

Emergency Rules

DECLARATION OF EMERGENCY

Department of Agriculture and Forestry
Office of Agriculture and Environmental Sciences
Seed Commission

Contaminated Seed Stock and Other Propagating Stock
(LAC 7:XIII.Chapter 3)

In accordance with the emergency provisions of the Administrative Procedure Act, R.S. 49:953(B), and under the authority of R.S. 3:1433, the Commissioner of Agriculture and Forestry declares an emergency to exist and adopts by emergency process the attached rules and regulations governing the sale, distribution and planting of contaminated seed stock, in particular, Cheniere rice.

In August of 2006, the United States Department of Agriculture (USDA) announced that trace amounts of a genetically modified trait, LibertyLink 601 (LL traits) had been found in the U.S. rice supply. Foundation seed of Cheniere rice produced in 2003 has been found to have LL traits. The announcement also indicated that based on the scientific data reviewed, the USDA and the U. S. Food and Drug Administration concluded that no human health, food safety, or environmental concerns were associated with this genetically modified rice. The rice industry in Louisiana contributes over \$250,000,000 to Louisiana's economy through the sale of rice.

Following that announcement, the rice market has experienced turmoil because of the uncertainty of being able to market such rice, despite the conclusions regarding human health, food safety and environmental concerns. Some rice importing countries have expressed concerns about genetically modified rice. The European Union has stated that the countries in the union will not buy rice contaminated with LL traits. It is vital that Louisiana's rice industry maintain the European Union as a market for Louisiana rice. Further it is necessary to forestall any embargo of rice that comes from Louisiana by other rice importing countries.

Maintaining markets for Louisiana rice is vital to both Louisiana's rice industry and to Louisiana's overall economy. The embargo by the European Union and the treat of an embargo by other rice importing countries created an imminent peril to the welfare of the citizens of Louisiana and to Louisiana's economy. The Seed Commission has determined that limiting the sale, distribution and planting of seeds of Cheniere rice and other varieties of rice that test positive for LL traits will best serve Louisiana's rice industry. This Emergency Rules is enabled by R.S. 3:1433.

This Emergency Rule becomes effective upon signature, May 23, 2007, and will remain in effect for 120 days.

Title 7

AGRICULTURE AND ANIMALS

Part XIII. Seeds

Chapter 3. Contaminated Seed Stock and Other Propagating Stock

§301. Planting of Cheniere Rice and Other Varieties with LL Traits

A. The following seeds may not be sold, offered for sale, or planted in Louisiana as seed for purposes of producing a new plant, except as otherwise provided by this Chapter:

1. the Cheniere variety of rice;
2. any portion of any variety of rice that tests positive, according to tolerances established by the department, for LL traits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, LR 33:

§303. Planting of Breeder, Foundation or Registered Cheniere Rice Seed Stock

A. Breeder, Foundation or Registered Cheniere rice seed may be sold, offered for sale or planted in Louisiana only for the purpose of seed stock increase, subject to the sampling and testing requirements set out in this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, LR 33:

§305. Planting of Breeder, Foundation or Registered Rice Seed of Other Varieties Stock

A. Breeder, Foundation or Registered seed of other varieties of rice where the variety as a whole is found to test positive, according to tolerances established by the department, for LL traits may be sold, offered for sale or planted in Louisiana only for the purpose of seed stock increase, subject to the sampling and testing requirements set out in this Chapter.

B. If a portion of a variety of rice, other than Cheniere rice, is found to test positive for LL traits according to tolerances established by the department, but there is no need to declare the variety as a whole to be contaminated with LL traits then the variety may continue to be planted in Louisiana. However, the portion found to test positive shall be placed under a "stop-sale" order.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, LR 33:

§307. Sampling of Rice Seed for the Detection of LL Traits

A. Samples of all breeder, foundation, registered and certified rice seed shall be taken by the Louisiana Department of Agriculture and Forestry (department) for testing. The department shall conduct the testing or cause the testing to be done in laboratories approved by the department. The department shall determine the method and manner of sampling and the number of samples that are needed.

B. Each sample must test negative for LL traits according to tolerances established by the department.

C. All costs incurred by the department in regard to sampling, including but not limited to the taking, transportation, testing, and disposal of samples, shall be paid by the person or entity requesting the sampling.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, LR 33:

§309. Stop-Sale

A. If any lot of breeder, foundation, registered or certified rice seed that are subject to the requirements of this Chapter tests positive for LL traits according to tolerances established by the department then such seed shall be placed under a "stop-sale" order and moved, handled or disposed of only with the express permission of the commissioner or his designate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1433.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Seed Commission, LR 33:

Bob Odom
Commissioner

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DECLARATION OF EMERGENCY

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

Hospital Services—Inpatient Hospitals
Disproportionate Share Hospital Payment Methodologies
(LAC 50:V.Chapter 3)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Emergency Rule in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgated an Emergency Rule to repeal and replace all Rules governing disproportionate share hospital payment methodologies (*Louisiana Register*, Volume 31, Number 6). In compliance with Act 182 and Act 323 of the 2005 Regular

Session, the June 20, 2005 Emergency Rule was amended to establish provisions for provider fees levied on hospitals as a result of the Healthcare Affordability Act (*Louisiana Register*, Volume 31, Number 7) and to revise the definition of a small rural hospital (*Louisiana Register*, Volume 31, Number 9). The June 20, 2005 Rule was subsequently amended to incorporate the provisions of the July 1, 2005 and September 1, 2005 Emergency Rules (*Louisiana Register*, Volume 31, Number 10).

