treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer;

c. treatment is being provided in accordance with a clinical trial approved by one of the following entities:

i. one of the United States National Institutes of Health;

ii. a cooperative group funded by one of the United States National Institutes of Health;

iii. the FDA in the form of an investigational new drug application;

iv. the United States Department of Veterans Affairs;

v. the United States Department of Defense;

vi. a federally funded general clinical research center;

vii. the Coalition of National Cancer Cooperative Groups;

d. the proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks;

e. the facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

f. there is no clearly superior, non-investigational approach;

g. the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and

h. the patient has signed an institutional review board-approved consent form;

35. routine colorectal cancer screening provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations, including:

- a. fecal occult blood test;
- b. flexible sigmoidoscopy; or
- c. colonoscopy.

B. Emergency Services. Subject to all applicable terms of the plan, emergency services will be considered eligible expenses whether rendered by a participating provider or non-participating provider, as follows.

1. Emergency services provided to a covered person who is later determined not to have required emergency services will be considered eligible expenses except:

a. when the covered person's medical condition would not have led a prudent lay person, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to health, serious impairment to bodily functions, or serious dysfunction of any bodily organ, unless the covered person was referred for emergency services by a participating provider or by an agent of OGB; or

b. when there was material misrepresentation, fraud, omission, or clerical error.

2. If a covered person requires hospitalization at a non-participating provider medically necessary inpatient services rendered by the non-participating provider will be considered eligible expenses until the covered person can be transferred to a participating provider.

3. OGB must be notified of the emergency services within 48 hours following commencement of treatment or admission, or as soon as medical circumstances permit. See also §307.C regarding the requirement for pre-admission certification (PAC) for emergency admissions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR

Family Impact Statement

The proposed Rule has no known impact on family formation, stability, or autonomy, except as follows: The Rule implements benefits not previously authorized for routine colorectal screening, in accordance with the provisions of R.S. 22:215.12.

Interested persons may present their views, in writing, to Tommy D. Teague, Chief Executive Officer, Office of Group Benefits, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Monday, August 21, 2006.

Tommy D. Teague
Chief Executive Officer

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: PPO, EPO, and MCO Plans of
Benefits—Colorectal Screening**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is estimated that this benefit modification would cost the PPO, EPO and MCO plans of OGB approximately \$812,000 in FY 06/07, \$894,000 in FY 07/08, and \$983,000 in FY 08/09. Although the increase of \$812,000 in FY 06/07 for the cost of this benefit to OGB is paid from Agency-Self Generated Funds, 66 percent of the impact (\$539,920) is on the State General Fund for employer contribution of premiums paid to OGB. This benefit would require coverage for colorectal cancer screening provided in accordance with the most recently published recommendations established by the American College of Gastroenterology. This rule is being adopted as a result of Act 505 of the 2005 Regular Session. It is anticipated \$3,000 in expenses will be incurred with the publishing of this rule in FY 06/07.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Revenue collections of State or Local Governmental units should not be affected.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This rule will result in PPO, EPO and MCO members (approximately 245,000) having the benefit of colorectal screening including an annual fecal occult blood test, flexible sigmoidoscopy, or colonoscopy. These tests will need to be performed in accordance with recommendations of the American College of Gastroenterology. There is no direct premium increase for members as a result of this additional benefit, but increased costs have been considered for premium rates that are effective July 1, 2006.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Competition and employment will not be affected.

Tommy D. Teague
Chief Executive Officer
0607#050

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

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

PPO Plan of Benefits
(LAC 32:III.Chapters 1-7)

In accordance with the applicable provisions of R.S. 49:950, et seq., the Administrative Procedure Act, and pursuant to the authority granted by R.S. 42:801(C) and 802(B)(1), as amended and reenacted by Act 1178 of 2001, 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 finds that it is necessary to revise and amend provisions of the PPO Plan Document. The reason for this action is to enhance member clarification and be able to administer health care benefits effectively for the program and member.

Accordingly, OGB hereby gives Notice of Intent to adopt the following Rule to become effective upon promulgation:

Title 32

EMPLOYEE BENEFITS

Part III. Preferred Provider (PPO) Plan of Benefits

Chapter 1. Eligibility

§101. Persons to Be Covered

Eligibility requirements apply to all participants in the Program, including the PPO plan, the EPO plan, the MCO plan, an HMO plan, or the life insurance plan.

A. - A.2. ...

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

a. if employment begins on the first day of the month, coverage is effective on the first day of the following month (For example, if hired on July 1, coverage will begin on August 1);

b. if employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (For example, if hired on July 15, coverage will begin on September 1);

c. employee coverage will not become effective unless the Employee completes an Enrollment Form within 30 days following the date of employment. If completed after 30 days following the date of employment, the Employee will be considered an overdue applicant.

d. an Employee who transfers employment to another Participating Employer must complete a Transfer Form within 30 days following the date of transfer to maintain coverage without interruption. If completed after 30 days following the date of transfer, the Employee will be considered an overdue applicant.

4. Re-enrollment, Previous Employment for Health Benefits and Life Insurance

A.4.a. - B.1.a. ...

b. An Employee retired from a Participant Employer may not be covered as an Employee.

c. Retirees are not eligible for coverage as overdue applicants.

2. Effective Date of Coverage

a. Retiree coverage will be effective on the first day of the month following the date of retirement if the Retiree and Participant Employer have agreed to make and are making the required contributions (For example, if retired July 15, coverage will begin August 1).

C. - C.2. ...

a. Dependents of Employees. Coverage will be effective on the date the Employee becomes eligible for Dependent Coverage.

C.2.b. - D. ...

1. The terms of the following paragraphs apply to all eligible Employees who apply for coverage after 30 days from the date the Employee became eligible for coverage and to all eligible Dependents of Employees and Retirees for whom the application for coverage was not completed within 30 days from the Date Acquired.

D.2. - E.2. ...

a. A special enrollment application must be made within 30 days of either the termination date of the prior coverage or the date the new Dependent is acquired. If it is made more than 30 days after eligibility, they will be considered overdue applicants subject to a pre-existing condition limitation.

b. ...

i. for loss of other coverage or marriage, the first day of the month following the date the Program receives all required forms for enrollment;

ii. - iii. ...

c. Special enrollment applicants must complete the "Acknowledgment of Pre-existing Condition" form and "Statement of Physical Condition" form.

E.2.d. - G.2. ...

H. Medicare+Choice/Medicare Advantage Option for Retirees (effective July 1, 1999). Retirees who are eligible to participate in a Medicare+Choice/Medicare Advantage plan who cancel coverage with the Program upon enrollment in a Medicare+Choice/Medicare Advantage plan may re-enroll in the Program upon withdrawal from or termination of coverage in the Medicare+Choice/Medicare Advantage plan, at the earlier of the following:

H.1. - I. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1827 (October 1999), amended LR 27:721 (May 2001), LR 28:2343 (November 2002), LR 29:341, 342 (March 2003), LR 32:

§103. Continued Coverage

A. ...

1. Leave of Absence without Pay, Employer Contributions to Premiums

a. A participating employee who is granted leave of absence without pay due to a service related injury may continue coverage and the participating employer shall continue to pay its portion of health plan premiums for up to twelve months.

b. A participating employee who suffers a service related injury that meets the definition of a total and permanent disability under the workers' compensation laws of Louisiana may continue coverage and the participating employer shall continue to pay its portion of the premiums until the employee becomes gainfully employed or is placed on state disability retirement.

c. A participating employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (F.M.L.A.) may continue coverage during the time of such leave and the participating employer may continue to pay its portion of premiums.

2. Leave of Absence without Pay; No Employer Contributions to Premiums. An employee granted leave of absence without pay for reasons other than those stated in Paragraph A, may continue to participate in an Office of Group Benefits benefit plan for a period up to twelve months upon the employee's payment of the full premiums due.

B. - B.2. ...

C. Surviving Dependents/Spouse

1. Benefits under the Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurred unless the surviving covered Dependents elect to continue coverage.

a. The surviving legal spouse of an Employee or Retiree may continue coverage unless or until the surviving spouse is or becomes eligible for coverage in a Group Health Plan other than Medicare.

b. The surviving never married Dependent Child of an Employee or Retiree may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a Group Health Plan other than Medicare, or until attainment of the termination age for Children, whichever occurs first.

c. Surviving Dependents will be entitled to receive the same Participant Employer premium contributions as Employees and Retirees, subject to the provisions of Louisiana Revised Statutes, Title 42, Section 851 and rules promulgated pursuant thereto by the Office of Group Benefits.

d. Coverage provided by the Civilian Health and Medical Program for the Uniformed Service (CHAMPUS/TRICARE) or successor program will not be sufficient to terminate the coverage of an otherwise eligible surviving legal spouse or a Dependent Child.

2. A surviving spouse or Dependent Child cannot add new Dependents to continued coverage other than a Child of the deceased Employee born after the Employee's death.

3. Participant Employer/Dependent Responsibilities

a. It is the responsibility of the Participant Employer and surviving covered Dependent to notify the Program within 60 days of the death of the Employee or Retiree;

b. The Program will notify the surviving Dependents of their right to continue coverage;

c. Application for continued coverage must be made in writing to the Program within 60 days of receipt of notification, and premium payment must be made within 45 days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated;

d. Coverage for the surviving spouse under this section will continue until the earliest of the following:

- i. failure to pay the applicable premium timely;
- ii. eligibility of the surviving spouse for coverage under a Group Health Plan other than Medicare.

e. Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:

- i. failure to pay the applicable premium timely;
- ii. eligibility of the surviving Dependent Child for coverage under any Group Health Plan other than Medicare.
- iii. the attainment of the termination age for Children.

4. The provisions of paragraphs 1 through 3 this subsection are applicable to surviving Dependents who, on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree. Continued coverage for surviving Dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

D. - D.3. ...

E. Military Service. Members of the National Guard or of the United States military reserves who are called to active military duty, and who are OGB participating Employees or covered Dependents will have access to continued coverage under OGB's health and life plans.

1. Health Plan Participation. When called to active military duty, participating employees and covered dependents may:

a. continue participation in the OGB health plan during the period of active military service, in which case the participating employer may continue to pay its portion of premiums; or

b. cancel participation in the OGB health plan during the period of active military service, in which case such plan participants may apply for reinstatement of OGB coverage within 30 days of:

- i. the date of the Employee's reemployment with a participating employer;
- ii. the Dependent's date of discharge from active military duty, or
- iii. the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select;

iv. plan participants who elect this option and timely apply for reinstatement of OGB coverage will not be subject to a pre-existing condition (PEC) limitation, and the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in R.S. 42:851E and the corresponding Rules promulgated by OGB.

2. Life Insurance. When called to active military duty, Employees with OGB life insurance coverage may:

a. continue participation in the OGB life insurance during the period of active military service, however, the Accidental Death and Dismemberment coverage will not be in effect during the period of active military duty; or

b. cancel participation in the OGB life insurance during the period of active military service, in which case such Employee may apply for reinstatement of OGB life insurance within 30 days of the date of the Employee's reemployment with a participating employer; Employees

who elect this option and timely apply for reinstatement of OGB life insurance will not be required to provide evidence of insurability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1827 (October 1999), amended LR 30:1191 (June 2004), LR 32:

§105. COBRA

A. Employees

1. Coverage under this Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of Absence has expired, unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.

2. It is the responsibility of the Participant Employer to notify the Program within 30 days of the date coverage would have terminated because of any of the foregoing events, and the Program will notify the Employee within 14 days of his or her right to continue coverage.

3. Application for continued coverage must be made in writing to the Program within 60 days of the date of the election notification and premium payment must be made within 45 days of the date the Employee elects continued coverage, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 18 months from the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the Employer ceases to provide any group health plan for its employees.

5. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or a Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered spouse and/or covered Dependent Children may elect to continue coverage at his/her/their own expense. The elected coverage will be subject to the above-stated notification and termination provisions.

B. Surviving Dependents

1. Coverage under this Plan for covered surviving Dependents of an Employee or Retiree will terminate on the last day of the month in which the Employee's or Retiree's death occurs, unless the surviving covered Dependents elect to continue coverage at his/her own expense.

2. It is the responsibility of the Participant Employer or surviving covered Dependents to notify the Program within 30 days of the death of the Employee or Retiree. The Program will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of the date of the election notification.

3. Premium payment must be made within 45 days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for the surviving Dependents under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the Employer ceases to provide any group health plan for its employees.

C. Divorced Spouse

1. Coverage under this Plan for an Employee's spouse will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce from the Employee or Retiree, unless the covered divorced spouse elects to continue coverage at his or her own expense.

2. It is the responsibility of the divorced spouse to notify the Program within 60 days from the date of divorce and the Program will notify the divorced spouse within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of the election notification.

3. Premium payment must be made within 45 days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for the divorced spouse under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the employer ceases to provide any group health plan for its employees.

D. Dependent Children

1. Coverage under this Plan for a covered Dependent Child of a covered Employee or Retiree will terminate on the last day of the month during which the Dependent Child no longer meets the definition of an eligible covered Dependent, unless the Dependent elects to continue coverage at his or her own expense.

2. It is the responsibility of the Dependent to notify the Program within 60 days of the date coverage would have terminated and the Program will notify the Dependent within 14 days of his or her right to continue coverage. Application for continued coverage must be made in writing to the Program within 60 days of receipt of the election notification.

3. Premium payment must be made within 45 days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for Children under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the Employer ceases to provide any group health plan for its employees.

E. Dependents of COBRA Participants

1.a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered spouse or a covered Dependent Child becomes ineligible for coverage due to:

- i. death of the Employee;
- ii. divorce from the Employee; or
- iii. a Dependent Child no longer meets the definition of an eligible covered Dependent.

b. Then, the spouse and/or Dependent Child may elect to continue COBRA coverage at his/her own expense. Coverage will not be continued beyond 36 months from the date coverage would have otherwise terminated.

2. It is the responsibility of the spouse and/or the Dependent Child to notify the Program within 60 days of the date COBRA coverage would have terminated.

3. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

4. Coverage for Children under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months beyond the date coverage would have otherwise terminated;

- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the Employer ceases to provide any group health plan for its employees.

F. Disability COBRA

1. If a Covered Employee or Covered Dependent is determined by the Social Security Administration or by the Program staff (in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment), to have been totally disabled on the date the Covered Person became eligible for continued coverage or within the initial 18 months of coverage, coverage under this Plan for the Covered Person who is totally disabled may be extended at his or her own expense up to a maximum of 29 months from the date coverage would have otherwise terminated.

2. To qualify the Covered Person must:

- a. submit a copy of his or her Social Security Administration's disability determination to the Program before the initial 18-month continued coverage period expires and within 60 days after the latest of:
 - i. the date of issuance of the Social Security Administration's disability determination; and
 - ii. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours.

b. In the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment, submit proof of total Disability to the Program before the initial 18-month continued coverage period expires. The staff and medical director of the Program will make the determination of total Disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history, and other relevant evidence presented by the applicant.

3. For purposes of eligibility for continued coverage under this section, total Disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of 12 months. To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

4. Monthly payments for each month of extended COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

5. Coverage under this section will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 29 months from the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan

for a pre-existing condition of the covered person have been exhausted or satisfied;

e. the Employer ceases to provide any group health plan for its employees; or

f. 30 days after the month in which the Social Security Administration determines that the Covered Person is no longer disabled. (The Covered Person must report the determination to the Program within 30 days after the date of issuance by the Social Security Administration.) In the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment, 30 days after the month in which the Program determines that the Covered Person is no longer disabled.

G. Medicare COBRA

1. If an Employee becomes entitled to Medicare less than 18 months before the date the Employee's eligibility for benefits under this Plan terminates, the period of continued coverage available for the Employee's covered Dependents will continue until the earliest of the following:

- a. failure to pay the applicable premium timely;
- b. 36 months from the date of the Employee's Medicare entitlement;
- c. entitlement to Medicare;
- d. coverage under a Group Health Plan, but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the covered person have been exhausted or satisfied; or
- e. the Employer ceases to provide any group health plan for its employees.

2. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of 30 days after the first day of the month will be provided for each monthly payment.

H. Miscellaneous Provisions. During the period of continuation, benefits will be identical to those provided to others enrolled in this Plan under its standard eligibility provisions for Employees and Retirees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1828 (October 1999), amended LR 32:

§107. Change of Classification

A. Adding or Deleting Dependents. The Plan Member must notify the Program when a Dependent is added to or deleted from the Plan Member's coverage that results in a change in the class of coverage. Notice must be provided within 30 days of the addition or deletion.

B. ...

1. When there is a change in family status (e.g., marriage, birth of child) that affects the class of coverage, the change in classification will be effective on the date of the event. Application for the change must be made within 30 days of the date of the event.

2. When the addition of a Dependent changes the class of coverage, the additional premium will be charged for the entire month if the date of change occurs before the 15th day of the month. If the date of change occurs on or after the 15th day of the month, an additional premium will not be charged until the first day of the following month.

C. Notification of Change. It is the Employee's responsibility to notify the Program of any change in

classification of coverage that affects the Employee's contribution amount. If failure to notify is later determined, it will be corrected on the first day of the following month.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1829 (October 1999), amended LR 32:

Chapter 2. Termination of Coverage

§201. Active Employee and Retired Employee Coverage

A. ...

1. the date the Program terminates;
2. the date the group or agency employing the covered Employee terminates or withdraws from the Program;

3. the date contribution is due if the group or agency fails to pay the required contribution for the covered Employee;

4. the date contribution is due if the Covered Person fails to make any contribution which is required for the continuation of coverage;

5. the last day of the month of the covered Employee's death;

6. the last day of the month in which the covered Employee ceases to be eligible.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1830 (October 1999), amended LR 32:

§203. Dependent Coverage

A. ...

1. the last day of the month the Employee ceases to be covered;

2. the last day of the month in which the Dependent, as defined in this Plan, ceases to be an eligible Dependent of the covered Employee;

3. - 4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1830 (October 1999), amended LR 32:

Chapter 3. Medical Benefits

§301. Eligible Expenses

A. Eligible Expenses are the charges incurred for the following services, drugs, supplies, and devices, when performed, prescribed, or ordered by a Physician and Medically Necessary for the Treatment of a Covered Person. All charges are subject to applicable deductibles, copayments, and/or coinsurance amounts (unless otherwise specifically provided), Fee Schedule limitations, Schedule of Benefits, exclusions, and other provisions of the Plan. A charge is incurred on the date that the service, drug, supply, or device is performed or furnished. Eligible expenses are:

1. - 3. ...

4. anesthesia and its administration when ordered by the operating Physician and administered by an appropriately licensed nurse anesthetist or Physician in conjunction with a covered surgical service;

5. - 6. ...

7. blood, blood derivatives, and blood processing, when not replaced;

8. - 8.c. ...

d. ostomy supplies, except supplies for nutritional and/or enteral feeding;

e. - l. ...

9. services of a licensed speech therapist when pre-approved through Outpatient Procedure Certification (§309, below) for the purpose of restoring partial or complete loss of speech resulting from stroke, surgery, cancer, radiation laryngitis, cerebral palsy, accidental injury, or other similar structural or neurological disease, limited to 26 visits per Plan Year;

10. ...

11. services rendered by a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) for the Treatment of Accidental Injury to a Covered Person's natural teeth, under the following conditions:

a. coverage was in effect with respect to the individual at the time of the accident;

b. treatment commences within 90 days from the date of the accident and is completed within two years from the date of the accident;

c. coverage remains continuously in effect with respect to the Covered Person during the course of the Treatment;

d. eligible expenses are limited to the cost of Treatment as estimated at the time of initial Treatment;

e. eligible expenses may include dental braces and orthodontic appliances, upon review and approval by the Program's Dental Consultant, and only under the following circumstances:

i. to return the alveolar alignment to its former state prior to a covered dental accident. The Program will allow benefits for orthopedic correction to establish reasonable occlusal function;

ii. a covered surgery that requires the use of braces for stabilization;

iii. severe skeletal deformity (i.e., cleft palate). The Program will allow benefits for orthopedic correction to establish reasonable occlusal function;

f. as used herein Accidental Injury means a condition occurring as a direct result of a traumatic bodily injury sustained solely through accidental means from an external force, and with respect to injuries to teeth, the act of chewing does not constitute an external force.

12. Durable medical equipment subject to the lifetime maximum payment limitation as listed in the Schedule of Benefits. The Program will require written certification by the treating Physician to substantiate the Medical Necessity for the equipment and the length of time that it will be used. The purchase of Durable Medical Equipment will be considered an Eligible Expense only upon a showing that the rental cost would exceed the purchase price. Under no circumstances may the Eligible Expense for an item of Durable Medical Equipment exceed the purchase price of such item;

13. - 17. ...

18. orthopedic shoes prescribed by a Physician and completely custom built, limit one pair per plan year;

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

20. ...

21. services of a Physical Therapist or Occupational Therapist licensed in the state in which the services are rendered, under the following conditions:

a. services are prescribed by a licensed Physician and rendered in an individual setting;

b. restorative potential exists;

c. services meet the generally accepted standards for medical practice;

d. services are reasonable and Medically Necessary for Treatment of a disease, illness, accident, injury, or post-operative condition;

e. services are approved through Case Management when rendered in the home;

f. services are limited to 50 visits per Plan Year. Additional visits subject to approval by Utilization Management;

22. cardiac rehabilitation when:

a. rendered at a medical facility under the supervision of a licensed Physician;

b. - c. ...

NOTE: Charges incurred for dietary instruction, educational services, behavior modification literature, biofeedback, health club membership, exercise equipment, preventive programs, and any other items excluded by the Plan are not covered, unless provided for under Paragraph 30 of this subsection.

23. preventive care consisting of routine physical examinations, lab work, and immunizations (including a yearly influenza vaccination) as follows:

a. well baby care expenses subject to the annual deductible and co-payments:

i. newborn facility and professional charges;

ii. birth to age 1—all office visits for scheduled immunizations and screening;

b. well child care expenses subject to the annual deductible and co-payments:

i. age 1 until age 3—three office visits per year for scheduled immunizations and screening;

ii. age 3 until age 15—one office visit per year for scheduled immunizations and screening;

c. well adult care expenses, not subject to the annual deductible, but limited to a maximum benefit of \$200:

i. age 16 until age 40—once during a 3-year period;

ii. age 40 until age 50—once during a 2-year period;

iii. age 50 and over—once during a 1-year period.

NOTE: Benefits for Well Baby Care, Well Child Care and routine physical examinations for Well Adult Care, including immunizations, are based on the U.S. Preventive Services Task Force guidelines and recommendations of the National Immunization Program of the Centers for Disease Control and Prevention. All services must be rendered on an outpatient basis to monitor and maintain health and to prevent illness.

24. specialized, age-appropriate wellness care, not subject to the annual deductible, as follows:

a. one pap test for cervical cancer per plan year;

b. mammographic examinations performed according to the following schedule:

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

ii. one mammogram every two plan years for any person who is 40-49 years of age;

iii. one mammogram every 12 months for any person who is 50 years of age or older;

c. testing for detection of prostate cancer, including digital rectal examination and prostate-specific antigen testing, once every 12 months for men over the age of 50 years;

25. - 26. ...

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

a. perfusionists and registered nurse assistants assisting in the operating room;

b. physician assistants and Registered Nurse Practitioners;

28. - 30. ...

31. testing of sleep disorders only when the tests are performed at either:

a. a facility accredited by the American Academy of Sleep Medicine or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

b. a sleep study facility located within a healthcare facility accredited by JCAHO. No benefits are payable for surgical treatment of sleep disorders (including LAUP) except following demonstrated failure of non-surgical treatment and upon approval by the Program;

32. - 33.c. ...

34. treatment provided in accordance with a clinical trial for cancer, including costs of investigational treatments and of associated protocol-related patient care if all of the following criteria are met:

a. treatment is being provided with a therapeutic or palliative intent for patients with cancer, or for the prevention or early detection of cancer;

b. treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer;

c. treatment is being provided in accordance with a clinical trial approved by one of the following entities:

i. one of the United States National Institutes of Health;

ii. a cooperative group funded by one of the United States National Institutes of Health;

iii. the FDA in the form of an investigational new drug application;

iv. the United States Department of Veterans Affairs;

v. the United States Department of Defense;

vi. a federally funded general clinical research center;

vii. the Coalition of National Cancer Cooperative Groups.

d. the proposed protocol has been reviewed and approved by a qualified institutional review board which operates in this state and which has a multiple project assurance contract approved by the office of protection from research risks;

e. the facility and personnel providing the protocol provided the treatment within their scope of practice, experience, and training and are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

f. there is no clearly superior, non-investigational approach;

g. the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as the non-investigational alternative; and

h. the patient has signed an institutional review board-approved consent form.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1830 (October 1999), amended LR 28:480 (March 2002), LR 29:339,343 (March 2003), LR 30:1192 (June 2004), LR 31:441 (February 2005), LR 32:

§303. Fee Schedule

A. The fee schedule establishes the maximum allowable charges for eligible expenses. The fee schedule applies to both contracted (PPO) health care providers, who have entered into agreements with OGB regarding reimbursement under this plan, and to non-contracted (non-PPO) health care providers who have not entered into such agreements.

B. Plan members may be subject to greater financial responsibility for services, drugs, supplies, and devices provided by non-contracted health care providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1832 (October 1999), amended LR 32:

§305. Automated Claims Adjusting

A. OGB utilizes commercially licensed software that applies all claims against its medical logic program to identify improperly billed charges and charges for which this Plan provides no benefits. Any claim with diagnosis or procedure codes deemed inadequate or inappropriate will be automatically reduced or denied. Providers accepting assignment of benefits cannot bill the Plan Member for the differential on the denial amount, in whole or in part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1832 (October 1999), amended LR 32:

§307. Utilization Review—Pre-Admission

Certification, Continued Stay Review

A. - A.2. ...

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

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1832 (October 1999), amended LR 32:

§309. Outpatient Procedure Certification (OPC)

A. The purpose of OPC is for the Plan to certify that particular outpatient procedures and therapies are Medically Necessary. If OPC is not obtained when required, no benefits are payable under this Plan.

A.1. - B. ...

1. Speech therapy, subject to the limitations set forth in §301.A.9 of this Part.

2. - 7.d. repealed.

C - C.2. ...

D. repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1832 (October 1999), amended LR 32:

§311. Case Management

A - D.3.b.

E. - E.8. repealed.

F. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1833 (October 1999), amended LR 32:

§313. Dental Surgical Benefits

A. ...

B. If a Covered Person requires dental treatment in a hospital setting that is otherwise an Eligible Expense, the Plan will provide benefits for anesthesia rendered in the hospital and associated hospital charges. Prior authorization for hospitalization for dental treatment is required in the same manner as prior authorization is required for other covered medical services.

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

D. The provisions of this section shall not apply to Treatment rendered for Temporomandibular joint (TMJ) diseases or disorders.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1833 (October 1999), amended LR 32:

§315. Medicare Reduction

A. ...

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1833 (October 1999), amended LR 32:

§317. Exceptions and Exclusions

A. No benefits are provided under this Plan for the following:

1. injury compensable under any worker's compensation program, regardless of whether the patient has filed a claim for benefits. This applies to compensation provided on an expense-incurred basis or blanket settlements for past and future losses;

2. maintenance therapy consisting of convalescent, skilled nursing, sanitarium, custodial care, assisted living facilities, or rest cures designed to assist in daily living activities, maintain present physical and/or mental condition, or provide a structured or safe environment;

3. expenses for elective, non-therapeutic voluntary abortions (abortions performed for reasons other than to save the life of the mother);

4. injuries sustained by a Covered Person while in an aggressor role;

5. expenses incurred as a result of a Covered Person's commission or attempted commission of an illegal act;

6. services, supplies, or treatment for cosmetic purposes, including cosmetic surgery and any cosmetic complications of cosmetic surgery, unless necessary for the immediate repair of a deformity caused by a disease and/or injury that occurs while coverage is in force. No payment will be made for expenses incurred in connection with the treatment of any body part not affected by the disease and/or injury;

7. shoes and related items, such as wedges, cookies, and arch supports;

8. dental and orthodontic services, appliances, supplies, and devices, including, but not limited to the following:

a. dental braces and orthodontic appliances, except as specifically provided in §301(A)(11) (e) of this Part;

b. treatment of periodontal disease;

c. dentures, dental implants, and any surgery for their use, except if needed as the result of an accident that meets the program's requirements;

d. treatment for Temporomandibular Joint (TMJ) diseases or disorders, except as specifically provided in §301.A.28 of this Part;

e. expenses incurred for services rendered by a dentist or oral surgeon and any ancillary or related services, except for covered dental surgical procedures, as specifically set forth herein, dental procedures which fall under the guidelines of treatment of accidental injury, procedures necessitated as a result of or secondary to cancer, or oral and maxillofacial surgeries which are shown to the satisfaction of the Program to be Medically Necessary, non-dental, non-cosmetic procedures;

9. medical services, supplies, treatments, and prescription drugs provided without charge to the Covered Person or for which the Covered Person is not legally obligated to pay;

10. maternity expenses incurred by any person other than the Employee or the Employee's legal Spouse;

11. personal convenience items including, but not limited to, admit kits, bedside kits, telephone, television, guest meals, and beds, and charges for luxury accommodations in any hospital or allied health facility

provided primarily for the patient's convenience which are not deemed Medically Necessary by the Program;

12. charges for services, supplies, treatment, drugs, and devices which are in excess of the maximum allowable under the Medical Fee Schedule, Outpatient Surgical Facility Fee Schedule, or any other limitations of the Plan;

13. services, supplies, treatment, drugs, devices, and deluxe medical equipment which are not deemed Medically Necessary by the Program;

14. services rendered for remedial reading and recreational, visual, and behavioral modification therapy, biofeedback, pain rehabilitation control and/or therapy, and dietary or educational instruction for all diseases and/or illnesses, except diabetes;

15. services and supplies for the treatment of and/or related to gender dysphoria or reverse sterilization;

16. artificial organ implants, penile implants, transplantation of non-human organs, and any surgery and other treatment, services, or supplies, related to such procedures, or to complications related to such procedures;

17. expenses subsequent to the initial diagnosis for infertility and complications, including but not limited to, services, drugs, procedures, or devices to achieve fertility, in-vitro fertilization, low tubal transfer, artificial insemination, intracytoplasmic sperm injection, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, donor eggs, and reversal of sterilization procedures;

18. non-medical supplies such as air conditioners and/or filters, dehumidifiers, air purifiers, wigs or toupees, heating pads, cold devices, home enema equipment, rubber gloves, swimming pools, saunas, whirlpool baths, home pregnancy tests, lift chairs, devices or kits to stimulate the penis, exercise equipment, any other items not normally considered medical supplies, and any items the Program determines are not medical supplies;

19. administrative fees, interest, penalties, or sales tax;

20. marriage counseling, family relations counseling, divorce counseling, parental counseling, job counseling, and career counseling;

21. charges for Physician services rendered to a Covered Person over the telephone or in a non-face-to-face setting;

22. radial keratotomy, laser surgery, and any other procedures, services, or supplies for the correction of refractive errors of the eyes;

23. services, supplies, surgeries, and treatments for excess body fat, resection of excess skin and/or fat following weight loss or pregnancy, and/or obesity, and morbid obesity.

24. hearing aids and any examination to determine the fitting or necessity of hearing aids, except as specifically provided for in §301.A.33 of this Part;

25. hair plugs and/or transplants;

26. routine physical examinations and/or immunizations not provided for under Eligible Expenses;

27. eye examinations, glasses, and contact lenses, except as specifically provided for as an Eligible Expense in §301.A.15 of this Part;

28. diagnostic or treatment measures that are not recognized as generally accepted medical practice;

29. medical supplies not listed under Eligible Expenses;

30. treatment or services for mental health and substance abuse provided outside the treatment plan developed by the Program's managed care contractor or by therapists with whom or at facilities with which the Program's managed care contractor does not have a contract;

31. genetic testing, except when determined to be Medically Necessary during a covered pregnancy;

32. services rendered by a private-duty Registered Nurse (R.N.) or by a private-duty Licensed Practical Nurse (L.P.N.);

33. services rendered by a Physician or other health care Provider related to the patient by blood, adoption, or marriage;

34. expenses for services rendered by a Physician or other health care Provider who is not licensed in the state where such services are rendered or in any facility not holding a valid license in the state and for the services rendered;

35. facility fees for services rendered in a Physician's office or in any facility not approved by the federal Health Care Finance Administration for Medicare reimbursement;

36. glucometers;

37. augmentative communication devices;

38. charges to obtain medical records or any other information needed and/or required to adjudicate a claim;

39. charges greater than the global allowance for any laboratory, pathology, or radiological procedure;

40. speech therapy or the services of a speech therapist except as specifically provided in §301.A.9.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1834 (October 1999), amended LR 26:488 (March 2000), LR 27:720 (May 2001), LR 28:2343 (November 2002), LR 31:441 (February 2005), LR 32:

§321. Preferred Provider Program

A. The Program may implement Preferred Provider Organization (PPO) arrangements or other agreements to discount payable fees. The Program reserves the right to negotiate the amount of discounts, incentives offered to Plan Members, and all other provisions which are a part of any discount fee arrangement. To be eligible, the Program must be the primary carrier at the time services are rendered.

1. - 2.a. ...

b. If a Covered Person receives services from a PPO Provider, services are reimbursed at 90 percent of the Eligible Expenses, and payments made to the PPO Provider. There is a contractual assignment to every PPO Provider. If a non-PPO provider is used by a Plan Member who resides in Louisiana, the Plan Member is reimbursed 70 percent of the Eligible Expenses. If a non-PPO Provider is used by a Plan Member who resides outside Louisiana, the Plan Member is reimbursed 90 percent of the Eligible Expenses. Eligible Expenses of non-PPO Providers are based upon the OGB's Fee Schedule.

NOTE: Both PPO and non-PPO services are subject to the applicable deductibles, limitations, and exclusions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1835 (October 1999), amended LR 27:722 (May 2001), LR 29:339 (March 2003), LR 32:

§323. Prescription Drug Benefits

A. This Plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription and are dispensed by a licensed pharmacist or pharmaceutical company.

1. These include and shall not be limited to:

a. Insulin;

b. Retin-A dispensed for covered persons under the age of 27;

c. Vitamin B-12 injections;

d. Prescription Potassium Chloride; and

e. over-the-counter diabetic supplies including, but not limited to, strips, lancets, and swabs.

2. In addition, this Plan allows benefits limited to \$200 per month for expenses incurred for the purchase of low protein food products for the treatment of inherited metabolic diseases if the low protein food products are Medically Necessary and are obtained from a source approved by the OGB. Such expenses shall be subject to coinsurance and co-payments relating to prescription drug benefits. In connection with this benefit, the following words shall have the following meanings:

a. *Inherited metabolic disease* shall mean a disease caused by an inherited abnormality of body chemistry and shall be limited to:

i. Phenylketonuria (PKU);

ii. Maple Syrup Urine Disease (MSUD);

iii. Methylmalonic Acidemia (MMA);

iv. Isovaleric Acidemia (IVA);

v. Propionic Acidemia;

vi. Glutaric Acidemia;

vii. Urea Cycle Defects; or

viii. Tyrosinemia.

b. *Low protein food products* mean food products that are especially formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease. Low protein food products shall not include natural foods that are naturally low in protein.

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

1. appetite suppressant drugs;

2. dietary supplements;

3. topical forms of Minoxidil;

4. Retin-A dispensed for a covered person over age 26;

5. amphetamines dispensed for diagnoses other than Attention Deficit Disorder or Narcolepsy;

6. nicotine, gum, patches, or other products, services, or programs intended to assist an individual to reduce or cease smoking, or other use of tobacco products;

7. nutritional or parenteral therapy;

8. vitamins and minerals;

9. drugs available over the counter;

10. Serostim dispensed for any diagnoses or therapeutic purposes other than AIDS wasting;

11. drugs prescribed for the treatment of impotence, except following the surgical removal of the prostate gland; and

12. glucometers.

C. - C.7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1835 (October 1999), amended LR 27:720, 721 (May 2001), LR 27:1887 (November 2001), LR 28:2344 (November 2002), LR 29:342 (March 2003), LR 32:

Chapter 4. Uniform Provisions

§401. Statement of Contractual Agreement

A. This Plan, as amended, including the Schedule of Benefits, together with the Application for Coverage and any related documents executed by or on behalf of the covered Employee, constitute the entire agreement between the parties.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1836 (October 1999), amended LR 32:

§403. Properly Submitted Claim

A. For Plan reimbursement, a claim must include:

1. - 4. ...

5. type of services rendered, with diagnosis and/or procedure codes that are valid and current for the date of service;

6. date and place of service;

7. - 10. ...

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1836 (October 1999), amended LR 32:

§405. When Claims Must Be Filed

A. - B. ...

C. Requests for review of payment or corrected bills must be submitted within 18 months of receipt date of the original claim. Requests for review of payment or corrected bills received after that time will not be considered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1836 (October 1999), amended LR 28:479 (March 2002), LR 32:

§407. Right to Receive and Release Information

A. Without notice or consent the Program may release to or obtain from any company, organization, or person, any information regarding any person which the Program deems necessary to carry out the provisions of this Plan, or to determine how, or if, they apply. Any claimant under the Plan must furnish the Program with any information necessary to implement this provision. OGB retains information for the minimum period of time required by law. After such time, information may no longer be available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1836 (October 1999), amended LR 32:

§409. Legal Limitations

A. ...

B. Information provided by the Program or any of its employees or agents to Plan Members does not modify or override the terms and provisions of the Plan. In the event of any conflict between the written provisions of this Plan and any information provided, the written provisions of this Plan shall supercede and control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1836 (October 1999), amended LR 28:479 (March 2002), LR 32:

§413. Recovery of Overpayments

A. If an overpayment occurs, the Program retains the right to recover the overpayment. The Covered Person, institution, or Provider receiving the overpayment must return the overpayment. At the Plan's discretion, the overpayment may be deducted from future claims. Should legal action be required as a result of fraudulent statements or deliberate omissions on the application for coverage or a claim for benefits, the defendant will be responsible for attorney fees of 25 percent of the overpayment or \$1,000, whichever is greater. The defendant will also be responsible for court costs and legal interest from the date of judicial demand until paid.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1837 (October 1999), amended LR 32:

§415. Subrogation and Reimbursement

A. Upon payment of any eligible benefits covered under this Plan, the Office of Group Benefits shall succeed and be subrogated to all rights of recovery of the covered Employee, his Dependents or other Covered Persons, or their heirs or assigns, for whose benefit payment is made, and they shall execute and deliver instruments and papers and do whatever is necessary to secure such rights, and shall do nothing after loss to prejudice such rights.

B. The Office of Group Benefits shall be entitled, to the extent of any payment made to a covered Employee, his Dependents or other Covered Persons, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a covered Employee, his Dependents or other Covered Persons, against any person or entity legally responsible for the disease, illness, accident or injury for which said payment was made. To this end, covered Employees, their Dependents, or other Covered Persons agree to immediately notify the Office of Group Benefits of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident or injury.

C. These subrogation and reimbursement rights also apply when a Covered Person recovers under, but not limited to, an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1837 (October 1999), amended LR 32:

§417. Employer Responsibility

A. It is the responsibility of the Participant Employer to submit enrollment and change forms and all other necessary documentation to the Program on behalf of its Employees. Employees of a Participant Employer will not, by virtue of furnishing any documentation to the Program, 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 OGB when 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 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. A Participant Employer that receives a Medicare Secondary Payer (MSP) collection notice or demand letter shall deliver the MSP notice to the OGB MSP Adjuster within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a covered Employee. If not timely forwarded, OGB will assume responsibility only for Covered Plan benefits due to Medicare for a covered Employee. The Participant Employer will be responsible for interest, fines, and penalties due.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1837 (October 1999), amended LR 29:1819 (September 2003), LR 32:

§419. Program Responsibility

A. OGB will administer the Plan in accordance with its terms, state and federal law, the OGB's established policies, interpretations, practices, and procedures. OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding eligibility for benefits and to decide disputes which may arise relative to a Covered Person's rights.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1837 (October 1999), amended LR 32:

§423. Amendments to or Termination of the Plan and/or Contract

A. OGB has the statutory responsibility of providing health and accident and death benefits to Covered Persons to the extent that funds are available. OGB reserves the right to terminate or amend the eligibility and benefit provisions of the Plan from time to time as necessary to prudently discharge its duties. Such modifications will be promulgated subject to the applicable provisions of law, and nothing contained herein shall be construed to guarantee or vest benefits for any Employee, whether active or retired.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1837 (October 1999), amended LR 32:

Chapter 6. Definitions

§601. Definitions

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

Appeal—a request by a Plan Member for and a formal review of a medical claim for benefits or an eligibility determination.

Benefit Payment—payment of Eligible Expenses due or owing by a Covered Person, after applicable deductibles, co-payments, and coinsurance, and subject to all limitations and exclusions, at the rate shown under Percentage Payable in the Schedule of Benefits.

Board of Trustees—repealed.

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

Calendar Year—repealed.

* * *

Child or Children includes—

1. a legitimate, duly acknowledged, and/or legally adopted Child of the Employee and/or the Employee's legal spouse's who is dependent upon the Employee for support;

2. a Child in the process of being adopted by the Employee through an agency adoption, who is living in the household of the Employee, and is or will be included as a Dependent on the Employee's federal income tax return for the current or following tax year (if filing is required);

3. a child in the legal custody of the Employee, who lives in the household of the employee and is or will be included as a dependent on the employee's federal income tax return for the current or following tax year (if filing is required);

4. a grandchild of the Employee that is not in the legal custody of the Employee, who is dependent upon the Employee for support and whose parent is a covered Dependent. If the Employee seeking to cover a Grandchild is a paternal grandparent, the Program will require that the biological father, i.e. the covered son of the Employee, execute an acknowledgement of paternity.

NOTE: If the Employee Dependent parent becomes ineligible for coverage under the Program, the Employee's Grandchild will also be ineligible for coverage, unless the Employee has legal custody of his/her Grandchild.

COBRA—the federal continuation of coverage laws originally enacted in the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Committee—repealed.

Convalescent, Maintenance Care, or Rest Cures—treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by oneself, family, or other caregivers who are not eligible Providers. The services are primarily designed to help the patient with daily living activities, maintain the patient's present physical and mental condition, and/or provide a structured or safe environment.

Covered Person—an active or retired Employee, his/her eligible Dependent, or any other individual eligible for coverage for whom the necessary application forms have been completed and for whom the required contribution is made.

Covered Services—to those health care services for which a Plan Member is entitled to receive Benefit Payments in accordance with the terms of this Plan.

Custodial Care—

1. care designed to assist an individual in the performance of daily living activities (i.e. services which constitute personal care such as walking, getting in and out of bed, bathing, dressing, eating, and using the toilet) that does not require admission to a hospital or other institution for the treatment of a disease, illness, accident, or injury, or for the performance of surgery;

2. care primarily intended to provide room and board to an individual with or without routine nursing care, training in personal hygiene, or other forms of self-care;

3. supervisory care provided by a Physician whose patient who is mentally or physically incapacitated and is not under specific medical, surgical, or psychiatric treatment, when such care is intended to reduce the patient's incapacity to the extent necessary to enable the patient to live outside of an institution providing medical care, or when, despite treatment, there is not reasonable a likelihood that the incapacity will be reduced.

Date Acquired—the date a Dependent of a covered Employee is acquired in the following instances and on the following dates only:

1. legal spouse—the date of marriage;
2. child or children—
 - a. natural child—the date of birth;
 - b. child in the process of being adopted;
 - c. agency adoption—the date the adoption contract was executed between the employee and the adoption agency;
 - d. private adoption—the date the Act of Voluntary Surrender is executed in favor of the Employee. The Program must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date it Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;
 - e. child who lives in the household of the covered Employee and is currently or will be included as a Dependent on the Employee's federal income tax return—the date of the court order granting legal custody;
 - f. grandchild of the Employee that is not in the legal custody of the Employee, but who is dependent upon the Employee for support and whose parent is a covered Dependent:
 - i. the date of birth of the Grandchild, if all of the above requirements are met at the time of birth; or
 - ii. the date on which the coverage becomes effective for the covered Dependent, if all of the above requirements are not met at the time of birth.

Deductible—the dollar amount that a Covered Person must pay as shown in the Schedule of Benefits before benefits will be paid in a Plan Year.

Dependent—any of the following persons who are enrolled for coverage as Dependents, if they are not also covered as an Employee:

1. the covered Employee's legal Spouse;
2. a never married Child from date of birth up to 21 years of age and dependent upon the Employee for support ;
3. a never married Child who is a fulltime student under 24 years of age and financially dependent upon the Employee for support;
4. a never married Child of any age who meets the criteria set forth in §103.D, above;

Durable Medical Equipment (DME)—equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of an illness or injury, and is appropriate for use in the home. DME includes, but is not limited to, items such as wheelchairs, hospital beds, respirators, braces (non-dental), custom orthotics which must be specially made and not available at retail stores.

Emergency Medical Condition—a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or with respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or unborn child.

Emergency Room Services—medical services eligible for reimbursement that are necessary to screen, evaluate, and stabilize an Emergency Medical Condition and are provided at a hospital Emergency Room and billed by a hospital.

Employee—a full-time Employee as defined by a Participant Employer and in accordance with state law.

Family Unit Limit—that each of three covered members of a family unit have met the dollar amount shown in the Schedule of Benefits as Plan Year deductible for an individual. Once the Family Unit Limit is met, the deductibles of all other covered members of the family unit will be considered satisfied for that Plan Year.

Fee Schedule—the maximum allowable charges for professional or hospital services adopted by the OGB that may be considered as an Eligible Expense.

Future Medical Recovery—repealed.

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

Group Health Plan—a plan (including a self-insured plan) offered or contributed to, by an employer (including a self-employed person) or employee organization to provide health care to employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, and/or their families.

Health Insurance Coverage—benefits consisting of medical care offered by a health insurance issuer under any

hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract.

* * *

HIPAA—the Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and Federal Regulations promulgated pursuant thereto.

Hospital—an institution that is currently licensed as a hospital by the state in which services are rendered and is not primarily an institution for rest, the aged, the treatment of pulmonary tuberculosis, a nursing home, extended care facility, remedial training institution, or a facility primarily for the treatment of conduct and behavior disorders.