The October 25, 2005 Emergency Rule was amended to: 1) change the provisions governing DSH payments to other uninsured hospitals; 2) establish provisions governing payments to private community hospitals for services rendered to displaced, uninsured citizens from mandatory evacuation parishes affected by Hurricanes Katrina and Rita; 3) change the provisions governing DSH payments to high uninsured hospitals and to establish provisions governing payments to public community hospitals (*Louisiana Register*, Volume 32, Number 7); and 4) revise the provisions governing disproportionate share hospital payments to non-rural community hospitals as a result of the allocation of additional funds by the Legislature during the 2006 Regular Session (*Louisiana Register*, Volume 32, Number 9). The department subsequently amended the October 25, 2005 Emergency Rule to incorporate the provisions of the June 28, 2006 and September 15, 2006 Emergency Rules (*Louisiana Register*, Volume 32, Number 10) and to revise the definition of a small rural hospital (*Louisiana Register*, Volume 33, Number 1). The department amended the October 23, 2006 Emergency Rule to incorporate the provisions of the December 18, 2006 Emergency Rule (*Louisiana Register*, Volume 33, Number 2). This Emergency Rule is being promulgated to continue the provisions of the February 21, 2007 Emergency Rule. This action is being taken to enhance federal revenue.

Effective June 22, 2007, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following provisions, as contained in the February 21, 2007 Emergency Rule, governing disproportionate share hospital payment methodologies.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Medical Assistance Program—Hospital Services

Subpart 1. Inpatient Hospitals

Chapter 3. Disproportionate Share Hospital Payment Methodologies

§301. General Provisions

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

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

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

disproportionate share allotment and the state disproportionate share appropriated amount.

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

3. DSH payments to a hospital determined under any of the methodologies described in this Chapter 3 shall not exceed the hospital's net uncompensated cost as defined in §§305-313 or the disproportionate share limits as defined in Section 1923(g)(1)(A) of the Social Security Act for the state fiscal year to which the payment is applicable. Any Medicaid profit shall be used to offset the cost of treating the uninsured in determining the hospital specific DHH limits.

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

5. Hospitals shall be notified by letter at least 60 days in advance of calculation of DSH payment to submit documentation required to establish DSH qualification. Only hospitals that timely return DSH qualification documentation will be considered for DSH payments. The required documents are:

- a. obstetrical qualification criteria;
- b. low income utilization revenue calculation;
- c. Medicaid cost report; and
- d. uncompensated cost calculation.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:

§303. Disproportionate Share Hospital Qualifications

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

1. have at least two obstetricians who have staff privileges and who have agreed to provide obstetric services to individuals who are Medicaid eligible. In the case of a

hospital located in a rural area (i.e., an area outside of a metropolitan statistical area), the term *obstetrician* includes any physician who has staff privileges at the hospital to perform nonemergency obstetric procedures; or

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

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

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

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

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

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

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

5. effective November 3, 1997, be a small rural hospital as defined in §311.A.2.a-h; or

6. effective June 28, 2006, be a public community hospital as defined in §305.A; or

7. effective June 28, 2006, be a private community hospital as defined in §307.A; or

8. effective September 15, 2006, be a non-rural community hospital as defined in §308.A; and

9. effective July 1, 1994, must also have a Medicaid inpatient utilization rate of at least 1 percent.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:

§305. Public Community Hospitals

A. Definitions

Public Community Hospital—a hospital owned by a parish, city, or other local government instrumentality that does not qualify as a small rural hospital.

Uncompensated Care Costs—net uncompensated care cost is the total allowable cost of inpatient and outpatient hospital services less Medicare costs, Medicaid payments (excluding DSH payments), costs associated with patients who have insurance for services provided, private payer payments and all other inpatient and outpatient payments received from patients.

B. DSH payments to a public community hospital shall be calculated as follows.

1. Each qualifying public community hospital shall certify to the Department of Health and Hospitals its uncompensated care costs. The basis of the certification shall be 100 percent of the hospital's allowable costs for these services, as determined by the most recently filed Medicare/Medicaid cost report. The certification shall be submitted in a form satisfactory to the department each fiscal year. The department will claim the federal share for these certified public expenditures. The department's subsequent reimbursement to the hospital may be more or less than the federal share so claimed.