Incurred Date—the date when a particular service or supply is rendered or obtained. When a single charge is made for a series of services, each service will bear a prorated share of the charge.

* * *

Lifetime Maximum Benefit—the maximum amount of benefits that will be paid under the Plan for all Eligible Expenses incurred by a Covered Person.

Medically Necessary—a service, treatment, procedure, equipment, drug, device, item, or supply, which, in the judgment of the Program:

1. is appropriate and consistent with a Covered Person's diagnosis and treatment as well as with nationally accepted medical standards; and

2. is not primarily for personal comfort or convenience or Custodial Care.

Medicare—the health insurance available through Medicare laws enacted by the Congress of the United States.

* * *

Occupational Therapy—the application of any activity one engages in for the purposes of evaluation, interpretation, treatment planning, and treatment of problems interfering with functional performance in persons impaired by physical illness or injury in order to significantly improve functioning.

* * *

Participating Provider—a PPO, as defined herein.

Physical Therapy—the evaluation of physical status as related to functional abilities and treatment procedures as indicated by that evaluation. And licensed for the state where services are rendered.

Physician—

1. *Physician* means the following persons, appropriately licensed to practice their respective professional skills at the time and place the service is rendered:

- a. a Doctor of Medicine (M.D.);
- b. a Doctor of Dental Surgery (D.D.S.);
- c. a Doctor of Dental Medicine (D.M.D.);
- d. a Doctor of Osteopathy (D.O.);
- e. a Doctor of Podiatric Medicine (D.P.M.);
- f. a Doctor of Chiropractic (D.C.);
- g. a Doctor of Optometry (O.D.)
- h. a Psychologist meeting the requirements of the National Register of Health Service Providers in Psychology;
- i. a mental health counselor;
- j. a substance abuse counselor;
- k. an Audiologist.

2. The term *physician* does not include a medical doctor in the capacity of supervising interns, residents, senior residents, or fellows enrolled in a training program who does not personally provide medical Treatment or perform a surgical procedure for the Covered Person.

Plan—coverage offered by the Office of Group Benefits under this contract including PPO benefits, prescription drug benefits, mental health and substance abuse benefits, and comprehensive medical benefits. The term Plan as defined herein is used interchangeably with the term Program as defined below.

* * *

Plan Year—the period from July 1, or the date the Covered Person first becomes covered under the Plan, through the next following June 30. Each successive Plan Year will be the twelve month period from July 1 through the next following June 30.

* * *

Program—the Office of Group Benefits and/or the Plan.

Provider—one or more entities which offer health care services and shall include but not be limited to individuals, or groups of physicians, individuals or groups of psychologists, nurse midwives, ambulance service companies, hospitals, and other health care entities that provide Covered Services to Covered Individuals.

Recovery—with respect to Subrogation and Reimbursement (§ 413) recovery means any and all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for losses allegedly caused by injury or sickness, whether or not the losses reflect medical or dental charges covered by the Program.

Referee—repealed.

Rehabilitation and Rehabilitation Therapy—care concerned with the management and functional ability of patients disabled by disease, illness, accident, or injury.

Reimbursement—repayment to the Program for Benefits Payments made by the Program.

Retiree—

1. Retiree means an individual who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

- a. immediately received retirement benefits from an approved state or governmental agency defined benefit plan;
- b. was not eligible for participation in such plan or legally opted not to participate in such plan; and either:
 - i. began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65; or
 - ii. began employment after September 16, 1979, has 10 years of continuous state service, and has reached the age of 70; or
 - iii. was employed after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or
 - iv. maintained continuous coverage with the Program as an eligible Dependent until he/she became eligible as a former state employee to receive a retirement benefit from an approved state governmental agency defined benefit plan;

c. immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to the Office of Group Benefits.

2. *Retiree* also means an individual who was a covered Employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of Subparagraphs i, ii, or iii above.

Room and Board—all expenses necessary to maintain and sustain a Covered Person upon admittance to a hospital and during a hospital confinement. This can include, but is not limited to, facility charges for the maintenance of the Covered Person's hospital room, dietary and food services, nursing services performed by nurses employed by or under contract with the hospital, and housekeeping services.

* * *

Utilization Management—the process of evaluating the necessity, appropriateness, and efficiency of health care services against established guidelines and criteria.

Utilization Review Organization (URO)—an entity that has established one or more utilization review programs which evaluates the medical necessity, appropriateness, and efficiency of the uses of health care services, procedures, and facilities.

Well Adult Care—covered persons age 16 and older and means a routine physical examination by a physician that may include an influenza vaccination, lab work, and x-rays performed as part of the exam in that physician's office, when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedures and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as *Well Adult Care*.

Well Baby Care—covered persons from birth until age 1 and means routine care to a well, newborn infant that may include physical examinations and active immunizations provided by a physician when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedures and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as *Well Baby Care*.

Well Child Care—covered persons from age 1 through age 15 and means routine physical examinations and active immunizations provided by a physician, when such services are billed by that physician with wellness procedure and diagnosis codes. Other health care services billed with wellness procedure and diagnosis codes, as well as treatment and/or diagnosis of a specific illness, will not be considered as *Well Child Care*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1840 (October 1999), amended LR 29:339 (March 2003), LR 32:

Chapter 7. Schedule of Benefits—PPO

§701. Comprehensive Medical Benefits

A. Eligible Expenses for professional medical services are reimbursed on a fee schedule of maximum allowable charges. All eligible expenses are determined in accordance with plan limitations and exclusions.

Lifetime maximum for all benefits, except outpatient prescription drug benefits, per person	\$1,000,000
Lifetime maximum for outpatient prescription drug benefits, per person	\$250,000

A. - C.3. ...

²Participating providers are reimbursed at 100% of Eligible Expenses up to the maximum benefit; Non-Participating providers are reimbursed at 70% of Eligible Expenses up to the maximum benefit

Services include screenings to detect illness or health risks during a Physician office visit. The covered services are based on prevailing medical standards and may vary according to age and family history.

Specialized age appropriate wellness (not subject to deductible) – For a complete list of benefits, see §301.A.24 of this Part.

D. ...

E. repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(1).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1843 (October 1999), amended LR 26: 488 (March 2000), LR 27:719, 720, 722 (May 2001), LR 27:1887 (November 2001), LR 28:2345 (November 2002), LR 29:340, 342, 343 (March 2003), repromulgated LR 29:578 (April 2003), amended LR 30:1192 (June 2004), LR 32:

Family Impact Statement

The proposed Rule has no known impact on family formation, stability, or autonomy.

Interested persons may present their views, in writing, to Tommy D. Teague, Chief Executive Officer, Office of Group Benefits, Box 44036, Baton Rouge, LA 70804, until 4:30 p.m. on Monday, August 21, 2006.

Tommy D. Teague
Chief Executive Officer

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: PPO Plan of Benefits**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

This rule change is to clarify the current PPO Plan of Benefits and make certain technical amendments to the document. The reason for this action is to enhance member clarification and be able to administer health care benefits effectively for the Program and the member. It is anticipated \$3,000 in expenses will be incurred with the publishing of this rule in FY 06/07.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Revenue collections of State or Local Governmental units should not be affected by this rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This rule modifies and updates the PPO Plan of Benefits for the clarification of the members and effectiveness of the Program. This rule contains numerous amendments that incorporates the current administrative practices of the Office of Group Benefits.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Competition and employment will not be affected.

Tommy D. Teague
Chief Executive Officer
0607#052

H.Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

**Office of the Governor
Division of Administration
Racing Commission**

Exacta (LAC 35:XIII.10701, 10707, and 10709)

The Louisiana State Racing Commission hereby gives notice that it intends to amend LAC 35:XIII.Chapter 107 "Exacta," to provide for a new "jackpot" exacta wager, and provisions thereof, at Louisiana's race tracks.

This proposed Rule has no known impact on family formation, stability, and/or autonomy as described in R.S. 49:972.

The full text of this proposed Rule may be viewed in the Emergency Rule section of this *Louisiana Register*.

The domicile office of the Louisiana State Racing Commission is open from 8:30 a.m. to 5 p.m., and interested parties may contact Charles A. Gardiner III, executive director, or Larry Munster, assistant executive director, at (504) 483-4000 (holidays and weekends excluded), or by fax (504) 483-4898, for more information. All interested persons may submit written comments relative to this proposed Rule through August 11, 2006, to 320 North Carrollton Avenue, Suite 2-B, New Orleans, LA 70119-5100.

Charles A. Gardiner III
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Exacta

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Other than one-time costs directly associated with the publication of this rule there are no additional costs to the Commission as a result of this action.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

As a result of this action, revenue collections should increase due to increased wagering activity. Prior to enacting this emergency rule, there was no "jackpot" component of exacta waters. The pool of money from exacta wagers was paid

out in its entirety to holders of winning exacta tickets. The rule change maintains the exacta wager in its present form but also allows a track to add the "jackpot" component should they choose to do so. The jackpot component is expected to be popular with bettors as it incorporates a jackpot similar to that in the gaming industry which has proven to be very popular.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

As a result of this rule change, bettors who choose to play and win the "exacta jackpot" will share increased profits.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Passage of this rule should not affect employment. However, it should place Louisiana tracks in a more favorable competitive environment with other tracks around the country. This rule change is unique to Louisiana racing and will likely increase wagering.

Charles A. Gardiner III
Executive Director
0607#017

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

**Office of the Governor
Division of Administration
Racing Commission**

Pick Four (LAC 35:XIII.11615)

The Louisiana State Racing Commission hereby gives notice that it intends to amend LAC 35:XIII.Chapter 116 "Pick Four" to provide for dead heats in a pick four wager, and provisions thereof.

This proposed Rule has no known impact on family formation, stability, and/or autonomy as described in R.S. 49:972.

The full text of this proposed Rule may be viewed in the Emergency Rule section of this *Louisiana Register*.

The domicile office of the Louisiana State Racing Commission is open from 8:30 a.m. to 5 p.m., and interested parties may contact Charles A. Gardiner III, executive director, or Larry Munster, assistant executive director, at (504) 483-4000 (holidays and weekends excluded), or by fax (504) 483-4898, for more information. All interested persons may submit written comments relative to this proposed Rule through August 11, 2006, to 320 North Carrollton Avenue, Suite 2-B, New Orleans, LA 70119-5100.

Charles A. Gardiner III
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Pick Four

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Other than one-time costs directly associated with the publication of this rule there are no additional costs to the Commission as a result of this action.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

As a result of this action, revenue collections should increase due to increased wagering activity. Prior to enacting

this emergency rule, payoffs for horses involved in dead heats (tie for a place) in "Pick Four" races were identical. This proved to be unpopular with bettors who had wagered on the horse with longer odds in the dead heat. These bettors believed their choice with longer odds should pay out more when the winners of the other three legs of the Pick Four were combined with the long shot. This action of providing a "consolation" ticket paying out more than that combined with a favorite or horse with shorter odds should be more popular with bettors, thereby creating an environment for increased wagering. As wagering increases, revenue collections for pari-mutuel taxes should increase.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Passage of this rule should result in economic benefits to bettors of the longer odd horse in dead heats in Pick Four races. However, the extent of the benefit cannot be directly measured.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Passage of this rule should not affect employment. However, it should place Louisiana tracks in a more favorable competitive environment with other tracks around the country that have already employed this model for payouts in certain limited circumstances, namely, a winning ticket in a Pick Four race where one or more of the placed horses dead heat for a position.

Charles A. Gardiner III
Executive Director
0607#021

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

**Office of the Governor
Division of Administration
Racing Commission**

Triple Play (LAC 35:XIII.11515 and 11517)

The Louisiana State Racing Commission hereby gives notice that it intends to amend LAC 35:XIII.Chapter 115 "Triple Play" to provide for scratches/nonstarters and dead heats in a triple play wager, and provisions thereof.

This proposed Rule has no known impact on family formation, stability, and/or autonomy as described in R.S. 49:972.

The full text of this proposed Rule may be viewed in the Emergency Rule section of this *Louisiana Register*.

The domicile office of the Louisiana State Racing Commission is open from 8:30 a.m. to 5 p.m., and interested parties may contact Charles A. Gardiner III, executive director, or Larry Munster, assistant executive director, at (504) 483-4000 (holidays and weekends excluded), or by fax (504) 483-4898, for more information. All interested persons may submit written comments relative to this proposed rule through August 11, 2006, to 320 North Carrollton Avenue, Suite 2-B, New Orleans, LA 70119-5100.

Charles A. Gardiner III
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: Triple Play

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Other than one-time costs directly associated with the publication of this rule there are no additional costs to the Commission as a result of this action.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

As a result of this action, revenue collections should increase due to increased wagering activity. Prior to enacting this emergency rule, in the event of a late scratch, the bettor who had selected in his/her wager the horse that was scratched was assigned automatically the post time betting favorite. With the change in the rule governing Triple Play races, the bettor whose horse is scratched prior to the first leg of the Triple Play will receive a full refund. After the first leg of the Triple Play is run, any winning combination with the bettors choice, when coupled with a scratched horse, will receive a consolation payoff. Also, in the event of a dead heat (tie for a place) involving a bettors choice, the bettor will be paid a consolation Triple Play payoff.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Passage of this rule should result in economic benefits to bettors of the longer odd horse in dead heats in Triple Play races. The rule change will be more popular with bettors in the circumstance that a bettor's choice in horses scratched prior to the first leg of the Triple Play because the bettor will receive a full refund of his/her wager. Prior to the change, the bettor was automatically given the post time favorite as a substitute for the scratched horse. However, the extent of the benefit cannot be directly measured.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Passage of this rule should not affect employment. However, it should place Louisiana tracks in a more favorable competitive environment with other tracks around the country that have already employed this model for payouts in certain limited circumstances, namely, a winning ticket in a Triple Play race where one or more of the placed horses dead heat for a position. Also, it will likely be more popular to pay out a consolation price in Triple Play races where there is a dead heat (tie for a place) where a consolation payoff will be employed.

Charles A. Gardiner III
Executive Director
0607#019

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Board of Medical Examiners**

Acupuncturists' Assistants; Licensing and Certification
(LAC 46:XLV.2131)

Notice is hereby given in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., that pursuant to the authority vested in the Louisiana State Board of Medical Examiners (board) by the Louisiana Medical Practice Act, R.S. 37:1270(B) and 37:1275, and the

Acupuncturists' Assistants Practice Act, R.S. 37:1360, the board intends to adopt LAC Title 46:XLV, Subpart 2, Chapter 21, Subchapter F, §2131, to facilitate issuance of a temporary permit allowing the provision of specified voluntary, gratuitous health care services during and following a state declared emergency.

The proposed amendment has no known impact on family formation, stability or autonomy as described in R.S. 49:972.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLV. Medical Professions

Subpart 2. Licensure and Certification

Chapter 21. Acupuncturists and Acupuncturists' Assistants

Subchapter F. Restricted Licensure, Permits

§2131. Temporary Permit

A. The board may issue a temporary permit to an acupuncturist's assistant, valid for a period of not more than 60 days, to provide voluntary, gratuitous acupuncture services in this state during a public health emergency and for such periods thereafter as the Louisiana Department of Health and Hospitals ("DHH") shall deem the need for emergency services to continue to exist, at sites specified by DHH or approved by the board.

B. To be eligible for issuance of such a permit an individual shall:

1. hold a current, unrestricted license in good standing issued by the licensing authority of any state to practice as an acupuncturist's assistant;

2. prior to providing such services present or cause to be presented to the board:

a. indisputable personal identification;

b. a copy of his or her license to practice as an acupuncturist's assistant or such other information as may be deemed satisfactory to the board by which to verify state licensure;

c. a completed application containing such information as may be required by the board; and

d. notification of intent to practice on a form provided by the board, signed by a physician licensed to practice medicine in this state who will fulfill the functions of a supervising physician as described in this Section. An individual is responsible for updating the board should any of the information required and submitted on the applicant's notice of intent change after a temporary permit has been issued under this Section.

C. To be eligible for approval as a supervising physician under this Section a physician shall:

1. possess a current, unrestricted license to practice medicine in Louisiana; and

2. submit a completed application containing such information as may be required by the board.

D. Although a physician must notify the board each time the physician intends to undertake the supervision of an acupuncturist's assistant under this Section, registration with the board is only required once. Notification of supervision of new or additional acupuncturist's assistants by a registered supervising physician shall be deemed given to the board upon the acupuncturist's assistant's filing with the board a notice of intent to practice in accordance with §2131.B of this Section.

E. The board shall maintain a list of physicians who are registered to supervise acupuncturists' assistants under this Section. Each registered physician is responsible for updating the board should any of the information required and submitted on the physician's application change after the physician has become registered.

F. An acupuncturist's assistant holding a permit under this Section shall practice in this state only on a voluntary, gratuitous basis, shall perform only those acupuncture services authorized by this Section, and shall practice only at sites specified by DHH or approved by the board.

G. Acupuncture services performed by an individual issued a permit under this Section shall be limited to auricular acupuncture (insertion of disposable needles at a specified combination of points on the surface of the outer ear) utilizing the five-point protocol adopted by the National Acupuncture Detoxification Association and approved by the supervising physician. Such services may be performed under the general direction and supervision, rather than patient-specific order, of the supervising physician. All services shall be documented in written form by the acupuncturist's assistant and available for review by the supervising physician but need not be countersigned. The supervising physician shall be available during normal working hours by telephonic or other means of communication to address any questions or concerns that may arise from the provision of acupuncture services under this Section.

H. A temporary permit may be issued upon such terms, conditions, limitations or restrictions as to time, place, nature, and scope of practice as are, in the judgment of the board, deemed necessary or appropriate to its responsibilities under law. The board may, in addition, waive or modify any of the requirements of Chapters 21 and 51 of these rules, applicable to certification as an acupuncturist's assistant, that it may deem necessary or appropriate to effectuate the purposes of this Section.

I. An acupuncturist's assistant shall visibly display a permit issued under this Section, or such other identifying information as the board may specify, in plain view on his or her person at all times while exercising the privileges of such permit.

J. A temporary permit creates no right or entitlement to certification as an acupuncturist's assistant or renewal of the permit after its expiration. A temporary permit shall expire and become null and void on the earlier of:

1. 60 days from the date on which it was issued;

2. a date specified on the permit less than 60 days from the date of issuance;

3. the date the acupuncturist's assistant's term of voluntary, gratuitous service is terminated; or

4. the date on which the acupuncturist's assistant's relationship with the supervising physician, identified in the notice of intent, terminates.

K. The board may, in its discretion, extend or renew for one or two additional 60-day periods a permit that has expired provided that all conditions prerequisite to original issuance are satisfied.

L. Following termination of a declaration of emergency the board may issue, extend or renew a 60-day permit under this Section during such period as DHH shall deem the need for emergency services to continue to exist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270, 37:1275 and R.S. 37:1360.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 32:

Interested persons may submit written data, views, arguments, information or comments on the proposed Rule until 4 p.m., August 19, 2006, to Rita Arceneaux, Executive Assistant, Louisiana State Board of Medical Examiners, at Post Office Box 30250, New Orleans, LA, 70190-0250 (630 Camp Street, New Orleans, LA, 70130).

Robert Marier, M.D.
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: **Acupuncturists' Assistants; Licensing and Certification**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Other than notice and rule publication costs estimated at a combined total of \$556, which costs will be absorbed within the Board's budget during FY 2006, it is not anticipated that the proposed rule will result in any additional costs or savings to the Board or any other state or local governmental unit.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on the Board's revenue collections or those of any other state or governmental unit.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule will allow acupuncturists' assistants licensed and in good standing in any state to provide specified acupuncture services on a voluntary, gratuitous basis at sites designated by the Louisiana Department of Health and Hospitals and/or approved by the Board. The Board does not anticipate that implementation of the proposed rule will result in any costs or impose an adverse economic impact on licensees, volunteers or any other non-governmental group. Louisiana citizens and others located in this state receiving this healthcare service will receive an economic benefit as such services will be provided free of charge.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is not anticipated that the proposed rule will have any material impact on competition or employment in either the public or private sector.

Robert Marier, M.D.
Executive Director
0607#044

Robert E. Hosse
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Board of Veterinary Medicine

Temporary Registration during Declared Public Health Emergency (LAC 46:LXXXV.309)

The Louisiana Board of Veterinary Medicine proposes to amend and adopt LAC 46:LXXXV.309 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953 et seq., and the Louisiana Veterinary Practice Act,

R.S. 37:1569. In keeping with its function as set forth by the state legislature in R.S. 29:769(E), as amended in the 2006 Regular Session and effective on the governor's signature on June 2, 2006, the board has developed and adopted this Rule thereby creating the process for adopting of a future Emergency Rule implementing temporary registration in Louisiana, during a public health emergency lawfully declared as such by the governor, for out-of-state veterinarians or veterinary technicians, whose licenses, certifications or registrations are current and unrestricted in another jurisdiction of the United States.

The proposed Rule amendment has no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

This Rule is currently in effect as an Emergency Rule adopted on June 9, 2006 for the next 120 days from this date or until adoption of the final Rule, whichever occurs first.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXXXV. Veterinarians

Chapter 3. Licensure Procedures

§309. Temporary Registration during a Declared Public Health Emergency

A. In a public health emergency lawfully declared as such by the governor of Louisiana, the requirement for a Louisiana license (veterinarian) or Louisiana registration (veterinary technician) may be suspended by the board through its emergency rule-making authority at that time to those out of state veterinarians and/or veterinary technicians, whose licenses, certifications or registrations are current and unrestricted in another jurisdiction of the United States, for a period of time not to exceed the duration and scope of R.S. 29:769(E), as more particularly set forth in this rule.

B. The emergency rule implemented by the board pursuant to the provisions of the Administrative Practice Act shall address the necessity for such an emergency rule and the specificity necessary to address the needs of the particular declared emergency at issue. Such information will be posted on the board's Internet website along with the appropriate forms for review and use by interested parties.

C. Accordingly, the following requirements for temporary registration may be imposed pursuant to the emergency rule issued and/or any other requirements which more properly address the needs of the particular declared emergency.

D. A veterinarian or veterinary technician not licensed, certified or registered in Louisiana, whose licenses, certifications or registrations are current and unrestricted in another jurisdiction of the United States, may gratuitously provide veterinary services if:

1. the veterinarian or veterinary technician has photo identification and a license to verify a current and unrestricted license, certification or registration in another jurisdiction of the United States, and properly registers with the board prior to providing veterinary services in Louisiana as follows;

2. the veterinarian or veterinary technician is engaged in a legitimate relief effort during the emergency period, and provides satisfactory documentation to the board of the location site(s) that he will be providing gratuitous veterinary services;

3. the veterinarian or veterinary technician shall comply with the Louisiana Veterinary Practice Act, Board Rules, and other applicable laws, as well as practice in good faith, and within the reasonable scope of his skills, training, and ability; and

4. the veterinarian or veterinary technician renders veterinary services on a gratuitous basis with no revenue of any kind to be derived whatsoever from the provision of veterinary services within the state of Louisiana.

E. The authority provided for in the emergency rule shall be applicable for a period of time not to exceed 60 days at the discretion of the board, with the potential extension of up to two additional periods not to exceed 60 days for each extension as determined appropriate and necessary by the board.