C. It is mandatory that hospitals seek all third party payments including Medicare, Medicaid, other third party carriers and payments from patients. Hospitals must certify that excluded from net uncompensated cost are any costs for the care of persons eligible for Medicaid at the time of registration. Hospitals must maintain a log documenting the provision of uninsured care as directed by the department. Hospitals must adjust uninsured charges to reflect retroactive Medicaid eligibility determination. Hospitals shall submit an attestation that patients whose care is included in the hospital's net uncompensated costs are not Medicaid eligible at the time of registration.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:

§307. Private Community Hospitals

A. Definitions

Community Hospital—a private hospital that is not a small rural hospital which provided services to uninsured evacuees during the period February 1, 2006 through June 30, 2006.

Evacuee—a Louisiana citizen who resided in one of the mandatory evacuated parishes for Hurricane Katrina on August 24, 2005 or Hurricane Rita on September 23, 2005.

Mandatory Evacuated Parish or Area—a parish or a designated area of a parish for which a mandatory evacuation order was issued for Hurricane Katrina or Hurricane Rita. The parishes and designated areas include:

a. The mandatory evacuated parishes and designated areas for Hurricane Katrina include:

- i. Orleans Parish;
- ii. Jefferson Parish;
- iii. St. Bernard Parish;
- iv. Plaquemines Parish;
- v. Assumption Parish;
- vi. St. John Parish;
- vii. St. Charles Parish;
- viii. Lafourche Parish;
- ix. Terrebonne Parish;
- x. St. James Parish [south of Vacherie past LA Highway 20 and LA Highway 3127 and part of Paulina (Grand Point) past LA Highway 642 and LA Highway 3125, (zip codes 70090 and 70763)];

xi. St. Tammany Parish [all areas south of Interstate 12 including Slidell, Lacombe, Mandeville, and Covington, (zip codes 70458, 70461, 70445, 70471, 70448, 70447, 70433, and 70435)];

xii. Tangipahoa Parish [areas south of LA Highway 22 including Akers, Bedico & Lee's Landing, (zip codes 70454 and 70421)];

xiii. St. Mary Parish [Cypremont Point, (zip code 70538) and Burns (zip code 70522)]; and

xiv. Iberia Parish [areas south of LA Highway 90 and down LA Highway 14 including Delcambre, (zip codes 70560 and 70528)].

b. The mandatory evacuated parishes and designated areas for Hurricane Rita include:

- i. Calcasieu Parish;
- ii. Cameron Parish;
- iii. Jefferson Davis Parish;
- iv. Plaquemines Parish;
- v. Acadia Parish (areas south of LA Highway 92);
- vi. Jefferson Parish (Lafitte, Crown Point, Barataria and Grand Isle);

vii. Iberia Parish (Delcambre and areas south of LA Highway 90);

viii. Lafourche Parish (south of Leon Theriot Floodgate and the lower portion of Pointe-Aux-Chenes);

ix. St. Mary Parish (all areas south of the Intercoastal Canal including Cypremont Point, Burns, Four Corners, and Louisa);

x. Terrebonne Parish (Grand Caillou/Dulac, Bayou du Large/Theriot, Pointe-Aux-Chenes and from the Montegut Fire Station south); and

xi. Vermilion Parish (south of LA Highway 14 between Cameron Parish line and LA Highway 335, south of La 335, below Kaplan and Abbeville; south of Jacqueline Street in Abbeville and back to LA Highway 14 [near Erath and Delcambre], and all mobile homes south of LA Highway 14).

Uncompensated Care Costs—net uncompensated care cost is the total allowable cost of inpatient and outpatient hospital services less Medicare costs, Medicaid payments (excluding DSH payments), costs associated with patients who have insurance for services provided, private payer payments, and all other inpatient and outpatient payments received from patients.

Uninsured—a person having no health insurance or sources of third party payment for services provided.

B. DSH payments to a private community hospital shall be calculated as follows.

1. Payment for allowable evacuee uninsured services shall be calculated by multiplying each qualifying hospital's allowable uninsured evacuee charges by its hospital specific cost-to-charge ratio as determined by the department. DSH payments to each qualifying community hospital shall not exceed the hospital specific net uncompensated care costs for the state fiscal year.

C. Hospitals shall submit supporting evacuee uninsured patient specific data for hospital services provided from February 1, 2006 through June 30, 2006 in a format specified by the department. The deadline for submission of all payment requests is October 18, 2006. Submitted uninsured patient data shall be subject to verification by the department before DSH payments are made.

D. It is mandatory that hospitals seek all third party payments including Medicare, Medicaid and other third party carriers and payments from patients. Hospitals must certify that excluded from net uncompensated cost are any costs for the care of persons eligible for Medicaid at the time of registration. Hospitals must maintain a log documenting the provision of uninsured care as directed by the department. Hospitals must adjust uninsured charges to reflect retroactive Medicaid eligibility determination. Hospitals shall submit an attestation that patients whose care is included in the hospital's net uncompensated costs are not Medicaid eligible at the time of registration.