F. All interested veterinarians or veterinary technicians shall submit a copy of their respective current and unrestricted licenses, certifications or registrations issued in other jurisdictions of the United States and photograph identification, as well as other requested information, to the Louisiana Board of Veterinary Medicine office for registration with this agency prior to gratuitously providing veterinary services in Louisiana.

G. Should a qualified veterinarian or veterinarian technician registered with the board thereafter fail to comply with any requirement or condition established by this rule, the board may terminate his registration upon notice and hearing.

H. In the event a veterinarian or veterinarian technician fails to register with the board, but practices veterinary medicine, whether gratuitously or otherwise, then such conduct will be considered the unlawful practice of veterinary medicine and prosecuted accordingly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 32:

Interested parties may submit written comments to Wendy D. Parrish, Administrative Director, Louisiana Board of Veterinary Medicine, 263 Third Street, Suite 104, Baton Rouge, LA 70801, or by facsimile to (225) 342-2142. Comments will be accepted through the close of business on August 17, 2006. If it becomes necessary to convene a public hearing to receive comments in accordance with the Administrative Procedure Act, the hearing will be held on Thursday, August 24, 2006, at 10 a.m. at the office of the Louisiana Board of Veterinary Medicine, 263 Third Street, Suite 104, Baton Rouge, LA.

Wendy D. Parrish
Administrative Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Temporary Registration during Declared Public Health Emergency

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

There will be no costs or savings to state or local governmental units, except for those associated with publishing

the amendment (estimated at \$300 in FY 2007). Licensees will be informed of this rule change via the board's regular newsletter or other direct mailings, which result in minimal costs to the board.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on revenue collections of state or local governmental units as no increase in fees will result from the amendment.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The proposed rule, pursuant to Act 207 of the 2006 Regular Session, creates the process for adopting of a future emergency rule implementing temporary registration in Louisiana, during a public health emergency lawfully declared as such by the Governor, for out of state veterinarians or veterinary technicians, whose licenses, certifications or registrations are current and unrestricted in another jurisdiction of the United States.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

No impact on competition and employment is anticipated as a result of the proposed rule.

Wendy D. Parrish
Administrative Director
0607#043

Robert E. Hosse
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

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

CommunityCARE Program (LAC 50:I.2903)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing proposes to amend LAC 50:I.2903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing established the CommunityCARE Program as an optional statewide covered service under the Medicaid State Plan instead of a waiver service, and provided for the exclusion of certain additional Medicaid recipients from mandatory participation in the program and provided for their optional voluntary enrollment (*Louisiana Register*, Volume 32, Number 3). The bureau now proposes to amend the March 20, 2006 Rule to remove the provisions that allowed for voluntary enrollment in the CommunityCARE Program.

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. It is anticipated that this proposed Rule will have no impact on family functioning, stability, or autonomy as described in R.S. 49:972.

**Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE**

Part I. Administration

Subpart 3. Medicaid Managed Care

Chapter 29. CommunityCARE

§2903. Recipient Participation

A. - B.11. ...

12. recipients in foster care, other out-of-home placement or receiving adoption assistance;

13. clients of the Office of Youth Development (in state custody); and

14. children under age 19 who are:

a. eligible for SSI under Title XVI;

b. eligible under Section 1902(e)(3) of the Social Security Act (New Opportunities Waiver and Children's Choice recipients); or

c. receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

C. Requests for medical exemptions shall be reviewed for approval on a case-by-case basis for certain medically high risk recipients that may warrant the direct care and supervision of a non-primary care specialist.

D. Repealed.

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 29:908 (June 2003), amended LR 32:404 (March 2006), LR 32:

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 Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, August 24, 2006 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, Louisiana. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for the receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Frederick P. Cerise, M.D., M.P.H.
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

RULE TITLE: CommunityCARE Program

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 06-07. It is anticipated that \$272 (\$136 SGF and \$136 FED) will be expended in FY 06-07 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect federal revenue collections other than the federal share of the promulgation costs for FY 06-07. It is anticipated that \$136 will be expended in FY 06-07 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This rule proposes to amend the provisions governing the CommunityCARE Program to exclude certain Medicaid recipients (approximately 33,100 children under the age of 19 who are SSI recipients, waiver recipients or receive services in a Title V grant program) that were allowed to optionally enroll in the program. No member of this group has participated in the optional enrollment. It is anticipated that implementation of this proposed rule will not have estimable cost or economic benefits for directly affected persons or non-governmental groups in FY 06-07, FY 07-08, and FY 08-09.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known impact on competition and employment.

Jerry Phillips
Acting Medicaid Director
0607#078

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

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

Federally Qualified Health Centers
(LAC 50:XI.Chapters 101-107)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing proposes to adopt LAC 50:XI.Chapters 101 and 107, and to amend Chapters 103-105 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing furnishes coverage and reimbursement to federally qualified health centers (FQHCs) under the Medicaid Program. In November 2004, the bureau repealed and replaced previous rules governing the reimbursement methodology for FQHCs and established a prospective payment system, as well as amended the provisions which included FQHC visits in the maximum allowable outpatient physician visit limit for Medicaid recipients (*Louisiana Register*, Volume 30, Number 11).

The bureau now proposes to establish provisions governing provider enrollment and to clarify the provisions governing services and the reimbursement methodology for FQHCs.

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. It is anticipated that this proposed Rule will have no impact on family

functioning, stability, or autonomy as described in R.S. 49:972.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XI. Clinic Services

Subpart 13. Federally Qualified Health Centers

Chapter 101. General Provisions

§10101. Purpose

A. Section 330 of the Public Health Service (PHS) Act of 1991 authorized the development of federally qualified health centers (FQHCs) through a grant funding program to provide care and improve the health status of medically underserved populations.

B. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), certifies the FQHC status of organizations that receive grant funding under Section 330 of the PHS Act.

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 32:

Chapter 103. Provider Participation

§10301. Provider Enrollment

A. In order to enroll and participate in the Medicaid Program, an FQHC must submit a completed provider enrollment packet that includes a copy of the HRSA grant approving its FQHC status.

B. The effective date of an FQHC's enrollment to participate in the Medicaid Program shall not be prior to the date of receipt of the completed enrollment packet.

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 30:2328 (October 2004), repromulgated LR 30:2487 (November 2004), amended LR 32:

§10303. Standards for Participation

A. Federally qualified health centers must comply with the applicable licensure, accreditation and program participation standards for all services rendered. If an FQHC wishes to initiate participation, it shall be responsible for meeting all of the enrollment criteria of the program. The FQHC provider shall:

1. maintain an acceptable fiscal record keeping system that readily distinguishes one type of service from another type of service that may be provided;

2. retain all records necessary to fully disclose the extent of services provided to recipients for five years from the date of service and furnish such records, and any payments claimed for providing such services, to the Medicaid Program upon request; and

3. abide by and adhere to all federal and state regulations and policy manuals.

B. If an FQHC receives approval for a satellite site, the satellite site must enter into a separate provider agreement and obtain its own Medicaid provider number.

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 30:2328 (October 2004), repromulgated LR 30:2488 (November 2004), amended LR 32:

Chapter 105. Services

§10501. Scope of Services

A. Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician. The following services shall be covered:

1. services furnished by a physician within the scope of practice of his profession under Louisiana law;

2. services furnished by a:

- a. physician assistant;
- b. nurse practitioner;
- c. nurse midwife;
- d. clinical social worker;
- e. clinical psychologist; or
- f. dentist;

3. services and supplies that are furnished as an incident to professional services furnished by all eligible professionals; and

4. other ambulatory 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 Health Services Financing, LR 30:2328 (October 2004), repromulgated LR 30:2488 (November 2004), amended LR 32:

§10503. Service Limits

A. Federally qualified health center visits (encounters) are limited to 15 visits per year for medically necessary services rendered to Medicaid recipients who are 21 years of age or older. Visits for Medicaid recipients who are under 21 years of age and for prenatal and postpartum care are excluded from the service limitation.

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 32:

Chapter 107. Reimbursement Methodology

§10701. Prospective Payment System

A. Payments for Medicaid covered services will be made under a prospective payment system (PPS) and paid on a per visit basis.

B. A visit is defined as a face-to-face encounter between a facility health professional and a Medicaid eligible patient for the purpose of providing medically necessary outpatient services.

1. Encounters with more than one facility health professional that take place on the same day and at a single location constitute a single encounter.

2. Services shall not be arbitrarily delayed or split in order to bill additional encounters.

NOTE: Refer to the FQHC and Physician's Current Procedural Terminology (CPT) Manuals for the definition of an encounter.

C. If an FQHC receives approval for a satellite site, the PPS per visit rate paid for the services performed at the satellite site would be the weighted average cost payment rate per encounter for all FQHCs.

D. The PPS per visit rate for a facility which enrolls and receives approval to operate shall be the weighted average cost payment rate per encounter for all FQHCs.

E. The PPS per visit rate for each facility will be increased on July 1 of each year by the percentage increase

in the published *Medicare Economic Index* (MEI) for primary care services.

F. Federally qualified health center services furnished to dual eligibles will be reimbursed reasonable cost which is equivalent to the provider specific prospective payment rate.

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 32:

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 Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, August 24, 2006 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for the receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Frederick P. Cerise, M.D., M.P.H.
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Federally Qualified Health Centers**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no programmatic fiscal impact to the state other than cost of promulgation for FY 06-07. It is anticipated that \$544 (\$272 SGF and \$272 FED) will be expended in FY 06-07 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect federal revenue collections other than the federal share of the promulgation costs for FY 06-07. It is anticipated that \$272 will be expended in FY 06-07 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This rule proposes to establish provisions governing provider enrollment and to clarify the provisions governing services and the reimbursement methodology for FQHCs (approximately 40 facilities) as such enrollment provisions were not included in the previous rule. It is anticipated that implementation of this proposed rule will not have estimable cost or economic benefits for directly affected persons or non-governmental groups in FY 06-07, FY 07-08, and FY 08-09.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known impact on competition and employment.

Jerry Phillips
Acting Medicaid Director
0607#074

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

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

Louisiana Hurricane Relief Waiver
Uncompensated Care Costs Pool
(LAC 50:XXII.Chapters 41-53)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing proposes to adopt LAC 50:XXII.Chapters 41-53 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing requested and received approval from the Centers for Medicare and Medicaid Services (CMS) to implement a multi-state 1115 demonstration waiver to ensure the continuity of health care services for individuals displaced as a result of Hurricanes Katrina and Rita. Under the demonstration waiver, Louisiana will provide services through its Medicaid Program to evacuees who qualify as members of the demonstration population consisting of parents, pregnant women, children under age 19, individuals with disabilities, low income Medicare beneficiaries, and individuals in need of long term care whose income is within the levels listed on the simplified eligibility chart.

In addition, CMS approved the establishment of a fund, the Uncompensated Care Costs (UCC) Pool, to reimburse health care providers that incur uncompensated care costs for medically necessary services and supplies rendered to evacuees and other affected individuals who do not have coverage through insurance or other options, including Title XIX and Title XXI of the Social Security Act. The bureau promulgated an Emergency Rule to adopt the provisions governing the administration of the UCC pool (*Louisiana Register*, Volume 32, Number 3). This proposed Rule is being promulgated to continue the provisions of the March 13, 2006 Emergency Rule.

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. It is anticipated that this proposed Rule will have no impact on family functioning, stability, or autonomy as described in R.S. 49:972.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXII. 1115 Demonstration Waivers

Subpart 5. Louisiana Hurricane Relief Waiver

Chapter 41. General Provisions

§4101. Purpose

A. As a result of the devastation caused by Hurricanes Katrina and Rita, many Louisiana health care providers have incurred costs in furnishing medical services and supplies to hurricane evacuees and other affected individuals who do not have health care coverage through insurance or any other financial mechanism. The purpose of the Uncompensated Care Costs (UCC) Pool is to provide reimbursement to health care providers through federal financial participation for services rendered for which there is no other source of payment.

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 32:

Chapter 43. Eligible Populations

§4301. Definitions

Affected Individual—an individual who resided in a designated individual assistance county or parish pursuant to Section 408 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, as declared by the President as a result of Hurricanes Katrina and Rita, and continues to reside in the same state where such county or parish is located.

Evacuee—an affected individual who has been displaced to another state.

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 32:

§4303. Eligibility Requirements

A. In order to qualify as a member of the eligible population, an individual must be either a United States citizen or a legal alien who resided in a designated individual assistance county or parish for Hurricane Katrina or Hurricane Rita as declared by the President.

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 32:

Chapter 45. Covered Services

§4501. Medicaid State Plan Services

A. Reimbursement is available through the UCC pool for the following services covered under the Louisiana Medicaid State Plan:

1. inpatient and outpatient hospital services, including ancillary services;
2. physician services (inpatient and outpatient);
3. mental health clinic services;
4. inpatient psychiatric services (free-standing psychiatric hospitals and distinct part psychiatric units);
5. emergency ambulance services;
6. home health services:
 - a. coverage of durable medical equipment and supplies is limited to emergency items;

7. nursing facility services;
8. pharmacy services;
9. laboratory services;
10. X-ray services;
11. hemodialysis services;
12. hospice services;
13. rural health clinic services; and
14. federally qualified health center 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 Health Services Financing, LR 32:

§4503. Non-Medicaid State Plan Services

A. Reimbursement is available through the UCC pool for methadone and suboxone substance abuse treatments only to the extent that these services are not otherwise reimbursable under other funding sources including, but not limited to, grant or reimbursement programs offered through:

1. the Federal Emergency Management Agency;
2. the Substance Abuse and Mental Health Services Administration;
3. the National Institutes of Health; or
4. any other federal or state program (Medicaid, SCHIP, Medicare), private insurance or any private source.

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 32:

Chapter 47. Provider Participation

§4701. Participation Requirements

A. In order to qualify for reimbursement through the UCC pool for Medicaid State Plan covered services, the provider must have been enrolled to participate in the Louisiana Medicaid Program on or before August 24, 2005.

B. In order to qualify for reimbursement through the UCC pool for methadone and suboxone substance abuse treatments, the provider must be approved by the Office of Addictive Disorders.

C. Qualifying providers may be either a public or a private 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 Health Services Financing, LR 32:

Chapter 49. Requests for Payment

§4901. Submission Requirements

A. Requests for payment must be "person specific" for each Hurricane Katrina or Rita evacuee or other affected individual. The request must contain the following data, if known, for the evacuee or other affected individual:

1. last name;
2. first name;
3. middle initial;
4. Social Security number;
5. date of birth;
6. residential address the week prior to Hurricane Katrina or Hurricane Rita;
7. parish of residence the week prior to Hurricane Katrina or Hurricane Rita;
8. date(s) of service; and

9. any other identifying data that would assist in establishing the recipient's identity in the absence of any of the items cited in Paragraphs 1-8 above.

B. Providers may submit requests for payment of costs incurred during the following time periods:

1. dates of service from August 24, 2005 through January 31, 2006 for Hurricane Katrina; and

2. dates of service from September 23, 2005 through January 31, 2006 for Hurricane Rita.

C. Providers shall be required to sign an attestation that confirms that:

1. the services provided were medically necessary;
2. they have not received payment from any other source;

3. they will not subsequently bill another source for payment;

4. they are not aware of any other payment source for the services rendered; and

5. payment will be accepted as payment in full for the services rendered.

D. The deadline for submission of all payment requests is June 30, 2006.

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 32:

Chapter 51. Uncompensated Care Pool Reimbursement

§5101. Allowable Payment

A. Reimbursement through the UCC pool is only available for covered services provided within the State of Louisiana to individuals who meet the requirements to be a member of the eligible population.

B. Payment through the UCC pool for Medicaid State Plan services shall be an interim payment up to 70 percent of the Medicaid fee-for-service rate currently on file for the respective service. Additional payments shall be contingent on the availability of funds in the UCC Pool.

1. UCC pool payments to hospitals that qualify for Medicaid disproportionate share hospital (DSH) payments will be offset from the cost of treating uninsured patients for the state fiscal year to which the DSH payment is applicable to determine the hospital specific DSH limits.

C. Payment through the UCC pool for methadone and suboxone substance abuse treatment services shall be an interim payment up to 70 percent of the fee schedule established by the Office of Addictive Disorders. Additional payments shall be contingent on the availability of funds in the UCC Pool.

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 32:

Chapter 53. Administrative Appeals

§5301. Fair Hearings and Appeals

A. There are no provisions under this demonstration waiver for fair hearings for those individuals who have received medical services or supplies and do not have insurance coverage or any other source of payment.

B. There are no provisions under this demonstration waiver for appeals for health care providers who have

incurred costs associated with the provision of the uncompensated care.

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 32:

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 Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, August 24, 2006 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, Louisiana. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for the receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Frederick P. Cerise, M.D., M.P.H.
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Louisiana Hurricane Relief Waiver Uncompensated Care Costs Pool

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no programmatic costs to the state for FY 05-06, FY 06-07, and FY 07-08. It is anticipated that \$748 (\$374 SGF and \$374 FED) will be expended in FY 06-07 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately \$175,000,000 for FY 05-06 and \$193,204,374 for FY 06-07. It is anticipated that \$374 will be expended in FY 06-07 for the federal administrative expenses for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed rule, which continues provisions of the March 13, 2006 emergency rule, establishes provisions governing the Uncompensated Care Costs Pool under the Louisiana Hurricane Relief Waiver. It is anticipated that implementation of this proposed rule will increase uncompensated care expenditures to medical providers (approximately 500) by approximately \$175,000,000 for FY 05-06 and \$193,204,000 for FY 06-07.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this rule will not have an effect on competition and employment.

Jerry Phillips
Acting Medicaid Director
0607#076

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

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

Mental Health Rehabilitation Program
(LAC 50:XV.Chapters 1-7)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing proposes to amend LAC 50:XV.Chapters 1-7 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgated a Rule to adopt the revised provisions governing the administration of the Mental Health Rehabilitation Program (*Louisiana Register*, Volume 31, Number 5). The bureau subsequently promulgated an Emergency Rule to delay the implementation of the provisions contained in the May 20, 2005 Rule and rescinded the language prohibiting the provision of certain mental health rehabilitation services to children and adolescents in the custody of the Office of Community Services or the Office of Youth Services (*Louisiana Register*, Volume 31, Number 6). The May 20, 2005 Rule was further amended to adopt revised medical necessity criteria and to clarify Medicaid policy governing provision of services in off-site locations and staffing requirements (*Louisiana Register*, Volume 31, Number 8). The bureau subsequently promulgated an Emergency Rule that continued the provisions of the June 1, 2005 and August 1, 2005 Emergency Rules (*Louisiana Register*, Volume 32, Number 1). This proposed Rule is being promulgated to: 1) continue the provisions of the January 28, 2005 Emergency Rule; 2) address service changes; 3) clarify provisions regarding provider certification and enrollment; and 4) establish emergency preparedness requirements within the Mental Health Rehabilitation Program.

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family as been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability or autonomy as described in R.S. 49:972.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 1. Mental Health Rehabilitation

Chapter 1. General Provisions

§101. Introduction

A. - C. ...

D. Mental Health Rehabilitation services shall be covered and reimbursed for any eligible Medicaid recipient who meets the medical necessity criteria for services. The department will not reimburse claims determined through the prior authorization or monitoring process to be a duplicated service.

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 31:1082 (May 2005), amended LR 32:

§103. Definitions and Acronyms

* * *

BHSF—Bureau of Health Services Financing

* * *

CPRP—Certified Psychosocial Rehabilitation Practitioner as designated by the Commission for Psychiatric Rehabilitation Certification through the United States Psychiatric Rehabilitation Services Association (USPRA).

* * *

ISRP—Individualized Service and Recovery Plan.

* * *

Off-Site Service Delivery Location—locations of service that are publicly available for, and commonly used by, members of the community other than the MHR provider and sites or locations that are directly related to the recipient's usual environment, or those sites or locations that are utilized in a non-routine manner. This can also include a location used solely for the provision of allowable off-site service delivery by a certified MHR provider.

* * *

Provider Contract—an agreement between DHH and a provider of MHR services.

QMP—Quality Management Program.

Recoupment—the authority of BHSF to recover payments made for services that are subsequently determined, for any reason, not to qualify for reimbursement.

* * *

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 31:1082 (May 2005), amended LR 32:

§105. Prior Authorization

A. Every mental health rehabilitation service shall be prior authorized by the bureau or its designee. Services provided without prior authorization will not be considered for reimbursement. There shall be no exceptions to the prior authorization requirement.

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 31:1083 (May 2005), amended LR 32:

Chapter 3. Covered Services and Staffing Requirements

Subchapter A. Service Delivery

§301. Introduction

A. ...

B. Service Package. Each MHR provider shall have a policy wherein they agree to identify and either provide or contract services as identified in every Individualized Service and Recovery Plan (ISRP). The provider shall be qualified to provide services, and the recipient shall be eligible to receive the services. The services for each individual shall be included in the ISRP.

C. Children's Services. There shall be family and/or legal guardian involvement throughout the planning and delivery of MHR services for children and adolescents. The agency or individual who has the decision making authority for children and adolescents in state custody must request and

approve the provision of MHR services to the recipient. The case manager or person legally authorized to consent to medical care must be involved throughout the planning and delivery of all MHR services and such involvement must be documented in the recipient's record maintained by the MHR agency.

1. The child or adolescent shall be served within the context of the family and not as an isolated unit. Services shall be appropriate for:

- a. age;
- b. development;
- c. education; and
- d. culture.

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 31:1083 (May 2005), amended LR 32:

Subchapter B. Mandatory Services

§311. Assessment

A. An assessment is an integrated series of diagnostic and evaluation procedures conducted with the recipient and his/her significant other(s) to provide the basis for the development of an effective, comprehensive and individualized service and recovery plan. It is an intensive clinical, psychosocial evaluation of a recipient's mental health conditions which results in an ISRP for the recipient. It may also be used to determine the recipient's level of care and medical necessity. An initial assessment shall be completed when an individual is determined to potentially qualify for the MHR Program and a reassessment shall be completed at the end of each prior authorization period or as deemed necessary by the bureau.

B. Initial assessments and reassessments shall include developing the recipient's ISRP, reviewing progress toward the goals of the ISRP and modifying the ISRP as indicated. The ISRP is an individualized, structured, goal-oriented schedule of services developed in conjunction with and agreed upon by the adult recipient or the child recipient and his/her family and the treatment team. Recipients must be actively involved in the process and have a major role in determining the direction of their ISRP. The ISRP must identify the goals, objectives, interventions, and services which are based on the results of the assessment/reassessment.

C. Staffing Requirements

1. Initial assessments and reassessments must be completed by practitioners operating within the scope of their licenses as required by the respective Louisiana Practice Acts.

2. A licensed mental health professional (LMHP) shall:

- a. have a face-to-face contact with the recipient for the purpose of completing the assessment;
- b. score the LOCUS/CALOCUS if he/she has been approved to be a clinical evaluator by the Office of Mental Health (OMH); and
- c. sign and date the assessment/reassessment and the ISRP.

3. A psychiatrist shall:

- a. have a face-to-face interview with the recipient at initial assessment;

- b. review and sign the Medical History Questionnaire section of the initial assessment;

- c. review and sign the ISRP at initial assessment/reassessment; and

- d. review and sign the Electronic Case Data Inquiry (eCDI) screen print, if data is available.

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 31:1083 (May 2005), amended LR 32:

§313. Service Planning

Repealed.

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 31:1083 (May 2005), repealed LR 32:

§317. Community Support

A. Community support services is the provision of mental health rehabilitation services and supports necessary to assist the recipient in achieving and maintaining rehabilitative, resiliency and recovery goals. The service is designed to meet the educational, vocational, residential, mental health treatment, financial, social and other treatment support needs of the recipient. Community support is the foundation of the recovery-oriented ISRP and is essential to all MHR recipients. Its goal is to increase and maintain competence in normal life activities and to gain the skills necessary to allow recipients to remain in or return to naturally occurring supports. This service includes the following specific goals:

1. achieving the restoration, reinforcement, and enhancement of skills and/or knowledge necessary for the recipient to achieve maximum reduction of his/her psychiatric symptoms;
2. minimizing the effect of mental illness;
3. maximizing the recipient's strengths with regard to the mental illness;
4. increasing the level of the recipient's age-appropriate behavior;
5. increasing the recipient's independent functioning to an appropriate level;
6. enhancing social skills;
7. increasing adaptive behaviors in family, peer relations, school and community settings;
8. maximizing linkage and engagement with other community services, including natural supports and resources;
9. applying decision-making methods in a variety of skill building applications; and
10. training caregivers to address the needs identified in the ISRP using preventive, developmental and therapeutic interventions designed for direct individual activities.

B. - B.3. ...

C. Service Exclusions. Community support is an individualized service and is not billable if delivered in a group setting or with more than one recipient per staff per contact.

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 31:1084 (May 2005), amended LR 32:

§319. Group Counseling

A. Group counseling is a treatment modality using face-to-face verbal interaction between two to eight recipients. It is a professional therapeutic intervention utilizing psychotherapy theory and techniques. The service is directed to the goals on the approved ISRP.

B. - B.2. ...

C. Clinical Exclusion. The MHR provider shall not admit any recipient into this service whose presence would pose a documented health and safety risk to the recipient or to other recipients and for whom the provider cannot provide the necessary care.

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 31:1084 (May 2005), amended LR 32:

§321. Individual Intervention

A. Individual intervention is a verbal interaction between the counselor therapist and the recipient receiving services that is brief, face-to-face, and structured. Individual intervention is a service provided to eliminate the psychosocial barriers that impede the skills necessary to function in the community. It includes services provided to eliminate psychosocial barriers that impede the skills necessary to function in the community.

1. Individual intervention is a range of professionally delivered therapeutic strategies provided individually and face-to-face to the recipient for the purpose of rehabilitating and restoring him/her to an optimal level of functioning and to reduce the risk of a more restrictive treatment intervention. It includes services provided to eliminate psychosocial barriers that impede the development/enhancement of skills necessary to function in the community.

2. Repealed.

B. Staffing Requirements. Individual intervention must be provided by a:

1. LMHP; or
2. MHP under the supervision of a LMHP.

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 31:1084 (May 2005), amended LR 32:

§323. Parent/Family Intervention (Counseling)

A. - B.2. ...

C. - D. Repealed.

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 31:1084 (May 2005), amended LR 32:

§325. Psychosocial Skills Training—Group (Youth)

A. Psychosocial Skills Training—Group (Youth) is a therapeutic, rehabilitative, skill building service for children and adolescents to increase and maintain competence in normal life activities and gain the skills necessary to allow them to remain in or return to their community. It is an organized service based on models incorporating psychosocial interventions.

B. - B.2. ...

C. Clinical Exclusion. The MHR provider shall not admit any recipient into this service whose presence would pose a documented health and safety risk to the recipient or to other recipients and for whom the provider cannot provide the necessary care.

D. Repealed.

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 31:1085 (May 2005), amended LR 32:

Subchapter C. Optional Services

§335. Parent/Family Intervention (Intensive)

A. Parent/Family Intervention (Intensive) is a structured service involving the recipient and one or more of his/her family members. It is an intensive family preservation intervention intended to stabilize the living arrangement, promote reunification, or prevent utilization of out of home therapeutic placement (i.e., psychiatric hospitalization, therapeutic foster care) for the recipient. These services focus on the family and are delivered to children and adolescents primarily in their homes. Therefore, Parent/Family Intervention (Intensive) is not appropriate for recipients whose families refuse to participate or to allow services in the home.

1. This service is comprehensive and inclusive of all other rehabilitative services, with the exception of assessment/reassessment and medication management which may be provided and billed for a recipient receiving Parent/Family Intervention (Intensive) services.

B. - B.3. ...

C. - D. Repealed.

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 31:1085 (May 2005), amended LR 32:

§337. Psychosocial Skills Training—Group (Adult)

A. Psychosocial Skills Training—Group (Adult) is a therapeutic, rehabilitative, skill building service for individuals to increase and maintain competence in normal life activities and gain the skills necessary to allow them to remain in or return to their community. It is designed to increase the recipient's independent functioning in his/her living environment through the integration of recovery and rehabilitation principles into the daily activities of the recipient. It is an organized program based on a psychosocial rehabilitation philosophy to assist persons with significant psychiatric disabilities, to increase their functioning to live successfully in the natural environments of their choice.

B. Staffing Requirements

1. All staff providing direct services shall have documented orientation to the psychosocial rehabilitation model being used in the program. This service shall be furnished under the supervision of a LMHP who is on site a minimum of 50 percent of the service operating hours. The supervising LMHP shall be a Certified Psychosocial Rehabilitation Practitioner (CPRP) as designated by the Commission for Psychiatric Rehabilitation Certification through the USPRA or eligible for certification with a written plan for achieving CPRP certification within 12

months of certification as a Psychosocial Skills Group (Adult) provider or within 12 months of being hired.

2. Psychosocial skills training (group) shall be provided by a:

- a. LMHP;
- b. MHP; or
- c. MHS.

3. There must be a minimum staffing ratio of one direct service staff person for eight recipients at all times of active program participation.

4. Group size may not exceed 15 recipients for any single skill training activity.

C. Clinical Exclusion. The MHR provider shall not admit any recipient into psychosocial skills training-group (adult) whose presence would pose a documented health and safety risk to the recipient or to other recipients and for whom the provider cannot provide the necessary care.

D. Repealed.

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 31:1085 (May 2005), amended LR 32:

Chapter 5. Medical Necessity Criteria

§501. General Provisions

A. When a recipient requests MHR services, an initial screening must be completed to determine whether the recipient potentially meets the medical necessity criteria for MHR services. If it is determined that the recipient potentially meets the criteria for services, an initial assessment shall be completed and fully documented in the recipient's record no later than 30 days after the request for services. Information in an initial assessment shall be based on current circumstances (within 30 days) and face-to-face interviews with the recipient, taking pertinent historical data into consideration. If the recipient is a minor, the information shall be obtained from a parent, legal guardian or other person legally authorized to consent to medical care. Reassessments shall be based on current circumstances (within 30 days) and face-to-face interview with the recipient. If the recipient is a minor, the information shall be obtained from a parent, legal guardian or other person legally authorized to consent to medical care.

B. If it is determined at the initial screening or assessment that a recipient does not meet the medical necessity criteria for services, the provider shall refer the recipient to his/her primary care physician, the nearest community mental health clinic, or other appropriate services with copies of all available medical and social information.

C. In order to qualify for MHR services, a recipient must meet the medical necessity criteria for services outlined in §503 or §505. These medical necessity criteria shall be utilized for authorization and reauthorization requests received on or after August 1, 2005.

D. Initially all recipients must meet the medical necessity criteria for diagnosis, disability, duration and level of care. MHR providers shall rate recipients on the CALOCUS/LOCUS at 90 day intervals, and these scores and supporting documentation must be submitted to the bureau or its designee upon request. Ongoing services must be requested every 90 days based on progress towards goals,

individual needs, and level of care requirements which are consistent with the medical necessity criteria.

E. The bureau or its designee reserves the right to require a second opinion evaluation by a licensed mental health professional that is not associated with the MHR provider that is seeking authorization or reauthorization of 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 Health Services Financing, LR 32:

§503. Adult Criteria for Services

A. In order to qualify for MHR services, Medicaid recipients age 18 or older must meet all the following criteria.

1. Diagnosis. The recipient must currently have or, at any time during the past year, had a diagnosable mental behavioral or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* or the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* or subsequent revisions of these documents. The diagnostic criteria specified under DSM-IV-TR "V" codes for substance use disorders and developmental disorders are excluded unless these disorders co-occur with another diagnosable serious mental illness.

2. Disability. In order to meet the criteria for disability, the recipient must exhibit emotional, cognitive or behavioral functioning which is so impaired, as a result of mental illness, as to substantially interfere with role, occupational and social functioning as indicated by a score within levels four or five on the LOCUS that can be verified by the bureau or its designee.

3. Duration. The recipient must have a documented history of severe psychiatric disability which is expected to persist for at least a year and requires intensive mental health services, as indicated by one of the following:

a. psychiatric hospitalizations of at least six months duration in the last five years (cumulative total); or

b. two or more hospitalizations for mental disorders in the last 12-month period; or

c. structured residential care, other than hospitalization, for a duration of at least six months in the last five years; or

d. documentation indicating a previous history of severe psychiatric disability of at least six months duration in the past year.

NOTE: Recipients who are age 18 and up to 21 and who have been determined not to meet the adult medical necessity criteria for MHR services, initial or continued care, shall be reassessed by the bureau or its designee using the children/adolescent medical necessity criteria for 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 Health Services Financing, LR 32:

§505. Child/Adolescent Criteria for Services

A. In order to qualify for MHR services, Medicaid recipients age 17 or younger must meet all the following criteria.

1. Diagnosis. The recipient must currently have or, at any time during the past year, had a diagnosable mental,

behavioral or emotional disorder of sufficient duration to meet the diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) or the *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM), or subsequent revisions of these documents. The diagnostic criteria specified under DSM-IV-TR "V" codes for substance use disorders and developmental disorders are excluded unless these disorders co-occur with another diagnosable serious mental illness.

2. Disability. In order to meet the criteria for disability, the recipient must exhibit emotional, cognitive or behavioral functioning which is so impaired, as a result of mental illness, as to substantially interfere with role, educational, and social functioning as indicated by a score within levels four or five on the CALOCUS that can be verified by the bureau or its designee.

NOTE: Youth returning to community living from structured residential settings or group homes under the authority of the Office of Community Services or the Office of Youth Services may be considered to meet the disability criteria for admission with a level three on the LOCUS or CALOCUS.

3. Duration. The recipient must have a documented history of severe psychiatric disability that is expected to persist for at least six months and requires intensive mental health services, as indicated by at least one of the following:

- a. past psychiatric hospitalization(s);
- b. past supported residential care for emotional/behavioral disorder;
- c. past structured day program treatment for emotional/behavioral disorder; or
- d. documentation indicating that an impairment or pattern of inappropriate behaviors has persisted for at least three months and is expected to persist for at least six months.

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 32:

§507. Exclusionary Criteria

A. Mental health rehabilitation services are not considered to be appropriate for recipients whose diagnosis is mental retardation, developmental disability or substance abuse unless they have a co-occurring diagnosis of severe mental illness or emotional/behavioral disorder as specified within DSM-IV-TR or ICD-9-CM, or its subsequent revisions of these documents.

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 32:

§509. Discharge Criteria

A. Discharge planning must be initiated and documented for all recipients at time of admission to MHR services. The written discharge plan must include a plan for the arrangement of services required to transition the recipient to a lower level of care within the community. Discharge from mental health rehabilitation services for current and new recipients shall be initiated if at least one of the following situations occurs:

1. the recipient's treatment plan/ISRP goals and objectives have been substantially met;

2. the recipient meets criteria for higher level of treatment, care, or services;

3. the recipient, family, guardian, and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment;

4. consent for treatment has been withdrawn; or

5. supportive systems that allow the recipient to be maintained in a less restrictive treatment environment have been arranged.

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 32:

Chapter 7. Provider Participation Requirements

Subchapter A. Certification and Enrollment

§701. Provider Enrollment Moratorium

A. A moratorium is implemented on the enrollment of mental health rehabilitation (MHR) providers to participate in the Medicaid Program. The department shall not approve enrollment for any new MHR provider office regardless of the status of the application.

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 31:668 (March 2005), amended LR 32:

§703. Application

A. To be certified or recertified as an enrolled mental health rehabilitation provider requires that the provisions of this Subpart 1, the provider manual and the appropriate statutes are met. A prospective provider who elects to enroll with the department to provide MHR services shall apply to the Bureau of Health Services Financing or its designee for certification. The prospective provider shall create and maintain documents to substantiate that the provider meets all prerequisites in order to enroll as a Medicaid provider of MHR services.

B. A prospective MHR provider shall submit the following documents for certification:

1. a completed Form PE 50 and addendum;
2. a completed disclosure of ownership form;
3. direct deposit authorization form;
4. nonrefundable application fee of \$500 paid by certified check to the State of Louisiana, Department of Health and Hospitals;
5. proof of a request for accreditation and a copy of the completed application with a national accrediting body approved by the bureau and proof of payment to the accrediting body. Proof of full accreditation is required within nine months of issuance of a Medicaid provider enrollment number;
6. an affidavit that identifies the applicant's licensed mental health professional and psychiatrist, including verification of current licensure. The LMHP identified must be an employee of the prospective MHR provider;
7. proof of the establishment and maintenance of a line of credit from a federally insured, licensed lending institution in an amount equal to three months of current operating expenses as proof of adequate finances. It is the MHR provider's responsibility to notify the bureau in the

event that the financial institution cancels or reduces the upper credit limit:

a. nonprofit agencies that have operated for five years or more and have an unqualified audit report for the most recent fiscal year prepared by a licensed certified public accountant, which reflects financial soundness of the nonprofit provider, are not required to meet this standard;

b. governmental entities or organizations are exempt from this requirement;

8. a statement identifying the population to be served:

NOTE: A change in the population group to be served cannot be made without prior written approval by the bureau.

a. adults with serious mental illness; or

b. children with an emotional/behavior disorder;

9. proof of the establishment and maintenance of a general liability and a professional liability insurance policy with at least \$1,000,000 coverage under each policy. The certificates of insurance for these policies shall be in the name of the MHR provider and certificate holder shall be the Department of Health and Hospitals. The provider shall notify the bureau when coverage is terminated for any reason. Coverage shall be maintained continuously throughout the time services are provided and thereafter for a period of one year:

a. governmental entities or organizations are exempt from this requirement;

10. identification of all the MHR provider's office locations and off-site service delivery locations;

11. proof that all owner and staff have attended mandatory training as required by the bureau;

12. proof that all equipment and technology requirements have been met as established by the bureau;

13. corporations must provide current proof of business registration with the Secretary of State;

14. proof of clinical competence as defined and required by the bureau;

15. a notarized report of any and all settled convictions and/or pending charges of malpractice and felonies for the business itself (in this or any other name), the owners, principals, partners and/or governing bodies, Board of Directors and the executive/managing director;

16. proof of current inspection and approval by the Office of State Fire Marshal;

17. proof of current inspection and approval by the Office of Public Health;

18. a comprehensive administrative policy and procedure manual that describes an administrative structure to provide MHR services including:

a. the names, addresses, composition, duties and responsibilities of the governing body;

b. policy governing creation and retention of administrative and personnel records;

c. a policy to utilize the current MHR SIS (or its successor) system that includes accurate MHR provider staff and client information;

d. written procedures for maintaining the security and the confidentiality of recipient records;

e. written emergency preparedness plan reviewed and approved by the bureau;

f. initial and annual recipient orientation policy.

The MHR provider shall adopt a procedure that requires each recipient to sign an acknowledgment form that verifies that the recipient was fully and completely informed of

his/her rights, orally and in writing and received a copy of the signed form. The policy shall include:

i. a mission statement;

ii. recipients' rights, including freedom of choice to select their MHR provider and right to confidentiality;

iii. the array and types of treatment services offered by the MHR provider;

iv. staff qualifications;

v. a statement of after hours access to services;

vi. crisis management procedures;

vii. complaint resolution procedures; and

viii. discharge planning procedures;

19. comprehensive training policy for all owners, employees, volunteers and students; and

20. an operations policy manual that includes a mission statement, program philosophy and goals for the MHR provider.

C. The MHR provider shall have a separate Medicaid provider number for each location where it routinely conducts business and provides scheduled services. This does not include those sites or locations that meet the definition of an off-site service delivery location.

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 31:1086 (May 2005), amended LR 32:

§705. Application and Site Reviews

A. A prospective MHR provider shall undergo one or more reviews by the department or its designee before certification to ensure compliance with provider enrollment and operational requirements:

1. an application review;

2. a first site review; and if necessary

3. a second site review.

B. The bureau or its designee may conduct a review of all application documents for compliance with MHR requirements. If the documentation is approved, the applicant will be notified and an appointment may be scheduled for a first site review of the prospective MHR provider's physical location. If the first site review is successful, the certification request may be approved and forwarded to Provider Enrollment for further processing.

C. If the application documentation furnished by the prospective MHR provider is not acceptable, the provider will be notified of the deficiencies. The applicant has 30 days to correct the documentation deficiencies and to request a site visit at their physical location.

1. If the prospective MHR provider requests a site visit in a timely manner, a site review of their physical location may be scheduled. At the onsite review, the bureau or its designee may review the corrected documents and make an assessment of the physical location. If the prospective provider has corrected the application document deficiencies and the physical location is deemed acceptable and sufficient to operate as a mental health rehabilitation provider, the bureau or its designee may approve the certification request and forward the necessary paperwork to Provider Enrollment for further processing.

2. If the prospective provider does not request a site visit within 30 days, the application may be rejected and the provider may not reapply for certification for one year from the date of the initial application review.

D. A second site review is necessary when a provider fails the first site review. The prospective provider will have 30 days from failure of the first site review to correct any deficiencies and to request the second site review.

1. If the prospective provider requests the second site review in a timely manner and the site review verifies that the applicant has corrected the deficiencies and the location is deemed acceptable and sufficient to operate as a mental health rehabilitation provider, the certification request may be approved and sent to Provider Enrollment for further processing.

2. If the prospective provider has not corrected all deficiencies, they may be denied certification and may not reapply for certification for one year from the date of the application review.

3. If the prospective provider does not request and schedule a second site review within 30 days, the application may be rejected and the provider may not reapply for certification for one year from the date of the application review.

E. ...

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 30:802 (April 2004), amended LR 31:1087 (May 2005), LR 32:

§707. Failure to Achieve Certification/Recertification

A. If the prospective MHR provider fails to meet any application or certification requirements, they may not be enrolled as an MHR provider.

B. There may be an immediate loss of certification if at any time, the enrolled MHR provider fails to obtain or maintain certification requirements, recertification requirements or accreditation status. The provider may not reapply for certification for one year following the date of loss of certification.

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 31:1087 (May 2005), amended LR 32:

§709. Certification and Recertification

A. Certification. The MHR provider may be enrolled when the bureau or its designee certifies compliance with all provider enrollment and operational requirements.

1. New providers must present proof of full accreditation by a bureau-approved national accrediting body within nine months following initial certification. Failure to comply may result in termination of the provider's certification.

B. Recertification. Certified providers shall apply for recertification annually. The application must be submitted 90 days prior to the expiration of the MHR provider's certification.

1. The bureau or its designee may conduct a recertification review to ensure continued compliance with all MHR regulations and policies.

C. Failure to Recertify. If a provider fails to meet all requirements for recertification, he/she will receive a written notice identifying the deficiencies. The MHR provider must correct these deficiencies within 60 days from the date of the notice of the deficiencies. If the deficiencies are not

corrected within this 60-day period, the provider's certification may be terminated.

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 31:1087 (May 2005), amended LR 32:

§711. Certification and Recertification

Repealed.

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 31:1087 (May 2005), repealed LR 32:

Subchapter B. Accreditation

§719. Accreditation

A. Currently enrolled and prospective providers of mental health rehabilitation service shall be accredited by a national accreditation organization for any services for which Medicaid reimbursement will be requested. The department shall only accept accreditation from the following national organizations for the purposes of enrolling a provider into the Mental Health Rehabilitation (MHR) Program:

1. the Council on Accreditation (COA);
2. the Commission on Accreditation of Rehabilitation Facilities (CARF); or
3. the Joint commission on Accreditation of Healthcare Organizations (JCAHO).

B. All enrolled providers of mental health rehabilitation services shall maintain accreditation status. Denial or loss of accreditation status, or any negative change in accreditation status, shall be reported to the department in writing within five working days of receiving the notice from the national accreditation organization. The written notification shall include information detailing a copy of the accreditation report and any related correspondence from the accrediting body including, but not limited to:

1. the provider's denial or loss of accreditation status;
2. any negative change in accreditation status;
3. the steps and timeframes, if applicable, the accreditation organization is requiring from the provider to maintain accreditation.

C. If at any time, a MHR provider loses accreditation, an automatic loss of certification may occur.

D. Failure to notify the department of denial or loss of accreditation status, or any negative change in accreditation status may result in sanctions to the mental health rehabilitation agency.

E. - F. Repealed.

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 31:1088 (May 2005), amended LR 32:

Subchapter C. Provider Responsibilities

§731. General Provisions

A. - A.1. ...

B. The MHR provider shall immediately report any suspected or known violations of any state or federal criminal law to the bureau.

C. Each MHR provider shall maintain written procedures and implement all required policies and procedures immediately upon acceptance of recipients for services.

1. - 3. Repealed.

D. The MHR provider shall develop a policy and procedure for hospitalization that is in conformity with the single point of entry (SPOE) policy and procedure.

E. The MHR provider shall request an expedited prior authorization review for any recipient whose discharge from a 24-hour care facility is dependent on follow-up mental health services.

F. The MHR provider shall develop a quality management plan (QMP) as outlined in the current MHR provider manual. It should address all aspects of the MHR provider operation.

G. If, as a result of a monitoring review, a written notice of deficiencies is given to the MHR provider, the provider may be required to submit a written corrective action plan to the bureau within 10 days of receipt of the notice from the department. If the MHR provider fails to submit a corrective action plan within 10 days from the receipt of the notice, sanctions may be imposed against the MHR provider.

H. The MHR provider must establish regular business office hours for all enrolled office locations. Business office locations must be fully operational at least eight hours a day, five days a week between the hours of 7 a.m. and 7 p.m. This requirement does not apply to off-site service delivery locations.

1. Each office shall contain office equipment and furnishings requisite to providing MHR services including, but not limited to:

- a. computers;
- b. facsimile machines;
- c. telephones; and
- d. lockable file cabinets.

2. Offices shall be located in areas separate and apart from areas of residential occupancy and be clearly identifiable as a separate office. The environment must be appropriate to the care and treatment of the recipient and ensure confidentiality and personal safety.

3. An office location is fully operational when the provider:

- a. has met all the requirements for and becomes certified to offer mental health rehabilitation services;
- b. has at least five active recipients at the time of any monitoring review, other than the initial application review;
- c. is capable of accepting referrals at any time during regular business hours;
- d. retains adequate staff to assess, process and manage the needs of current recipients;
- e. has the required designated staff on site (at each location) during business hours; and
- f. is immediately available to its recipients and BHSF by telecommunications 24 hours per day.