E. Aggregate DSH payments for qualifying community hospitals shall be limited to the state DSH appropriated amount for community hospitals. In the event that aggregate allowable uninsured evacuee costs for community hospitals exceeds the state appropriated amount, each qualifying hospital's payment shall be calculated as follows:

1. dividing each hospital's uninsured evacuee cost by the total uninsured evacuee cost for all qualifying other community hospitals during the state fiscal year; and then

2. multiplying by the state DSH-appropriated amount for community hospitals.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:

§308. Non-Rural Community Hospitals—SFY 2007

A. Definitions

Non-Rural Community Hospital—a non-state hospital that does not receive disproportionate share payments under any other qualification category. These hospitals may be either publicly or privately owned. In addition, psychiatric,

rehabilitation and long term hospitals may qualify for this category.

B. DSH payments to a public, non-rural community hospital shall be calculated as follows.

1. Each qualifying public, non-rural community hospital shall certify to the Department of Health and Hospitals its uncompensated care costs. The basis of the certification shall be 100 percent of the hospital's allowable costs for these services, as determined by the most recently filed Medicare/Medicaid cost report. The certification shall be submitted in a form satisfactory to the department no later than October 1st of each fiscal year. The department will claim the federal share for these certified public expenditures. The department's subsequent reimbursement to the hospital shall be in accordance with the qualifying criteria and payment methodology for non-rural community hospitals included in Act 17 and may be more or less than the federal share so claimed. Qualifying public, non-rural community hospitals that fail to make such certifications by October 1st may not receive Title XIX claim payments or any disproportionate share payments until the department receives the required certifications.

C. DSH payments to private, non-rural community hospitals located in Orleans, Jefferson, Calcasieu and Cameron Parishes shall be calculated as follows.

1. If the hospital's qualifying uninsured cost is less than 3.5 percent of total hospital cost, the payment shall be 30 percent of qualifying uninsured costs.

2. If the hospital's qualifying uninsured cost is equal to or greater than 3.5 percent of the total hospital cost but less than 6.5 percent of total hospital cost, the payment shall be 50 percent of qualifying uninsured cost.

3. If the hospital's qualifying uninsured cost is equal to or greater than 6.5 percent of total hospital cost but less than or equal to 8 percent of total hospital cost, the payment shall be 80 percent of qualifying uninsured cost.

4. If the hospital's qualifying uninsured cost is greater than 8 percent of total hospital cost, the payment shall be 90 percent of qualifying uninsured cost for the portion in excess of 8 percent of total hospital cost and 80 percent of qualifying uninsured cost for the portion equal to 8 percent of total hospital cost.

D. DSH payments to private, non-rural community hospitals located in all other parishes shall be calculated as follows:

1. If the hospital's qualifying uninsured cost is less than 3.5 percent of total hospital cost, no payment shall be made.

2. If the hospital's qualifying uninsured cost is equal to or greater than 3.5 percent of total hospital cost but less than 6.5 percent of total hospital cost, the payment shall be 50 percent of an amount equal to the difference between the total qualifying uninsured cost as a percent of total hospital cost and 3.5 percent of total hospital cost.

3. If the hospital's qualifying uninsured cost is equal to or greater than 6.5 percent of total hospital cost but less than or equal to 8 percent of total hospital cost, the payment shall be 80 percent of an amount equal to the difference between the total qualifying uninsured cost as a percent of total hospital cost and 3.5 percent of total hospital cost.

4. If the hospital's qualifying uninsured cost is greater than 8 percent of total hospital cost, the payment shall be 90

percent of qualifying uninsured cost for the portion in excess of 8 percent of total hospital cost and 80 percent of an amount equal to 4.5 percent of total hospital cost.

E. The department shall determine each qualifying hospital's uninsured percentage on a hospital-wide basis utilizing charges for dates of service from January 1, 2006 through June 30, 2006.

F. Hospitals shall submit supporting patient specific data in a format specified by the department. The deadline for submission of data used to determine qualification and the initial payment is October 31, 2006. The second payment to hospitals will be based on patient specific data for dates of service from July 1, 2006 through December 31, 2006. The deadline for submission of data used to calculate final payment is by March 31, 2007. Qualification for both payments is determined from the patient specific data for dates of services from January 1, 2006 through June 30, 2006.

1. Hospitals that were non-operational due to Hurricane Katrina and became operational between July 1, 2006 through December 31, 2006, the patient specific data during July 1, 2006 through December 31, 2006 will be used for qualification purposes.

2. Submitted hospital charge data must agree with the hospital's monthly revenue and usage reports which reconcile to the monthly and annual financial statements. The submitted data shall be subject to verification by the department before DSH payments are made.

G. In the event that the total payments calculated for all recipient hospitals are anticipated to exceed the total amount appropriated, the department shall reduce payments on a pro rata basis in order to achieve a total cost that is not in excess of the amounts appropriated for this purpose. The \$120,000,000 appropriation for the non-rural community hospital pool shall be effective only for state fiscal year 2007 and distributions from the pool shall be considered nonrecurring.

H. DSH payments shall be made as bi-annual lump sum payments.

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 33:

§309. Federally Mandated Statutory Hospitals Not Included In Any Other Group

A. Definition

Federally Mandated Statutory Hospital Not Included In Any Other Group—a hospital that meets the federal DSH statutory utilization requirements in §303.A.4.a-b.ii and is not included in any other qualifying group.