4. MHR services may be delivered in off site service delivery locations that are:

- a. publicly available for and commonly used by members of the community other than the provider (e.g., libraries, community centers, YMCA, church meeting rooms, etc.);
- b. directly related to the recipient's usual environment (e.g., home, place of work, school); or

c. utilized in a non-routine manner (e.g., hospital emergency rooms or any other location in which a crisis intervention service is provided during the course of the crisis).

NOTE: Services may not be provided in the home(s) of the MHR provider's owner, employees or agents. Group counseling and psychosocial skills training (adult and youth) services may not be provided in a recipient's home or place of residence.

Services may not be provided in the professional practitioner's private office.

5. Every location where services are provided shall be established with the intent to promote growth and development, client confidentiality and safety.

6. The MHR provider accepts full responsibility to ensure that its office locations meet all applicable federal, state and local licensing requirements. The transferring of licenses and certifications to new locations is strictly prohibited. It is also the responsibility of the MHR provider to immediately notify the bureau of any office relocation or change of address and to obtain a new certification and license (if applicable).

I. As part of the reassessment process, when it is determined that MHR discharge criteria has been met, the MHR provider shall refer the recipient to his/her primary care physician or to the appropriate medically necessary services, and document the referral.

J. Emergency Preparedness Plan

1. The provider shall develop and implement an emergency preparedness plan for fire, natural or declared disasters. The plan shall include:

- a. what measures will be taken to ensure the safety and security of employees and recipients;
- b. provisions to protect business records, including employee and recipient records;
- c. a means of communication with the bureau to report the status of the provider agency post-disaster.

2. If the provider must close its offices as a result of the disaster, the provider may not resume provision of reimbursable services until authorized to do so by the bureau.

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 31:1088 (May 2005), amended LR 32:

§735. Orientation and Training

A. Orientation and training shall be provided to all employees, volunteers, interns and student workers. This orientation should be comprised of no less than five face-to-face hours and may be considered as part of the overall requirement of 16 hours orientation.

1 - 5. ...

B. Exception. The following medical staff may substitute review of a bureau-approved training packet in lieu of the required 16 hours of orientation:

1. the psychiatrist;
2. an advanced practice registered nurse;
3. registered nurse; and
4. licensed practical nurse.

NOTE: The RN and LPN are only allowed to make the substitution for the 16 hours of orientation if medication management is the only service they will provide.

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 31:1089(May 2005), amended LR 32:

§737. Staffing Qualifications

A. MHR services shall be provided by individuals who meet the following education and experience requirements.

1. Licensed Mental Health Professional (LMHP). A LMHP is a person who has a graduate degree in a mental health-related field from an accredited institution and is licensed to practice in the state of Louisiana by the applicable professional board of examiners. All college degrees must be from a nationally accredited institution of higher education as defined in Section 102(b) of the Higher Education Act of 1965 as amended. In order to qualify as a mental health-related field, an academic program must have curriculum content in which at least 70 percent of the required courses for the major field of study are based upon the core mental health disciplines. The following professionals are considered to be LMHPs.

a. Psychiatrist. Each MHR provider shall implement and maintain a contract with a psychiatrist(s) to provide consultation and/or services on site as medically necessary. The psychiatrist must be a licensed medical doctor (M.D. or D.O.) who is board-certified or board-eligible, authorized to practice psychiatry in Louisiana, and enrolled to participate in the Louisiana Medicaid Program. A board eligible psychiatrist may provide psychiatric services to MHR recipients if he/she meets all of the following requirements.

i. The physician must hold an unrestricted license to practice medicine in Louisiana and unrestricted DEA and state and federal controlled substance licenses. If licenses are held in more than one state or jurisdiction, all licenses held by the physician must be documented in the employment record and also be unrestricted.

ii. The physician must have satisfactorily completed a specialized psychiatric residency training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), as evidenced by a copy of the certificate of training or a letter of verification of training from the training director which includes the exact dates of training and verification that all ACGME requirements have been satisfactorily met. If training was completed in child and adolescent psychiatry, the training director of the child and adolescent psychiatry program must document the child and adolescent psychiatry training.

NOTE: All documents must be maintained and readily retrieved for review by the Bureau or its designee.

b. Psychologist—an individual who is licensed as a practicing psychologist under the provisions of R.S. 37:2351-2367;

c. Registered Nurse—a nurse who is licensed as a registered nurse or an advanced practice registered nurse in the state of Louisiana by the Board of Nursing. An advanced practice registered nurse, who is a clinical nurse specialist in psychiatry, must operate under an OMH approved collaborative practice agreement with an OMH approved board-certified psychiatrist. A registered nurse must:

i. be a graduate of an accredited program in psychiatric nursing and have two years of post-master's supervised experience in the delivery of mental health services; or

ii. have a master's degree in nursing or a master's degree in a mental health-related field and two years of supervised post master's experience in the delivery of mental health services; and

NOTE: Supervised experience is experience in mental health services delivery acquired while working under the formal supervision of a LMHP.

iii. six CEUs regarding the use of psychotropic medications, including atypicals, prior to provision of direct service to MHR recipients.

NOTE: Every registered nurse providing MHR services shall have documented evidence of five CEUs annually that are specifically related to behavioral health and medication management issues.

d. Social Worker—an individual who has a master's degree in social work from an accredited school of social work and is a licensed clinical social worker under the provisions of R.S. 37:2701-2723.

e. Licensed Professional Counselor—an individual who has a master's degree in a mental health related field, is licensed under the provisions of R.S. 37:1101-1115 and has two years post-masters experience in mental health.

2. Mental Health Professional (MHP). The MHP is an individual who has a master's degree in a mental health-related field, with a minimum of 15 hours of graduate-level course work and/or practicum in applied intervention strategies/methods designed to address behavioral, emotional and mental disorders as a part of, or in addition to, the master's degree.

NOTE: The MHP must be an employee of the MHR provider and work under the supervision of a LMHP.

3. Mental Health Specialist (MHS). The MHS is an individual who meets one or more of the following criteria:

a. a bachelor's degree in a mental health related field; or

b. a bachelor's degree, enrolled in college and pursuing a graduate degree in a mental health-related field, and have completed at least two courses in that identified field; or

c. a high school diploma or a GED, and at least four years experience providing direct services in a mental health, physical health, social services, education or corrections setting.

NOTE: The MHS must be an employee of the MHR provider and work under the supervision of a LMHP.

4. Nurse. A registered nurse who is licensed by the Louisiana Board of Nursing or a licensed practical nurse who is licensed by the Louisiana Board of Practical Nurse Examiners may provide designated components of medication management services if he/she meets the following requirements.

a. A registered nurse must have:

i. a bachelor's degree in nursing and one year of supervised experience as a psychiatric nurse which must have occurred no more than five years from the date of employment or contract with the MHR provider; or

ii. an associate degree in nursing and two years of supervised experience as a psychiatric nurse which must

have occurred no more than five years from the date of employment or contract with the MHR provider; and

NOTE: Supervised experience is experience in mental health services delivery acquired while working under the formal supervision of a LMHP.

iii. six CEUs regarding the use of psychotropic medications, including atypicals, prior to provision of direct service to MHR recipients.

b. A licensed practical nurse may perform medication administration if he/she has:

i. one year of experience as a psychiatric nurse which must have occurred no more than five years from the date of employment/contract with the MHR provider; and

ii. six CEUs regarding the use of psychotropic medications, including atypicals, prior to provision of direct service to any recipient.

NOTE: Every registered nurse and licensed practical nurse providing MHR services shall have documented evidence of five CEUs annually that are specifically related to behavioral health and medication management issues.

c. Repealed.

5. Repealed.

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 31:1089 (May 2005), amended LR 32:

Subchapter D. Records

§755. Recipient Records

A. ...

B. This record, at a minimum, shall contain:

1. the target population eligibility;
2. the initial recipient assessment;
3. the proposed ISRP;
4. documentation of prior authorization for each service;
5. the discharge plan; and
6. clinical documentation sufficient to substantiate any and all claim(s) for reimbursement.

C. - E. ...

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 31:1090 (May 2005), amended LR 32:

§757. Personnel Records

A. A complete personnel records creation and retention policy shall be developed, implemented and maintained by the MHR provider. The MHR provider shall maintain documentation and verification of all relevant information necessary to assess qualifications for all staff, volunteers and consultants. All required licenses as well as professional, educational and work experience must be verified and documented in the employee's or agent's personnel record prior to the individual providing billable Medicaid services. The MHR provider's personnel records shall include the following documentation.

1. Employment Verification. Verification of previous employment shall be obtained and maintained in accordance with the criteria specified in the MHR Provider Manual.

2. Educational Verification. Educational documents, including diplomas, degrees and certified transcripts shall be

maintained in the records. Résumés and documentation of qualifications for the psychiatrist and LMHPs, including verification of current licensure and malpractice insurance, must also be maintained in the records.

3. Criminal Background Checks. There shall be documentation verifying that a criminal background check through the Louisiana Department of Public Safety (State Police) was conducted on all employees prior to employment. If the MHR provider offers services to children and adolescents, it shall have background checks performed as required by R.S. 15:587.1 and R.S. 15:587.3. The MHR provider shall not hire an individual with a record as a sex offender or permit these individuals to work for the provider.

4. Drug Testing. All prospective employees who apply to work shall be subject to a drug test for illegal drug use. The drug test shall be administered after the date of the employment interview and before an offer of employment is made. If a prospective employee tests positive for illegal drug use, the MHR provider shall not hire the individual. The MHR provider shall have a drug testing policy that provides for the random drug testing of employees and a written plan to handle employees who test positive for illegal drug use, whether the usage occurs at work or during off duty hours. This documentation shall be readily retrievable upon request by the bureau or its designee.

5. Tuberculosis Test. All persons, prior to or at the time of employment, shall be free of tuberculosis (TB) in a communicable state.

a. Any employee who has a negative Mantoux skin test for TB shall be retested annually in order to remain employed.

b. Any employee who has a positive Mantoux skin test must provide:

- i. evidence of a normal chest X-ray;
- ii. a statement from a physician certifying that the individual is noninfectious if the chest X-ray is other than normal; or
- iii. completion of an adequate course of therapy, as prescribed by a licensed physician if active TB is diagnosed.

c. Any employee who has a positive Mantoux skin test must provide an annual physician's statement that they are free of TB in a communicable state.

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 31:1090 (May 2005), amended LR 32:

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 Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, Louisiana 70821-9030. He is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, August 24, 2006 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, Louisiana. At that time all interested persons will be afforded

an opportunity to submit data, views or arguments either orally or in writing. The deadline for the receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Frederick P. Cerise, M.D., M.P.H.
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Mental Health Rehabilitation Program**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will result in an estimated increase in expenses to the state of \$154,454 for FY 06-07, \$239,092 for FY 07-08 and \$248,655 for FY 08-09. It is anticipated that \$2,380 (\$1,190 SGF and \$1,190 FED) will be expended in FY 06-07 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately \$354,082 for FY 06-07, \$550,511 for FY 07-08 and \$572,532 for FY 08-09. It is anticipated that \$1,190 will be expended in FY 06-07 for the federal administrative expenses for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This proposed Rule is being promulgated to: 1) continue the provisions of the January 28, 2005 Emergency Rule; 2) address service changes; 3) clarify provisions regarding provider certification and enrollment; and 4) establish emergency preparedness requirements within the Mental Health Rehabilitation Program (MHR) which impacts approximately 5,230 recipients. It is anticipated that implementation of this proposed rule will increase program expenditures for Mental Health Rehabilitation services by approximately \$506,156 for FY 06-07, \$789,603 for FY 07-08 and \$821,187 for FY 08-09.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this rule will not have an effect on competition and employment.

Jerry Phillips
Acting Medicaid Director
0607#077

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

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

Rural Health Clinics (LAC 50:XI.Chapters 161-167)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing proposes to adopt LAC 50:XI.Chapters 161-167 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing furnishes coverage and reimbursement for rural health clinic services under the Medicaid Program. In September 1995, the department adopted provisions which included rural health clinic visits in the maximum allowable outpatient physician visit limit for Medicaid recipients (*Louisiana Register*, Volume 22, Number 2). The bureau now proposes to adopt provisions governing services, provider participation and reimbursement methodology for rural health clinics.

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. It is anticipated that this proposed Rule will have no impact on family functioning, stability, or autonomy as described in R.S. 49:972.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XI. Clinic Services

Subpart 15. Rural Health Clinics

Chapter 161. General Provisions

§16101. Purpose

A. The Rural Health Clinic Act of 1977 authorized the development of rural health clinics to encourage and stabilize the provision of outpatient primary care in rural areas through cost-based reimbursement.

B. Rural health clinics improve the health status of Louisiana residents in rural and underserved areas by working proactively to build community health systems' capacity to provide integrated, efficient and effective health care services.

C. Rural health clinic (RHC) regulations distinguish between two types of rural health clinics.

1. The independent RHC is a free-standing practice that is not part of a hospital, skilled nursing facility, or home health agency.

2. The provider-based RHC is an integral and subordinate part of a hospital, skilled nursing facility, or 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 Health Services Financing, LR 32:

Chapter 163. Provider Participation

§16301. Provider Enrollment

A. In order to enroll and participate in the Medicaid Program, a RHC must submit a completed provider enrollment packet.

B. The effective date of enrollment to participate in the Medicaid Program shall not be prior to the date of receipt of the completed enrollment packet.

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 32:

§16303. Standards for Participation

A. Rural Health Clinics must comply with the applicable licensure, accreditation and program participation standards for all services rendered. If a RHC wishes to initiate participation, it shall be responsible for meeting all of the enrollment criteria of the program. The RHC provider shall:

1. maintain an acceptable fiscal record keeping system that readily distinguishes one type of service from another type of service that may be provided;

2. retain all records necessary to fully disclose the extent of services provided to recipients for five years from the date of service and furnish such records, and any payments claimed for providing such services, to the Medicaid Program upon request; and

3. abide by and adhere to all federal and state regulations and policy manuals.

B. Medicaid enrollment can be no sooner than Medicaid's receipt of the complete enrollment packet. A complete enrollment packet for RHCs must include a copy of the CMS provider certification letter approving rural health clinic status.

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 32:

Chapter 165. Services

§16501. Scope of Services

A. Medicaid reimbursement is limited to medically necessary services that are covered by the Medicaid State Plan and would be covered if furnished by a physician. The following services shall be covered:

1. services furnished by a physician, within the scope of practice of his profession under Louisiana law;

2. services furnished by a:

- a. physician assistant;
- b. nurse practitioner;
- c. nurse midwife;
- d. clinical social worker;
- e. clinical psychologist; or
- f. dentist;

3. services and supplies that are furnished as an incident to professional services furnished by all eligible professionals; and

4. other ambulatory 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 Health Services Financing, LR 32:

§16503. Service Limits

A. Rural health clinic visits (encounters) are limited to 12 visits per year for medically necessary services rendered to Medicaid recipients who are 21 years of age or older. Visits for Medicaid recipients who are under 21 years of age and for prenatal and postpartum care are excluded from the service limitation.

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 32:

Chapter 167. Reimbursement Methodology

§16701. Prospective Payment System

A. Payments for Medicaid covered services will be made under a Prospective Payment System (PPS) and paid on a per visit basis.

B. A visit is defined as a face-to-face encounter between a facility health professional and a Medicaid eligible patient for the purpose of providing medically needed outpatient services.

1. Encounters with more than one facility health professional that take place on the same day and at a single location constitute a single encounter.

2. Services shall not be arbitrarily delayed or split in order to bill additional encounters.

NOTE: Refer to the RHC and Physician's Current Procedural Terminology (CPT) Manuals for the definition of an encounter.

C. For facilities that enroll to participate in the Medicaid Program on or after the effective date of this rule, the PPS per visit rate will be the statewide weighted average payment rate per encounter for all RHCs.

1. A change in the scope of services will not be considered for an increase in the rate. An increase in the encounters due to the change should compensate the increased administrative costs.

D. The PPS per visit rate for each facility will be increased on July 1 of each year by the percentage increase in the published *Medicare Economic Index (MEI)* for primary services.

E. No interim or alternate payment methodologies will be developed by the Department without prior notification to each Medicaid licensed RHC.

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 32:

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 Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this proposed Rule. A public hearing on this proposed Rule is scheduled for Thursday, August 24, 2006 at 9:30 a.m. in the Department of Transportation and Development Auditorium, First Floor, 1201 Capitol Access Road, Baton Rouge, Louisiana. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for the receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Frederick P. Cerise, M.D., M.P.H.
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Rural Health Clinics

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

It is anticipated that the implementation of this proposed rule will have no programmatic fiscal impact to the state other than cost of promulgation for FY 06-07. It is anticipated that

\$544 (\$272 SGF and \$272 FED) will be expended in FY 06-07 for the state's administrative expense for promulgation of this proposed rule and the final rule.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is anticipated that the implementation of this proposed rule will not affect federal revenue collections other than the federal share of the promulgation costs for FY 06-07. It is anticipated that \$272 will be expended in FY 06-07 for the federal share of the expense for promulgation of this proposed rule and the final rule.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

This rule proposes to adopt provisions governing services, provider participation and reimbursement methodology for rural health clinics (approximately 70 facilities) which will align the rural health clinics with the federally qualified health centers. It is anticipated that implementation of this proposed rule will not have estimable cost or economic benefits for directly affected persons or non-governmental groups in FY 06-07, FY 07-08, and FY 08-09.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known impact on competition and employment.

Jerry Phillips
Acting Medicaid Director
0607#075

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Public Safety and Corrections
Office of State Fire Marshal**

Equal Access for Disabled Individuals
(LAC 55:V.1501)

In accordance with the provisions of R.S.40:1563(B)(6)(F) relative to the authority of the Office of State Fire Marshal to prepare, adopt and promulgate rules and regulations in accordance with the Administrative Procedure Act, the Office of State Fire Marshal hereby proposes to amend LAC 55:V:1501 Equal Access for Disabled Individuals to provide for enforcement of the HUD Fair Housing Accessibility Guidelines as amended in 1988 and published in the *Federal Register* on June 15, 1990.

Title 55

PUBLIC SAFETY

Part V. Fire Protection

Chapter 15. Public Places in General

§1501. Equal Access for Disabled Individuals

A. Buildings, structures, public facilities, governmental facilities and improved areas built between January 1, 1978 and August 14, 1995 shall be covered by the standards put forward in ANSI 117.1. Such entities built on or after August 14, 1995, shall be covered by the ADAAG guidelines to the Americans with Disabilities Act in effect on September 1, 1994.

B. Multi-family dwelling units of 15 or more dwelling units must have at least 5 percent or one dwelling unit which meets the regulations specified by ANSI A117.1 1992 edition.

C. Multi-family dwelling units, which are required to be accessible by Subsection B, shall comply with the requirements for dwelling units set forth in ANSI A117.1-1992 of the American National Standards Institute entitled *American National Standard Specifications for Making Buildings and Facilities Accessible to and Usable by Physically Handicapped People* which can be purchased from the American National Standards Institute, Inc., 1430 Broadway, New York, New York 10018.

D. Any dwelling unit in a facility which incorporates more than four dwelling units shall be made accessible in accordance with the HUD Fair Housing Accessibility Guidelines published on March 6, 1991.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1651(B) and R.S. 40:1734(B).

HISTORICAL NOTE: Promulgated by the Department of Public Safety, Office of Fire Protection, LR 4:465 (November 1978), repromulgated LR 6:74 (February 1980), amended by the Office of the State Fire Marshal, LR 7:588 (November 1981), amended by the Department of Public Safety and Corrections, Office of the State Fire Marshal, LR 23:1698 (December 1997), LR 32:

Family Impact Statement

The proposed adoption of the Rule change for R.S. 40:1734, regarding the enforcement Fair Housing Guidelines by the State Fire Marshal should not have any known or foreseeable impact on any family as defined by R.S. 49:972(D) or on family formation, stability and autonomy. The implementation of this proposed Rule will have no known or foreseeable effect on:

1. the stability of the family;
2. the authority and rights of parents regarding the education and supervision of their children;
3. the functioning of the family;
4. family earnings and family budget;
5. the behavior and personal responsibility of children;
6. the ability of the family or a local government to perform this function.

Interested persons may submit written comments on this proposed amendment to Henry Fry at 8181 Independence Boulevard, Baton Rouge, LA 70806. Comments will be accepted through close of business August 15, 2006.

Stephen J. Hymel
Undersecretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Equal Access for Disabled Individuals**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Additional costs, to state or local governments, are not anticipated as a result of the implementation of this amendment to the rule, as the Office of State Fire Marshal already reviews

plans and inspects facilities which incorporate more than four apartment dwelling units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

No effect on revenue collections of state or local governments is anticipated, as a result of the implementation of this amendment to the rule, as the Office of State Fire Marshal already reviews plans and inspects facilities which incorporate more than four apartment dwelling units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The economic benefit is that persons with disabilities will be reasonably assured, due to enforcement of the 'HUD Fair Housing Accessibility Guidelines' by the Office of State Fire Marshal, of the specified market of accessible apartment dwelling units required by federal law. There should be no significant costs to affected persons or non-governmental groups as the Fair Housing Act is already federal law.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on competition or employment.

Stephen J. Hymel
Undersecretary
0607#049

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Public Safety and Corrections
Office of State Police**

Breath and Blood Alcohol Analysis
Methods and Techniques
(LAC 55:I.503)

In accordance with the provisions of R.S.32:663 relative to the authority of the Office of State Police to promulgate and enforce rules, the Office of State Police hereby proposes to amend the following Rule regarding the qualifications of operators of the Intoxilyzer 5000.

**Title 55
PUBLIC SAFETY
Part I. State Police**

**Chapter 5. Breath and Blood Alcohol Analysis
Methods and Techniques**

Subchapter A. Analysis of Breath

§503. Operator Qualification

A. - A.2. ...

3. receipt of a high school diploma or satisfactory passing of the General Education Development (GED) test or an equivalent or higher educational background;

4. - 4.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 32:663.

HISTORICAL NOTE: Promulgated by the Department of Public Safety, Office of State Police, LR 4:390 (October 1978), amended LR 6:663 (November 1980), amended by the Department of Public Safety and Corrections, Office of State Police, LR 11:256 (March 1985), LR 14:362 (June 1988), repromulgated LR 14:442 (July 1988), amended LR 17:672 (July 1991), repromulgated LR 17:796 (August 1991), amended LR 27:1929 (November 2001), LR 32:

Family Impact Statement

1. The Effect of these Rules on the Stability of the Family. This Rule change will have no effect on the stability of the family.

2. The Effect of these Rules on the Authority and Rights of Parents Regarding the Education and Supervision of their Children. This Rule change will have no effect on the authority and rights of parents regarding the education and supervision of their children.

3. The Effect of these Rules on the Functioning of the Family. This Rule change will have no effect on the functioning of the family.

4. The Effect of these Rules on Family Earnings and Family Budget. This Rule change will have no effect on family earning and family budget.

5. The Effect of these Rules on the Behavior and Personal Responsibility of Children. This Rule change will have no effect on the behavior and personal responsibility of children.

6. The Effect of these Rules on the Ability of the Family or Local Government to Perform the Function as Contained in the Proposed Rules. This Rule change will have no effect on the ability of the family or local government to perform the function as contained in the proposed rules.