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

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

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

2. multiplying by the state disproportionate share appropriated amount for this pool of hospitals.

D. A pro rata decrease necessitated by conditions specified in §301.B.1-6 for hospitals in this group will be calculated based on the ratio determined by:

1. dividing the hospitals' Medicaid days by the Medicaid days for all qualifying hospitals in this group; then

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:

§311. Small Rural Hospitals

A. Definitions

Net Uncompensated Cost—the cost of furnishing inpatient and outpatient hospital services, net of Medicare costs, Medicaid payments (excluding disproportionate share payments), costs associated with patients who have insurance for services provided, private payer payments, and all other inpatient and outpatient payments received from patients. Any uncompensated costs of providing health care services in a rural health clinic licensed as part of a small rural hospital as defined below shall be considered outpatient hospital services in the calculation of uncompensated costs.

Small Rural Hospital—a hospital (excluding a long-term care hospital, rehabilitation hospital, or freestanding psychiatric hospital but including distinct part psychiatric units) that meets the following criteria:

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

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

i. met the qualifications of a sole community hospital as of June 30, 2005 and subsequently converts to critical access hospital status; or

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

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

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

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

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

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

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

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

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

i. has no more than 60 hospital beds or has notified DHH as of December 31, 2003 of its intent to reduce its number of hospital beds to no more than 60 and is located:

i. as measured by the 2000 census, in a municipality with a population of less than 7,000;

ii. as measured by the 2000 census, in a parish with a population of less than 53,000; and

iii. within 10 miles of a United States military base; or

j. has no more than 60 hospital beds as of September 26, 2002 and is located:

i. as measured by the 2000 census, in a municipality with a population of less than 10,000; and

ii. as measured by the 2000 census, in a parish with a population of less than 33,000; or

k. has no more than 60 hospital beds as of January 1, 2003 and is located:

i. as measured by the 2000 census, in a municipality with a population of less than 11,000; and

ii. as measured by the 2000 census, in a parish with a population of less than 90,000; or

l. has no more than 40 hospital beds as of January 1, 2005, and is located:

i. in a municipality with a population of less than 3,100; and

ii. in a parish with a population of less than 15,800 as measured by the 2000 census.

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

1. *Public (Nonstate) Small Rural Hospitals*—small rural hospitals as defined in §311.A.2 which are owned by a local government.

2. *Private Small Rural Hospitals*—small rural hospitals as defined in §311.A.2 that are privately owned.

C. Payment to hospitals included in §311.B.1-2. is equal to each qualifying rural hospital's pro rata share of uncompensated cost for all hospitals meeting these criteria for the latest filed cost report multiplied by the amount set for each pool. If the cost reporting period is not a full period (12 months), actual uncompensated cost data from the previous cost reporting period may be used on a pro rata basis to equate a full year.

D. Pro Rata Decrease

1. A pro rata decrease necessitated by conditions specified in §301.B.1-6 for rural hospitals described in this §311 will be calculated using the ratio determined by:

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

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

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

E. Qualifying hospitals must meet the definition for a small rural hospital contained in §311.A.2. Qualifying hospitals must maintain a log documenting the provision of uninsured care as directed by the department.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:

§313. Public State-Operated Hospitals

A. Definitions

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

Public State-Operated Hospital—a hospital that is owned or operated by the State of Louisiana.

B. DSH payments to individual public state-owned or operated hospitals shall be up to 100 percent of the hospital's net uncompensated costs. Final payment will be based on the uncompensated cost data per the audited cost report for the period(s) covering the state fiscal year.

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

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

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

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

specific data is required after July 1, 2003. Hospitals shall annually submit:

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

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

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

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 33:

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 at Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.
Secretary

0706#063

DECLARATION OF EMERGENCY

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

Nursing Facilities—Evacuation and Temporary Sheltering Costs (LAC 50:VII.1319)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts LAC 50:VII.1319 as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a Rule to establish a prospective payment system for nursing facilities based on recipient care needs that incorporates acuity measurements as determined under the Resource Utilization Group III (RUG III) resident classification methodology (*Louisiana Register*, Volume 28, Number 8). The August 20, 2002 Rule was subsequently amended to adopt provisions governing a quarterly adjustment of individual nursing facility rates based on overall case mix and allow for the offset of installation costs for automatic fire sprinkler systems and two-hour rated walls in Medicaid-

certified nursing facilities (*Louisiana Register*, Volume 32, Number 12).

Act 540 of the 2006 Regular Session of the Louisiana Legislature directed the department, in consultation with the Governor's Office of Homeland Security, to adopt provisions governing emergency preparedness requirements for nursing facilities, including facility-specific reimbursement for documented and allowable evacuation and temporary sheltering costs of a Medicaid-certified nursing facility. In compliance with the directives of Act 540, the department by Emergency Rule adopted provisions governing the reimbursement methodology for nursing facilities to provide for the facility-specific reimbursement of evacuation and temporary sheltering costs of Medicaid-certified nursing facilities (*Louisiana Register*, Volume 33, Number 3). This Emergency Rule is being promulgated to continue the provisions of the March 20, 2006 Emergency Rule. This action is being taken to prevent imminent peril to the health and well-being of nursing facility residents who may be evacuated as a result of disasters or other emergencies.

Effective March 20, 2007, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part VII. Long Term Care Services

Subpart 1. Nursing Facilities

Chapter 13. Reimbursement

§1319. Evacuation and Temporary Sheltering Costs

A. Nursing facilities required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

1. The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

2. Nursing facilities must first apply for evacuation or sheltering reimbursement from all other sources and request that the department apply for FEMA assistance on their behalf.

3. Nursing facilities must submit expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid nursing home residents to the department.

B. Eligible Expenses. Expenses eligible for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the department's discretion and may include the following:

1. Evacuation Expenses. Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another nursing facility. Evacuation expenses include:

a. resident transportation and lodging expenses during travel;

b. nursing staff expenses when accompanying residents, including:

- i. transportation;
- ii. lodging; and

iii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented.

(a). The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

c. any additional allowable costs as defined in the CMS Publication 15-1 that are directly related to the evacuation and that would normally be allowed under the nursing facility case-mix rate.

2. Non-nursing Facility Temporary Sheltering Expenses. Non-nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-nursing facility temporary shelter to the date all Medicaid residents leave the shelter. A non-nursing facility temporary shelter includes shelters that are not part of a licensed nursing facility and are not billing for the residents under the Medicaid case-mix reimbursement system or any other Medicaid reimbursement system. Non-nursing facility temporary sheltering expenses may include:

a. additional nursing staff expenses including:

i. lodging; and

ii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented.

(a). The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

b. care-related expenses as defined in the nursing facility case-mix rate system and incurred in excess of care-related expenses prior to the evacuation;

c. additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents; and

i. these expenses will be capped at a daily rental fee not to exceed the total purchase price of the item;

ii. the allowable daily rental fee will be determined by the department;

d. any additional allowable costs as defined in the CMS Publication 15-1 that are directly related to the temporary sheltering and that would normally be allowed under the nursing facility case-mix rate.

3. Host Nursing Facility Temporary Sheltering Expenses. Host nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed nursing facility to the date all temporary sheltered Medicaid residents are discharged from the nursing facility, not to exceed a six-month period.

a. The host nursing facility shall bill for the residents under Medicaid's case-mix reimbursement system.

b. Additional direct care expenses may be submitted when a direct care expense increase of 10 percent or more is documented.

i. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

C. Payment of Eligible Expenses

1. For payment purposes, total eligible Medicaid expenses will be the sum of non resident-specific eligible

expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses.

a. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

2. Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the department by the end of each calendar quarter.

3. All eligible expenses documented and allowed under §1319 will be removed from allowable expense when the nursing facility's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set case-mix reimbursement rates in future years.

a. Equipment purchases that are reimbursed on a rental rate under §1319.B.2.c may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the nursing facility and being used. If the remaining basis requires capitalization under CMS Publication 15-1 guidelines, then depreciation will be recognized.

4. Payments shall remain under the upper payment limit cap for nursing facilities.

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 33:

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 Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.
Secretary

0706#064

DECLARATION OF EMERGENCY

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

Nursing Facility Minimum Licensing Standards
Emergency Preparedness
(LAC 48:I.9729)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends LAC 48:I.9729 as authorized by R.S. 36:254 and R.S. 40:2009.1-2116.4. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgated a Rule to adopt minimum licensing standards for nursing homes (*Louisiana Register*, Volume 24, Number 1).

Act 540 of the 2006 Regular Session of the Louisiana Legislature directed the department, in consultation with the Governor's Office of Homeland Security, to adopt provisions governing emergency preparedness requirements for nursing facilities. In compliance with the directives of Act 540, the department amended the January 20, 1998 Rule to revise the provisions governing emergency preparedness requirements for nursing facilities (*Louisiana Register*, Volume 32, Number 12). The department now proposes to amend the December 20, 2006 Rule to further revise and clarify the provisions governing emergency preparedness requirements for nursing facilities.

This action is being taken to prevent imminent peril to the health and well-being of Louisiana citizens who are residents of nursing facilities that may be evacuated as a result of declared disasters or other emergencies. It is anticipated that the implementation of this Emergency Rule will have no programmatic costs for state fiscal year 2006-2007.

Effective June 10, 2007, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the provisions governing emergency preparedness requirements for nursing facilities.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensing

Chapter 97. Nursing Homes

Subchapter B. Organization and General Services

§9729. Emergency Preparedness

A. The nursing facility shall have an emergency preparedness plan which conforms to the Louisiana Model Nursing Home Emergency Plan and these regulations. The plan shall be designed to manage the consequences of declared disasters or other emergencies that disrupt the facility's ability to provide care and treatment or threatens the lives or safety of the residents. The facility shall follow and execute its approved emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency.