Interested persons may submit written comments on these proposed amendments to Sgt. Terry Chustz at 7901 Independence Boulevard, Baton Rouge, LA 70808. Comments will be accepted through close of business August 11, 2006.

Stephen J. Hymel
Undersecretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Breath and Blood Alcohol Analysis
Methods and Techniques**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

This change in agency rule, which clarifies the educational level requirements for the certification of an individual to conduct breath analysis utilizing the Intoxilyzer 5000, will not result in any increased costs or savings to state or local governmental units.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

The proposed rule will have no effect on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

There are no estimated costs and/or economic benefit to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on competition and employment.

Stephen J. Hymel
Undersecretary
0607#054

Robert E. Hosse
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Public Safety and Corrections Youth Services Office of Youth Development

Reporting and Documenting Escapes, Apprehensions,
Runaways, and AWOLs (LAC 22:I.771)

In accordance with the applicable provisions of R.S. 49:950 et seq., The Administrative Procedure Act, and pursuant to the authority granted by R.S. 36:405, the Department of Public Safety and Corrections, Division of Youth Services, Office of Youth Development gives notice of its intent to promulgate §771, Reporting and Documenting Escapes, Apprehensions, Runaways, and AWOLs. The purpose of the promulgation of this Rule is to establish the deputy secretary's policy and procedures regarding reporting and documenting escapes, apprehensions, runaways, and AWOLs.

Title 22

CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

Part I. Corrections

Chapter 7. Youth Services

Subchapter C. Field Operations

§771. Reporting and Documenting Escapes, Apprehensions, Runaways, and AWOLs

A. Purpose. This Rule establishes the policy and procedures for reporting and documenting, escapes, apprehensions, runaways, and AWOLs (absent without leave).

B. Applicability. Assistant secretary, facility directors, Probation and Parole Program Director, and Youth Services (YS) Regional Managers.

C. Policy. It is the deputy secretary's policy that all escapes, apprehensions, runaways, and AWOLs, whether from a secure or non-secure facility, shall be reported and documented. Appropriate law enforcement agencies shall be notified as outlined herein and each unit shall maintain appropriate vigilance in apprehending youth.

D. Procedures

1. All escapes, apprehensions, runaways, and AWOLs shall be reported to YS Central Office in accordance with YS rules.

2. When an escape from a secure facility occurs, appropriate law enforcement agencies shall be notified in accordance with R.S. 15:909, as well as the Control Center at the Jetson Center for Youth (JCY). The prosecuting district attorney shall be notified immediately if required by YS rules. Appropriate law enforcement agencies shall also be notified of runaways and AWOLs.

3. The JCY Control Center is responsible for notifying NCIC and appropriate local law enforcement agencies of all escapes, runaways, and AWOLs.

4. The YS Central Office Duty Officer shall confirm that all notifications of escapes, apprehensions, runaways, and AWOLs have been made or cleared as appropriate.

5. For escapes from secure care facilities, the Office of Youth Development (OYD) will obtain a fugitive warrant from an East Baton Rouge Parish judge for the unserved portion of the disposition.

6. Notification of all apprehensions shall be in accordance with YS rules. The prosecuting district attorney shall be notified of apprehensions if required by YS rules.

7. Notification to registered crime victims shall be made in accordance with YS rules.

8. Directors of secure care facilities shall maintain a record and description of every escape from their facility pursuant to R.S. 15:909.

9. The report shall be available for public inspection and shall list any prior escapes within the last five years from that facility.

10. YS Central Office Duty Officer

a. All escapes and apprehensions shall be reported by telephone immediately to the YS Central Office Duty Officer and followed up with return receipt e-mail notification.

b. YS Central Office shall monitor facility progress of apprehension efforts and shall actively participate in apprehension efforts for youth who escape from any facilities. Searches shall be coordinated with the facility from which the youth escaped and the appropriate law enforcement agencies.

c. Information regarding escapes and apprehensions shall be reported pursuant to YS rules.

11. Investigative Report. After any escape from a secure care facility, an investigative report shall be prepared and submitted to the deputy secretary outlining any operational failures or weaknesses that contributed to the escape, as well as a plan of action implemented to minimize a recurrence. A Critical Incident Review shall be conducted with the facility and Central Office staff within 14 days of the incident.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:549, R.S. 15:909, R.S. 46:1844, and Ch.C. Art. 811.1.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Youth Services, Office of Youth Development, LR 32:

Family Impact Statement

1. The proposed Rule will not affect the stability of the family.

2. The proposed Rule will not affect the authority and rights of persons regarding the education and supervision of their children.

3. The proposed Rule will not affect the functioning of the family.

4. The proposed Rule will not affect family earnings and family budget.

5. The proposed Rule will not affect the behavior and personal responsibility of children.

6. The proposed Rule is a function of state government.

Interested persons may submit written comments until 4:30 p.m., August 10, 2006, to Kathe R. Zolman, Dept. of Public Safety and Corrections, Office of Youth Development, Legal Dept., 7919 Independence Blvd., State Police Bldg., Baton Rouge, LA 70808.

Simon G. Gonsoulin
Deputy Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES**

**RULE TITLE: Reporting and Documenting Escapes,
Apprehensions, Runaways, and AWOLs**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENT UNITS (Summary)**

There are no estimated implementation costs (savings) to state or local government units. The proposed rule promulgates a previously implemented policy of Office of Youth Development regarding the reporting and documenting escapes, apprehensions, runaways, and AWOLs.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE
OR LOCAL GOVERNMENTAL UNITS (Summary)**

There will be no estimated effect on revenue collections of state or local government units.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO
DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL
GROUPS (Summary)**

There are no estimated costs and/or economic benefits to directly affected persons or non-governmental groups.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)**

There will be no estimated effect on competition and employment.

Simon G. Gonsoulin
Deputy Secretary
0607#056

Robert E. Hosse
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Revenue
Policy Services Division**

Presidential Disaster Relief (LAC 61:I.601)

Under the authority of R.S. 47:287.85(C) (2), R.S. 47:287.785, R.S. 47:293(3) and 47:1511, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue, Policy Services Division, proposes to amend LAC 61:I.601 to add the Low Income Housing Tax Credit and the New Markets Tax Credit as disaster relief credits.

Neither the low income housing tax credit nor the new markets tax credit was included in the original version of LAC 61:I.601 because the Gulf Opportunity Zone Act of 2005, Pub. L. No. 109-135, 119 Stat. 2577 (H.R. 4440), which extended both of these credits, was passed after the original drafting of LAC 61:I.601. The purpose of the proposed Rule is to declare these additional two credits as disaster relief credits and provide guidance regarding their applicability.

Title 61

REVENUE AND TAXATION

**Part I. Taxes Collected and Administered by the
Secretary of Revenue**

**Chapter 6. Presidential Disaster Relief
§601. Presidential Disaster Relief Credits**

A. Definitions

Gulf Opportunity Zone (GO Zone)—that portion of the Hurricane Katrina disaster area determined by the President to warrant individual or individual and public assistance from the federal government under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.

Hurricane Katrina Disaster Area—any area with respect to which a major disaster has been declared by the President before September 14, 2005, under Section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act by reason of Hurricane Katrina.

Hurricane Katrina Employee—an individual who on August 28, 2005, has a principal place of abode in the GO Zone and is hired during the two year period beginning on such date for a position with the principal place of employment in the GO Zone or an individual who on August 28, 2005, had a principal place of abode in the GO Zone but was displaced from such abode due to Hurricane Katrina and is hired during the period beginning on such date and ending on December 31, 2005, without regard to whether the new principal place of employment is in the GO Zone.

Hurricane Katrina Employer—any employer that conducted an active trade or business on August 28, 2005, in the GO Zone and the employer's active trade or business must have been inoperable on any day after August 28, 2005, and before January 1, 2006, as a result of damage sustained due to Hurricane Katrina.

Rita Gulf Opportunity Zone (Rita GO Zone)—that portion of the Hurricane Rita disaster area determined by the President to warrant individual or individual and public assistance from the Federal Government under the Robert T. Stafford Disaster Relief and Emergency Assistance Act by reason of Hurricane Rita.

Hurricane Rita Disaster Area—any area with respect to which a major disaster has been declared by the President before October 6, 2005, under Section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act by reason of Hurricane Rita.

Hurricane Rita Employee—an individual who on September 23, 2005, has a principal place of abode in the Rita GO Zone but was displaced from such abode due to Hurricane Katrina and is hired during the period beginning on such date and ending on December 31, 2005, without regard to whether the new principal place of employment is in the Rita GO Zone.

Hurricane Rita Employer—any employer that conducted an active trade or business on September 23, 2005, in the Rita GO Zone and the employer's active trade or business must have been inoperable on any day after September 23, and before January 1, 2006, as a result of damage sustained due Hurricane Rita.

B. The Katrina Emergency Tax Relief Act of 2005, Pub. L. No. 109-73, 119 Stat. 2016 (H.R. 3768) ("KETRA") and the Gulf Opportunity Zone Act of 2005, Pub. L. No. 109-135, 119 Stat. 2577 (H.R. 4440) provide for the following federal income tax credits, which the secretary hereby declares as presidential disaster area disaster relief credits.

1. Employee Retention Credit

a. This is a new credit. It provides a credit of 40 percent of the qualified wages paid by an eligible employer to an eligible employee in the GO Zone or the Rita GO Zone. The wages are capped at \$6,000. Thus, the maximum amount of the credit is \$2,400 or 40 percent of \$6,000.

b. GO Zone Qualified wages as defined in IRC 51(c)(1) are the wages paid or incurred by an eligible employer with respect to an eligible employee on any day after August 28, 2005, and before January 1, 2006, during the period when the trade or business first became

inoperable and ending on the date on which the business resumed significant operations. Qualified wages include wages paid to an employee whether the employee performed the service, whether the service was performed elsewhere other than the principal place of employment or whether paid before significant operations have resumed.

c. Rita GO Zone qualified wages as defined in IRC 51(c)(1) are the wages paid or incurred by an eligible employer with respect to an eligible employee on any day after September 23, 2005, and before January 1, 2006, during the period when the trade or business first became inoperable and ending on the date on which the business resumed significant operations. Qualified wages include wages paid to an employee whether the employee performed the service, whether the service was performed elsewhere other than the principal place of employment or whether paid before significant operations have resumed.

d. The secretary has determined that the Employee Retention Credit is a federal disaster relief credit granted for Hurricanes Katrina and Rita presidential disaster areas.

2. Work Opportunity Credit

a. Pre Hurricane Katrina

i. The Work Opportunity Credit is available on an elective basis to employers who employ individuals from one or more of eight target groups. The eight target groups are:

- (a) families that receive benefits from the Temporary Assistance for Needy Families Program;
- (b) high-risk youth;
- (c) qualified ex-felons;
- (d) vocational rehabilitation referrals;
- (e) qualified summer youth employees;
- (f) qualified veterans;
- (g) families receiving food stamps; and
- (h) persons receiving Supplemental Security Income benefits.

ii. Certification is required for an individual to be treated as a member of a targeted group.

iii. The credit equals 40 percent of qualified first-year wages, which are capped at \$6,000. The percentage decreases to 25 percent if the employee works less than 400 hours.

iv. This credit does not apply to rehires or wages paid to individuals who had previously been employed by the employer.

v. This credit expires December 31, 2005.

b. Post Hurricane Katrina

i. The KETRA Act provides that Hurricane Katrina employees are members of a targeted group for the purpose of the Work Opportunity Credit.

ii. The certification requirement for Hurricane Katrina employees is waived.

iii. Wages paid to individuals who had previously been employed, which would normally not be included in qualified first year wages, are now included for Hurricane Katrina employee unless they were employed by the employer on August 28, 2005.

iv. The expiration date is waived for Hurricane Katrina employees.

v. The secretary has determined that the Work Opportunity Credit, with respect to wages paid to Hurricane

Katrina employees, is a federal disaster relief credit granted for the Hurricane Katrina presidential disaster areas.

3. Employer-Provided Housing Credit for Individuals Affected by Hurricane Katrina

a. Definitions

Qualified Employee—with respect to a month, an individual who:

(1). on August 28, 2005, had a principal residence in the Gulf Opportunity ("GO") Zone; and

(2). performs substantially all of his or her employment services in the GO Zone for the qualified employer furnishing the lodging.

Qualified Employer—any employer with a trade or business located in the GO Zone.

b. Pre-Hurricane Katrina—Employer-Provided Housing is includable in income as compensation pursuant to IRC §61.

c. Post-Hurricane Katrina

i. The Gulf Opportunity Zone Act of 2005 provides temporary income exclusion for the value of in kind lodging for a month to a qualified employee by or on behalf of a qualified employer.

ii. The amount of the exclusion for any month can not exceed \$600.

iii. The provision also permits a temporary credit to a qualified employer of 30 percent of the value of the lodging excluded from the income of a qualified employee. The amount taken as a credit is not deductible by the employer.

iv. The secretary has determined that the Employer-Provided Housing Credit, with respect to wages paid to Hurricane Katrina employees, is a federal disaster relief credit granted for the Hurricane Katrina presidential disaster areas.

4. Rehabilitation Tax Credit

a. Definitions

Certified Historic Structure—any building that is listed in the National Register, or that is located in a registered historic district and is certified by the Secretary of the Interior to the Secretary of the Treasury as being of historic significance to the district.

Qualified Rehabilitated Building—a building that meets the following requirements: retention of existing external walls and internal structural framework of the building and a substantial rehabilitation requirement credit only if the rehabilitation expenditures during the 24-month period selected by the taxpayer and ending within the taxable year exceed the greater of:

(1). the adjusted basis of the building (and its structural components); or

(2). \$5,000.

b. Pre-Hurricane Katrina—A 20 percent credit is provided for qualified rehabilitation expenditures with respect to certified historic structures. A 10 percent credit is also provided for qualified rehabilitation expenditure with respect with a qualified rehabilitation building placed in service before 1936.

c. Post-Hurricane Katrina

i. The Gulf Opportunity Zone Act of 2005 increases the 20 percent credit to 26 percent with respect to certified historic structures. The Act also increases the 10

percent credit to 13 percent for qualified rehabilitation buildings.

ii. The qualifying certified historic structures and qualified rehabilitation buildings must be located in the GO Zone.

iii. These expenditures must have been incurred with respect to such buildings on or after August 28, 2005, and before January 1, 2009.

iv. The secretary has determined that the increase in the Rehabilitation Tax Credit, with respect to the rehabilitation of buildings is a federal disaster relief credit granted for the Hurricane Katrina presidential disaster areas.

5. Hope Scholarship and Lifetime Learning Credits

a. Pre-Hurricane Katrina

i. The Hope Scholarship credit is a nonrefundable credit of up to \$1,500 per student per year for qualified tuition and related expenses paid for the first two years of the student's post-secondary education in a degree or certificate program.

ii. The Lifetime Learning Credit is equal to 20 percent of qualified tuition and related expenses incurred during the taxable year on behalf of the taxpayer, the taxpayer's spouse, or any dependents. Up to \$10,000 of qualified tuition and related expenses per taxpayer return are eligible for the Lifetime Learning Credit. A taxpayer may claim the Lifetime Learning Credit for an unlimited number of taxable years.

iii. Both the Hope Scholarship and the Lifetime Learning Credits are available for "qualified tuition and related expenses," which include tuition and fees (excluding nonacademic fees) required to be paid to an eligible educational institution as a condition of enrollment or attendance of a student at the institution. Charges and fees associated with meals, lodging, insurance, transportation, and similar personal, living or family expenses are not eligible for the credit. The expenses of education involving sports, games, or hobbies are not qualified tuition expenses unless this education is part of the student's degree program, or the education is undertaken to acquire or improve the job skills of the student.

b. Post-Hurricane Katrina

i. The provision temporarily expands the Hope Scholarship and Lifetime Learning credits for students attending an eligible education institution located in the Gulf Opportunity Zone.

ii. The Hope Scholarship credit is increased to 100 percent of the first \$2,000 in qualified tuition and related expenses and 50 percent of the next \$2,000 of qualified tuition and related expenses for a maximum credit of \$3,000 per student.

iii. The Lifetime Learning credit rate is increased from 20 percent to 40 percent. Thus, the maximum amount of the credit is \$4000 or 40 percent of \$10,000.

iv. The provision expands the definition of qualified expenses to mean qualified higher education expenses as defined under the rules relating to qualified tuition programs, including certain room and board expenses for at least half-time students.

v. The secretary has determined that the increase in the Hope Scholarship and the Lifetime Learning Credits, with respect to qualified tuition and related expenses of students in the Gulf Opportunity Zone, are federal disaster

relief credits granted for the Hurricane Katrina presidential disaster areas.

6. Low Income Housing Credit

a. Pre Hurricane Katrina

i. The low-income housing credit may be claimed over a 10-year period for the cost of rental housing occupied by tenants having incomes below specified levels. The amount of the credit for any taxable year in the credit period is the applicable percentage of the qualified basis of each qualified low-income building. The qualified basis of any qualified low-income building for any taxable year equals the applicable fraction of the eligible basis of the building.

ii. In order to be eligible for the low-income housing credit, a qualified low-income building must be part of a qualified low-income housing project. In general, a qualified low-income housing project is defined as a project which satisfies one of two tests at the election of the taxpayer. The first test is met if 20 percent or more of the residential units in the project are both rent-restricted and occupied by individuals whose income is 50 percent or less of area median gross income (the "20-50 test"). The second test is met if 40 percent or more of the residential units in such project are both rent-restricted and occupied by individuals whose income is 60 percent or less of area median gross income (the "40-60 test").

iii. Generally, the aggregate credit authority provided annually to each state for calendar year 2006 is \$1.90 per resident with a minimum annual cap of \$2,180,000 for certain small population states. These amounts are indexed for inflation. These limits do not apply in the case of projects that also receive financing with proceeds of tax-exempt bonds issued subject to the private activity bond volume limit.

b. Post Hurricane Katrina

i. The otherwise applicable housing credit ceiling amount is increased for each of the states within the Gulf Opportunity Zone. This increase applies to calendar years 2006, 2007, and 2008. The additional credit cap for each of the affected states equals \$18 times the number of such state's residents within the Gulf Opportunity Zone. This amount is not adjusted for inflation. For purposes of this additional credit cap amount, the determination of population for any calendar year is made on the basis of the most recent census estimate of the resident population of the state in the Gulf Opportunity Zone released by the Bureau of the Census before August 28, 2005.

ii. Under the provision, the Gulf Opportunity Zone, the Rita Go Zone, and the Wilma Go Zone are treated as high-cost areas for purposes of the low income housing credit for property placed-in-service in calendar years 2006, 2007, and 2008. Therefore, buildings located in the Gulf Opportunity Zone, the Rita Go Zone, and the Wilma Go Zone are eligible for the enhanced credit. The 20-percent of population restriction is waived for this purpose. This enhanced credit applies regardless of whether the building receives its credit allocation under the otherwise applicable low-income housing credit cap or the additional credit cap.

iii. The additional credit cap available for states within the Gulf Opportunity Zone for calendar years 2006, 2007 and 2008 may not be carried forward from any year to

any other year. The present-law rules apply for purposes of the Rita Go Zone and the Wilma Go Zone.

iv. The secretary has determined that all amounts of the low income housing credit allocated throughout the state during calendar years 2006, 2007, and 2008 are federal disaster relief credits granted for the Gulf Opportunity Zone.

7. New Markets Tax Credit

a. Pre Hurricane Katrina

i. IRC Section 45D provides a new markets tax credit for qualified equity investments made to acquire stock in a corporation, or a capital interest in a partnership, that is a qualified community development entity ("CDE"). The amount of the credit allowable to the investor (either the original purchaser or a subsequent holder) is (1) a 5 percent credit for the year in which the equity interest is purchased from the CDE and for each of the following two years, and (2) a 6 percent credit for each of the following four years. The credit is determined by applying the applicable percentage (5 or 6 percent) to the amount paid to the CDE for the investment at its original issue, and is available for a taxable year to the taxpayer who holds the qualified equity investment on the date of the initial investment or on the respective anniversary date that occurs during the taxable year. The credit is recaptured if at any time during the seven-year period that begins on the date of the original issue of the investment the entity ceases to be a qualified CDE, the proceeds of the investment cease to be used as required, or the equity investment is redeemed.

ii. A qualified CDE is any domestic corporation or partnership: (1) whose primary mission is serving or providing investment capital for low-income communities or low-income persons; (2) that maintains accountability to residents of low-income communities by their representation on any governing board of or any advisory board to the CDE; and (3) that is certified by the Secretary of Treasury as being a qualified CDE. A qualified equity investment means stock (other than nonqualified preferred stock) in a corporation or a capital interest in a partnership that is acquired directly from a CDE for cash, and includes an investment of a subsequent purchaser if such investment was a qualified equity investment in the hands of the prior holder. Substantially all of the investment proceeds must be used by the CDE to make qualified low-income community investments. For this purpose, qualified low-income community investments include: (1) capital or equity investments in, or loans to, qualified active low-income community businesses; (2) certain financial counseling and other services to businesses and residents in low-income communities; (3) the purchase from another CDE of any loan made by such entity that is a qualified low-income community investment; or (4) an equity investment in, or loan to, another CDE.

iii. A "low-income community" is a population census tract with either (1) a poverty rate of at least 20 percent or (2) median family income which does not exceed 80 percent of the greater of metropolitan area median family income or statewide median family income (for a nonmetropolitan census tract, does not exceed 80 percent of statewide median family income). In the case of a population census tract located within a high migration rural county, low-income is defined by reference to 85 percent (rather than 80 percent) of statewide median family income. For this

purpose, a high migration rural county is any county that, during the 20-year period ending with the year in which the most recent census was conducted, has a net out-migration of inhabitants from the county of at least 10 percent of the population of the county at the beginning of such period.

iv. The maximum annual amount of qualified equity investments is capped at \$2.0 billion per year for calendar years 2004 and 2005, and at \$3.5 billion per year for calendar years 2006 and 2007.

b. Post Hurricane Katrina

i. The provision allows an additional allocation of the new markets tax credit in an amount equal to \$300,000,000 for 2005 and 2006, and \$400,000,000 for 2007, to be allocated among qualified CDEs to make qualified low-income community investments within the Gulf Opportunity Zone. To qualify for any such allocation, a qualified CDE must have as a significant mission the recovery and redevelopment of the Gulf Opportunity Zone. The carryover of any unused additional allocation is applied separately from the carryover with respect to allocations made under present law.

ii. The secretary has determined that the additional allocation of the new markets tax credit totaling \$300,000,000 for 2005 and 2006 and \$400,000,000 for 2007 are federal disaster relief credits granted for the Gulf Opportunity Zone.

8. The Employee Retention Credit, the Katrina disaster relief portion of the Work Opportunity Credit, the Low Income Housing Credit for years 2006, 2007, and 2008 and the Gulf Opportunity Zone portion of the New Markets Tax Credit are part of the general business credit under IRC §38. If the general business credit is limited, the lesser of the amount equal to total disaster relief credits that are components of the general business credit or the general business credit will be allowed as disaster relief credits granted for the Hurricane Katrina presidential disaster areas or Hurricane Rita Disaster presidential disaster areas.