1. Upon the department's request, a nursing facility shall forward its emergency preparedness information and documentation for review.

a. Emergency preparedness information and documentation shall, at a minimum, include:

- i. a copy of the nursing facility's emergency preparedness plan;
- ii. updates, amendments, modifications or changes to the nursing facility's emergency preparedness plan;
- iii. the number of operational beds; and
- iv. census information, including transportation requirements for residents.

2. After reviewing the nursing facility's plan, if the department determines that the plan is not viable or does not promote the health, safety and welfare of nursing facility residents, the facility shall, within 10 days of notification,

respond with an acceptable plan of correction to amend its emergency preparedness plan.

B. The emergency preparedness plan shall be individualized and site specific. At a minimum, the nursing facility shall have a written emergency preparedness plan that addresses:

1. the nursing facility's procedures and criteria for determining if they should evacuate the facility or shelter in place:

a. for evacuation determinations, the nursing facility's plan shall provide for a primary sheltering host site(s) and alternative sheltering host sites outside the area of risk. These host sites must be verified by written agreements or contracts;

b. if the state or parish Office of Homeland Security and Emergency Preparedness (OHSEP) has ordered a mandatory evacuation of the parish or area in which the nursing facility is located, the facility shall evacuate unless the facility receives a written exemption from the ordering authority;

c. the nursing facility shall provide a plan for monitoring weather warnings and watches and evacuation orders from local and state emergency preparedness officials;

2. the delivery of essential care and services to residents, whether the residents are housed in the nursing facility, at an off-site location, or when additional residents are housed in the nursing facility during an emergency;

3. the provisions for the management of staff, including provisions for adequate, qualified staff as well as provisions for distribution and assignment of responsibilities and functions, either within the nursing facility or at another location;

4. an executable plan for coordinating transportation services, that shall be air-conditioned when available, required for evacuating residents to another location, including the following:

a. a triage system for residents requiring specialized transportation and medical needs; and

b. a written binding transportation agreement(s) for evacuating residents to a safe location; or

c. a written plan for using transportation equipment owned by, or at the disposal of, the facility;

5. the procedures to notify the resident's family or responsible representative whether the facility is sheltering in place or evacuating. If the facility evacuates, notification shall include:

a. the date and approximate time that the facility is evacuating;

b. the place or location to which the nursing facility is evacuating, including the:

i. name;

ii. address; and

iii. telephone number;

c. a telephone number that the family or responsible representative may call for information regarding the facility's evacuation;

6. the procedure or method whereby each nursing facility resident has a manner of identification attached to his person which remains with him at all times in the event of sheltering in place or evacuation;

7. the procedure or method whereby each nursing facility resident has the following minimum information included with him during all phases of an evacuation:

- a. current and active diagnosis;
- b. medications, including dosage and times administered;
- c. allergies;
- d. special dietary needs or restrictions; and
- e. next of kin, including contact information;

8. the procedure for ensuring that an adequate supply of the following items accompany residents on buses or other transportation during all phases of evacuation:

- a. water;
- b. food;
- c. nutritional supplies and supplements;
- d. medication; and
- e. other necessary supplies.

9. the procedures for ensuring that licensed nursing staff accompany residents on buses or other transportation during all phases of evacuation;

10. staffing patterns for sheltering in place and for evacuation, including contact information for such staff;

11. a plan for sheltering in place if the nursing facility determines that sheltering is appropriate;

a. If the nursing facility shelters in place, the facility's plan shall include provisions for seven days of necessary supplies on hand to include:

- i. drinking water, a minimum of one gallon per day per person;
- ii. water for sanitation;
- iii. non-perishable food, including special diets;
- iv. medications;
- v. medical supplies;
- vi. personal hygiene supplies; and
- vii. sanitary supplies;

b. a posted communications plan for contacting emergency services and monitoring emergency broadcasts. The communication plan shall include:

- i. the type of equipment;
- ii. back-up equipment;
- iii. the equipment's testing schedule; and
- iv. the power supply for the equipment being used;

and

c. generator capabilities to include:

- i. HVAC system;
- ii. sewerage system;
- iii. water system;
- iv. medical equipment;
- v. refrigeration;
- vi. lights;
- vii. communications; and
- viii. a plan for a seven day supply of fuel; and

12. the nursing facilities subject to the provisions of R.S. 40:2009.25(A) shall have conducted a risk assessment of their facility to determine facility integrity in determining whether sheltering in place is appropriate. The assessment shall be reviewed and updated annually. The risk assessment shall include the following:

- a. the facility's latitude and longitude;
- b. flood zone determination, using the nursing facility's latitude and longitude;

c. elevations of the building(s), HVAC system(s), generator(s), fuel storage, electrical service and sewer motor, if applicable;

d. a building evaluation to include:

- i. the construction type;
- ii. roof type;
- iii. windows and shutters;
- iv. wind load; and
- v. interior safe zones;

e. an evaluation of each generator's fuel source(s), including refueling plans, output of the generator(s) and electrical load of required emergency equipment;

f. an evaluation of surroundings, including lay-down hazards and hazardous materials, such as:

- i. trees;
- ii. towers;
- iii. storage tanks;
- iv. other buildings; and
- v. pipe lines;

g. an evaluation of security for emergency supplies;

h. Sea, Lake and Overland Surge from Hurricanes (SLOSH) Modeling using the Maximum's of the Maximum Envelope of Waters (MOM); and

i. floor plans, of the building being used as the facility's shelter site, that indicate:

- i. the areas being used as shelter or safe zones;
- ii. emergency supply storage areas;
- iii. emergency power outlets;
- iv. communications center;
- v. posted emergency information; and
- vi. pre-designated command post.