AUTHORITY NOTE: Adopted in accordance with R.S. 47:1511, R.S. 47:287.85(C) (2), R.S. 47:293(3) and R.S. 47:287.785

HISTORICAL NOTE: Promulgated by the Department of Revenue, Policy Services Division, LR 32:

Family Impact Statement

The proposed adoption of LAC 61:I.601, regarding presidential disaster area disaster relief credits. Specifically, the implementation of this proposed Rule will have no known or foreseeable effect on:

1. the stability of the family;
2. the authority and rights of parents regarding the education and supervision of their children;
3. the functioning of the family;
4. family earnings and family budget;
5. the behavior and personal responsibility of children;
6. the ability of the family or a local government to perform this function.

Any interested person may submit written data, views, arguments or comments regarding this proposed Rule to Michael D. Pearson, Senior Policy Consultant, Policy Services Division, Office of Legal Affairs by mail to P.O. Box 44098, Baton Rouge, LA 70804-4098. All comments must be received no later than 5:30 p.m., August 29, 2006. A public hearing will be held on August 30, 2006, at 10 a.m. in

the River Room, on the seventh floor of the LaSalle Building, 617 North Third Street, Baton Rouge, LA.

Cynthia Bridges
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Presidential Disaster Relief**

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)

Implementation of this proposed regulation will have no impact on the agency's costs. The purpose of the proposed rule is to amend LAC:61:I.601 to declare the federal disaster relief credits, Low Income Housing Tax Credit and New Markets Tax Credit, as disaster relief credits and provide guidance regarding their applicability. The federal legislation extending these credits was not signed into law at the time of the original drafting.

There will be no impact on local government costs.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no effect on revenue collections of state or local governmental units. Official revenue forecasts do not incorporate an expectation of receiving any revenue from increased personal income tax collections which would have been caused by the hurricane Katrina and Rita events. The anticipated state revenue baseline is considered to be unaffected.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Taxpayers receiving the benefit of federal disaster tax relief because of the Low Income Housing Credit and/or the New Markets Credit will see no increase in their Louisiana tax liabilities.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed regulation should have no effect on competition or employment.

Cynthia Bridges
Secretary
0607#070

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

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

KCSP-FTAP-STEP—Parent Skills—IFG
(LAC 67:III.1209,1223, 1225, 1229, 1245,
1291, 4501, 4701, 4702, 4703, 4704, 5307,
5321, 5323, 5329, 5339, 5341, 5391,5711)

The Department of Social Services, Office of Family Support, proposes to amend LAC 67:III, Subpart 2, Subpart 10, Subpart 13, and Subpart 16.

Pursuant to the authority granted to the Department by Louisiana's Temporary Assistance to Needy Families Block Grant, the agency will amend §§1209, 1223, 1225, 1229, 1245, and 1291 in the Family Independence Temporary Assistance Program (FITAP); §§5307, 5321, 5323, 5329,

5339, 5341, and 5391 in the Kinship Care Subsidy Program (KCSP) and §5711 in the Strategies to Empower People (STEP) Program. These amendments were effected by a Declaration of Emergency signed May 1, 2006, and published in the May issue of the *Louisiana Register*.

Additionally, the agency is repealing Subpart 10, Individual and Family Grant (IFG) Program because effective October 15, 2002, IFG was replaced by the Individual and Households Program (IHP) which is administered by the Federal Emergency Management Agency.

Title 67

SOCIAL SERVICES

Part III. Family Support

Subpart 2. Family Independence Temporary Assistance Program

Chapter 12. Application, Eligibility, and Furnishing Assistance

Subchapter A. Application, Determination of Eligibility, and Furnishing Assistance

§1209. Notices of Adverse Action

A. A notice of adverse action shall be sent at least 13 days prior to taking action to reduce or terminate benefits. In some circumstances advance notice is not required. A concurrent notice shall be sent to the client at the time of action in the following situations:

1. - 9. ...
10. repealed.
11. - 16. ...

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474, R.S. 46:231.1.B. and R.S. 46:237; Act 58, 2003 Reg. Session, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 25:2447 (December 1999), amended LR 26:349 (February 2000), LR 28:2565 (December 2002), LR 30:493 (March 2004), LR 32:

Subchapter B. Conditions of Eligibility

§1223. Citizenship

A. Each FITAP recipient must be a United States Citizen, a non-citizen national, or a qualified alien. A non-citizen national is a person born in an outlying possession of the United States (American Samoa or Swain's Island) on or after the date the U.S. acquired the possession, or a person whose parents are U.S. non-citizen nationals. A qualified alien is:

1. - 9. ...

10. an alien who is a victim of a severe form of trafficking in persons or effective May 1, 2006, an eligible relative of a victim of a severe form of trafficking in persons.

- B. - B.8. ...

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474, R.S. 46:231.1.B., P.L. 106-386, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 25:2448 (December 1999), amended LR 26:1342 (June 2000), LR 27:2263 (December 2001), LR 28:1599 (July 2002), LR 32:

§1225. Enumeration

A. Each applicant for, or recipient of, FITAP is required to furnish a Social Security number or to apply for a Social Security number if such a number has not been issued or is

not known, unless effective May 1, 2006, good cause has been established.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474 and R.S. 46:231.1.B., Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 25:2449 (December 1999), amended LR 26:1342 (June 2000), LR 32:

§1229. Income

A. - B.2. ...

C. Earned Income Deductions. Each individual in the income unit who has earned income is entitled to the following deductions only.

1. Standard deduction of \$120.

2. \$900 Time-Limited Deduction. This deduction is applied for six months when a recipient's earnings exceed the \$120 standard deduction. The months need not be consecutive nor within the same certification periods. The deduction is applicable for a six-month lifetime limit for the individual.

3. Dependent Care Deduction. Recipients may be entitled to a deduction for dependent care for:

a. an incapacitated adult;

b. effective May 1, 2006, a child 13 or older who is not receiving CCAP; or

c. effective May 1, 2006, the amount charged by a child care provider that exceeds the CCAP maximum for a child in care.

D. - G. ...

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq. and 10602(c), R.S. 36:474, R.S. 46:231.1.B., R.S. 46:231.2, P.L. 108-447, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 25:2449 (December 1999), amended LR 26:1342 (June 2000), LR 26:2831 (December 2000), LR 31:2956 (November 2005), LR 32:

§1245. Parenting Skills Education

A. Effective May 1, 2006, recipients who are pregnant or have a child under age one shall participate in parenting skills education as outlined in LAC 67:III.Chapter 57, §5711.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474 and R.S. 46:231.5; Act 58, 2003 Reg. Session. Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 25:2453 (December 1999), amended LR 30:494 (March 2004), LR 32:

Subchapter D. Special Initiatives

§1291. Substance Abuse Treatment Program

A. - E.4. ...

5. Failure to Cooperate. Failure or refusal of a recipient to participate in substance abuse screening, testing, or participation in the education and rehabilitation program, without good cause, will result in the following actions effective May 1, 2006.

a. At application, the application is rejected, unless the person is an 18-year-old dependent child. Exclude any 18-year old dependent child that fails to cooperate until they participate.

b. For certified cases in which the family is not work-eligible, the case will be closed for at least one month and until the client complies with this requirement, whichever is later.

c. For certified cases in which the family is work-eligible, a STEP sanction will be imposed with the appropriate occurrence and reason. The case must remain closed for the duration of the sanction period and until the client complies with this requirement, whichever is later.

d. For certified cases in which an 18-year-old dependent child fails to cooperate, exclude him from the grant until he participates.

6. ...

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq.; R.S. 36:474 and 46:231; and Act 12, 2001 Reg. Session, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 28:1492 (June 2002), amended LR 32:

Subpart 10. Individual and Family Grant Program

Chapter 45. Administration

§4501. Authority

Repealed.

AUTHORITY NOTE: Promulgated in accordance with applicable sections of 44 CFR.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 17:1226 (December 1991), repealed LR 32:

Chapter 47. Application, Eligibility, and Furnishing Assistance

Subchapter A. Need and Amount of Assistance

§4701. Maximum Grant Amount

Repealed.

AUTHORITY NOTE: Promulgated in accordance with 44 CFR 206.131, P.L. 93-288 and F.R. 54:58378.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Eligibility Determinations, LR 15:744 (September 1989), amended by the Department of Social Services, Office of Family Support, LR 17:889 (September 1991), LR 19:213 (February 1993), LR 19:784 (June 1993), LR 20:449 (April 1994), LR 21:403 (April 1995), repealed LR 32:

§4702. Flood Insurance

Repealed.

AUTHORITY NOTE: Promulgated in accordance with 44 CFR 206.131 and 44 CFR Part 61 and P.L. 93-288.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Eligibility Determinations, LR LR 15:744 (September 1989), amended by the Department of Social Services, Office of Family Support, LR 17:889 (September 1991), LR 19:213 (February 1993), LR 19:784 (June 1993), LR 20:449 (April 1994), LR 21:403 (April 1995), LR 21:837 (August 1995), LR 22:1232 (December 1996), repromulgated LR 23:591 (May 1997), repealed LR 32:

§4703. Minimum Damage Threshold

Repealed.

AUTHORITY NOTE: Promulgated in accordance with 44 CFR 206.131.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 22:1232 (December 1996), repealed LR 32:

§4704. Special Condition of Eligibility

Repealed.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193 and P.L. 104-208; 44 CFR Parts 61 and 206.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 24:1953 (October 1998), repealed LR 32:

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

Subchapter A. Application, Eligibility, and Furnishing Assistance

§5307. Notices of Adverse Action

A. A notice of adverse action shall be sent at least 13 days prior to taking action to terminate benefits. In some circumstances advance notice is not required. A concurrent notice shall be sent to the client at the time of action in the following situations:

1. - 13. ...

14. effective May 1, 2006, the child has been certified for Supplemental Security Income and that fact has been established.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474, R.S. 46:231.1.B, R.S. 46:237, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 26:351 (February 2000), amended LR 28:2565 (December 2002), LR 32:

Subchapter B. Conditions of Eligibility

§5321. Age Limit

A. Effective May 1, 2006, a dependent child must be under 18 years of age.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474, R.S. 46:231.1.B and R.S. 46:237; Act 58, 2003 Reg. Session, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 26:352 (February 2000), amended LR 30:496 (March 2004), LR 31:103 (January 2005), LR 32:

§5323. Citizenship

A. Each KCSP recipient must be a United States Citizen, a non-citizen national, or a qualified alien. A non-citizen national is a person born in an outlying possession of the United States (American Samoa or Swain's Island) on or after the date the U.S. acquired the possession, or a person whose parents are U.S. non-citizen nationals. A qualified alien is:

1. - 9. ...

10. an alien who is a victim of a severe form of trafficking in persons, or effective May 1, 2006, an eligible relative of a victim of a severe form of trafficking in persons.

B. - B. 8. ...

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474, R.S. 46:231.1.B, R.S. 46:237, P.L. 106-386, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 26:352 (February 2000), amended LR 27:2264 (December 2001), LR 28:1600 (July 2002), LR 32:

§5329. Income

A. Income is any gain or benefit to a household that has monetary value and is not considered a resource. Count all income in determining pretest eligibility except income from:

1. - 28. ...

29. effective May 1, 2006, Supplemental Security Income (SSI).

B. - B. 2.c. ...

3. For purposes of this pretest, income is defined as countable income belonging to any member of the KCSP income unit. Exception effective May 1, 2006: Income for

children receiving foster care and Supplemental Security Income is not included in the income test.

C. Income after Pretest. The child is determined eligible for KCSP if the child's countable income is, effective July 1, 2006, less than \$280. If the child's countable income is effective July 1, 2006, \$280 or more, the child is ineligible.

D. Payment Amount. Effective July 1, 2006, payment amount is \$280 per month for each eligible child.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq. and 10602(c), R.S. 36:474, R.S. 46:231.1.B, R.S. 46:237, and P.L. 108-447, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 26:353 (February 2000), amended LR 26:2832 (December 2000), LR 31:2958 (November 2005), LR 32:

§5339. Parenting Skill Education

A. As a condition of eligibility for KCSP benefits, effective May 1, 2006, any child under age 18 who is pregnant or the parent of a child under the age of one must attend a parenting skills education program as outlined in LAC 67:III.Chapter 57, §5711.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474, R.S. 46:231.1.B, R.S. 46:237, Act 58, 2003 Reg. Session, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 26:355 (February 2000), amended LR 30:496 (March 2004), LR 32:

§5341. Drug Screening, Testing, Education, and Rehabilitation

Repealed.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq., R.S. 36:474, R.S. 46:231.1.B, R.S. 46:237; Act 58, 2003 Reg. Session, Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 26:355 (February 2000), amended LR 30:497 (March 2004), repealed LR 32:

Subchapter D. Special Initiatives

§5391. Substance Abuse Treatment Program

Repealed.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq.; R.S. 36:474 and 46:231; and Act 12, 2001 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 28:1493 (June 2002), repealed LR 32:

Subpart 16. Strategies to Empower People (STEP) Program

Chapter 57. Strategies to Empower People (STEP) Program

Subchapter B. Participation Requirements

§5711. Parenting Skills Education

A. Effective May 1, 2006, FITAP and KCSP recipients who are pregnant or have a child under age one shall participate in parenting skills education as the primary work activity under the Family Success Agreement. Parenting Skills Education consists of family strengthening, parenting information, and money management information. The lessons provide key parenting practices for parents to learn child nurturance that includes care, safety, and understanding child development. Applicable child care and transportation shall be provided to participants to enable their participation.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, R.S. 46:231, R.S. 46:460, Act 58, 2003 Reg. Session, and Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 30:498 (March 2004), amended LR 32:

Family Impact Statement

1. What effect will this Rule have on the stability of the family? This Rule will have no effect on the stability of the family.

2. What effect will this Rule have on the authority and rights of persons regarding the education and supervision of their children? This Rule will have no effect on the authority and rights of persons regarding the education and supervision of their children.

3. What effect will this Rule have on the functioning of the family? This Rule will have no effect on the functioning of the family.

4. What effect will this Rule have on family earnings and family budget? This Rule will have no effect on family earnings or budget.

5. What effect will this Rule have on the behavior and personal responsibility of children? This Rule will have no effect on the behavior and personal responsibility of children.

6. Is the family or local government able to perform the function as contained in this proposed Rule? No, this program is strictly an agency function.

Interested persons may submit written comments by August 24, 2006, to Adren O. Wilson, Assistant Secretary, Office of Family Support, Post Office Box 94065, Baton Rouge, LA 70804-9065. He is responsible for responding to inquiries regarding this proposed Rule.

A public hearing on the proposed rule will be held on August 24, 2006, at the Department of Social Services, Iberville Building, 627 North Fourth Street, Seminar Room 1-129, Baton Rouge, LA at 9 a.m. All interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at said hearing. Individuals with disabilities who require special services should contact the Bureau of Appeals at least seven working days in advance of the hearing. For assistance, call (225) 342-4120 (Voice and TDD).

Ann Silverberg Williamson
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: KCSP-FTAP-STEP Parent Skills—IFG

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

Pursuant to the authority granted to the Department by Louisiana's Temporary Assistance to Needy Families Block Grant, the agency is proposing to increase monthly benefits for Kinship Care Subsidy Program (KCSP) recipients by \$58 and to remove 18-year-old recipients from the KCSP rolls.

For FY 06/07 this rule change will result in a net cost of \$4,064,568. For FY 07/08 and 08/09 the net cost will be \$4,063,968. The cost/savings are calculated as follows:

FY 06/07—The cost is based on the average number of children receiving KCSP benefits (7,416 recipients X \$58/month increase in KCSP benefits x 12 months = \$5,161,536) plus \$600 for publishing rulemaking, printing

policy changes and revising forms for a total cost of \$5,162,136. The savings are based on the average number of 18-year-old recipients who will no longer receive KCSP benefits (412 recipients X \$222 monthly grant X 12 months = \$1,097,568). This will result in a net cost of \$4,064,568 (\$5,162,136 - \$1,097,568). The Temporary Assistance for Needy Families (TANF) block grant will provide the funding for the increased cost.

FY 07/08 and 08/09—The net costs will not include the \$600 implementation costs for publishing rulemaking, printing forms and policy. \$4,064,568 - \$600 = \$4,063,968.

The other changes in this rule including the repeal of the Individual and Family Grant (IFG) Program will result in no costs or savings to any state or local governmental unit.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

There will be no impact on revenue collections for state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

The increase in KCSP payments will result in an economic benefit to approximately 7,416 children who will receive an increase of \$58 per month in KCSP benefits. Removing 18-year olds from the KCSP rolls will have a negative economic impact on approximately 412 KCSP recipients who will no longer receive \$222 per month in KCSP benefits.

There are no anticipated costs or benefits to any non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no impact on competition and employment.

Adren O. Wilson
Assistant Secretary
0607#090

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Social Services Office of Family Support

TANF Initiatives—Third Party In-Kind
Contributions—Microenterprise
(LAC 67:III.5511 and 5583)

In accordance with R.S.49:950 et seq., the Administrative Procedure Act, the Department of Social Services, Office of Family Support, proposes to adopt LAC 67:III, Subpart 15, Chapter 55, §5511 Micro-Enterprise Development Program and §5583, Third Party In-Kind Contributions as TANF MOE.

As a result of Act 1 of the 2004 Regular Legislative Session, the agency repealed several TANF Initiatives including Micro-Enterprise Development effective September 2004, as funding was no longer available. Pursuant to Act 16 of the 2005 Regular Session of the Louisiana Legislature, the agency is re-establishing this program as funds have once again been appropriated for this initiative.

As a consequence of two hurricanes striking Louisiana in 2005, the Red Cross provided certain mass care in Louisiana to persons affected by the storms. The value of certain goods, services, and expenditures provided to eligible families by the Red Cross may count toward the state's Maintenance of Effort (MOE) requirement.

The Department of Social Services (DSS) has requested that the Red Cross advise the department of the total value of expenses paid by the organization between September 1 and December 31, 2005, for mass care so that DSS may count a portion of the total value towards the state's MOE requirement. This new TANF Initiative, Third Party In-Kind Contributions as MOE, provides a mechanism to capture the information on third party in-kind contributions for use as TANF MOE.

These initiatives were effected May 1, 2006, by a Declaration of Emergency and published in the May issue of the *Louisiana Register* pursuant to Act 16 of the 2005 Regular Session of the Louisiana Legislature.

Title 67

SOCIAL SERVICES

Part III. Family Support

Subpart 15. Temporary Assistance to Needy Families (TANF) Initiatives

Chapter 55. TANF Initiatives

§5511. Micro-Enterprise Development Program

A. Effective May 1, 2006, the Office of Family Support shall enter into a Memorandum of Understanding with the Department of Economic Development to provide assistance to low-income families who wish to start their own businesses.

B. These services meet the TANF goal to end the dependence of needy parents on government benefits by promoting job preparation, work, and marriage. This goal will be accomplished by providing assistance to low-income families through the development of comprehensive micro-enterprise development opportunities as a strategy for moving parents into self-sufficiency.

C. Eligibility for services is limited to needy families, that is, a family in which any member receives a Family Independence Temporary Assistance Program (FITAP) grant, Kinship Care Subsidy Program (KCSP) grant, Food Stamps, Child Care Assistance Program (CCAP) benefits, Medicaid, Louisiana Children's Health Insurance Program (LaCHIP), Supplemental Security Income (SSI), Free or Reduced School Lunch, or who has earned income at or below 200 percent of the federal poverty level. Only the parent or caretaker relative within the needy family is eligible to participate.

D. Services are considered non-assistance by the agency.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq.; R.S. 46:231 and R.S. 36:474; Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 32:

§5583. Third Party In-Kind Contributions as TANF MOE

A. The Office of Family Support (OFS) may enter into a Memorandum of Understanding with the American Red Cross and other third-party organizations to collect information on expenditures for services provided to families following a federally-declared disaster for the purpose of claiming eligible expenditures as TANF Maintenance of Effort (MOE). Eligible expenditures include activities and services provided on a congregate basis to the community as a whole, such as sheltering, feeding, bulk distribution of items, but not including any expenses for which the federal government is obligated to reimburse the third party.

B. The third party organization shall determine the total value of the expenses and advise OFS of this value on a periodic basis.

C. OFS shall establish a methodology to estimate the percentage of total expenses that were made on behalf of TANF-eligible families following a federally-declared disaster.

D. These services meet the TANF goal to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives.

E. Financial eligibility for these services is limited to eligible families. A family consists of a minor child living with a custodial parent or an adult caretaker relative. An eligible family is one with income at or below 200 percent of the federal poverty level.

F. OFS will count eligible third party in kind contributions as TANF Maintenance of Effort (MOE) funds starting September 2005.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq.; R.S. 46:231 and R.S. 36:474; Act 16, 2005 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 32:

Family Impact Statement

1. What effect will this Rule have on the stability of the family? Implementation of this Rule will have little impact on the stability of the family.

2. What effect will this have on the authority and rights of persons regarding the education and supervision of their children? There will be no effect on the authority and rights of persons regarding the education and supervision of their children.

3. What effect will this have on the functioning of the family? This Rule will have no effect on the functioning of the family.

4. What effect will this have on family earnings and family budget? There will be no impact on family earnings and budget.

5. What effect will this have on the behavior and personal responsibility of children? There will be no effect on the behavior and personal responsibility of the children.

6. Is the family or local government able to perform the function as contained in this proposed rule? No, this program is strictly an agency function.

All interested persons may submit written comments by August 24, 2006, to Adren O. Wilson, Assistant Secretary, Office of Family Support, P.O. Box 94065, Baton Rouge, LA, 70804-9065. He is responsible for responding to inquiries regarding this proposed Rule.

A public hearing on the proposed rule will be held on August 24, 2006, at the Department of Social Services, Iberville Building, 627 North Fourth Street, Seminar Room 1-129, Baton Rouge, beginning at 9 a.m. All interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at said hearing. Individuals with disabilities who require special services should contact the Bureau of Appeals at least seven working days in advance of the hearing. For assistance, call 225-342-4120 (Voice and TDD).

Ann Silverberg Williamson
Secretary

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: TANF Initiatives—Third Party In-Kind
Contributions—Microenterprise**

**I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO
STATE OR LOCAL GOVERNMENT UNITS (Summary)**

The estimated cost for the implementation and administration of the Micro-Enterprise Development Program for FY 06/07 is \$750,160. This includes \$160 for the cost of publishing rulemaking. Louisiana's Temporary Assistance for Needy Families (TANF) Block Grant will provide monies for this increase. Future expenditures are subject to legislative appropriation. The program will be discontinued if funding is not available.

There are no costs associated with the adoption of the TANF Initiative, Third Party In-Kind Contributions for MOE, other than the cost of publishing rulemaking.

There are no savings to state or local governmental units.

**II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE
OR LOCAL GOVERNMENTAL UNITS (Summary)**

This rule will have no effect on revenue collections of state or local governmental units.

**III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO
DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL
GROUPS (Summary)**

There are no anticipated costs to any persons or non-governmental groups as a result of this rule.

The Micro-Enterprise Development Initiative will provide assistance to low-income families to start their own business. Adoption of this rule will produce economic benefits in the form of business grants to some individuals. The initiative is targeting 400 people for screening, assessment and training and approximately 110 grants of up to \$4,000 will be awarded for business startup.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)**

The rule will have no impact on competition and employment.

Adren O. Wilson
Assistant Secretary
0607#089

H. Gordon Monk
Legislative Fiscal Officer
Legislative Fiscal Office