C. Emergency Plan Activation, Review and Summary

1. The nursing facility's plan shall be activated at least annually, either in response to an emergency or in a planned drill. The facility's performance during the activation of the plan shall be evaluated and documented. The plan shall be revised if indicated by the nursing facility's performance during the emergency event or the planned drill.

2. Nursing facilities subject to the provisions of R.S. 40:2009.25(B) shall submit a summary of the updated plan to the Department's Nursing Facility Emergency Preparedness Manager by March 1 of each year. If changes are made during the year, a summary of the amended plan shall be submitted within 30 days of the modification.

D. The nursing facility's plan shall be submitted to the OHSEP. Any recommendations by the OHSEP regarding the nursing facility's plan shall be documented and addressed by the facility.

E. ...

F. Evacuation, Temporary Relocation or Temporary Cessation

1. In the event that a nursing facility evacuates, temporarily relocates or temporarily ceases operation at its licensed location as a result of an evacuation order issued by the state or parish OHSEP, due to a declared disaster or other emergency, and that nursing facility sustains damages due to wind, flooding or experiences power outages for longer than 48 hours, the nursing facility shall not be reopened to accept returning evacuated residents or new admissions until surveys have been conducted by the Office of the State Fire Marshal, the Office of Public Health and the Bureau of

Health Services Financing, Health Standards Section, and the facility has received a letter of approval from the department for reopening the facility.

a. The purpose of these surveys is to assure that the facility is in compliance with the licensing standards including, but not limited to, the structural soundness of the building, the sanitation code, staffing requirements and the execution of emergency plans.

b. The Health Standards Section, in coordination with state and parish OHSEP, will determine the facility's access to the community service infrastructure, such as hospitals, transportation, physicians, professional services and necessary supplies.

c. The Health Standards Section will give priority to reopening surveys.

2. If a nursing facility evacuates, temporarily relocates or temporarily ceases operation at its licensed location as a result of an evacuation order issued by the state or parish OHSEP, due to a declared disaster or other emergency, and the nursing facility does not sustain damages due to wind, flooding or experiences power outages for longer than 48 hours, the nursing facility may be reopened without the necessity of the required surveys. Prior to reopening, the nursing facility shall notify the Health Standards Section in writing that the facility is reopening.

G. Authority to Reopen and Execution of Emergency Preparedness Plan

1. Before reopening at its licensed location, the nursing facility shall submit a written initial summary within 14 days from the date of evacuation to the licensing agency attesting how the facility's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

a. - d. ...

e. a list of all injuries and deaths of residents that occurred during the execution of the plan, evacuation and temporary relocation including the date, time, causes and circumstances of the injuries and deaths.

2. A more detailed report shall be submitted upon request by the licensing agency.

2.a. - c. Repealed.

H. Sheltering in Place

1. If a nursing facility shelters in place at its licensed location during a declared disaster or other emergency, the nursing facility shall submit a written initial summary within 14 days from the date of the emergency event to the licensing agency attesting how the facility's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

a. pertinent plan provisions and how the plan was followed and executed;

b. plan provisions that were not followed;

c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

d. contingency arrangements made for those plan provisions not followed; and

e. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of these injuries and deaths.

2. A more detailed report shall be submitted upon request by the licensing agency.

I. Unlicensed Sheltering Sites

1. In the event that a nursing facility evacuates, temporarily relocates or temporarily ceases operations at its licensed location due to an evacuation order issued by the state or parish OHSEP, the nursing facility shall be allowed to remain at an unlicensed sheltering site for a maximum of five days. A nursing facility may request one extension, not to exceed five days, to remain at the unlicensed sheltering site.

a. The request shall be submitted in writing to the Health Standards Section and shall be based upon information that the nursing facility's residents will return to its licensed location, or be placed in alternate licensed nursing home beds within the extension period requested.

b. The extension will be granted for good cause shown and for circumstances beyond the control of the nursing facility.

c. This extension will be granted only if essential care and services to residents are ensured at the current sheltering facility.

2. Upon expiration of the five days or upon expiration of the written extension granted to the nursing facility, all residents shall be relocated to a licensed nursing facility and the Health Standards Section and OHSEP shall be informed of the residents' new location(s).

J. Notification

1. In the event that a nursing facility evacuates, temporarily relocates or temporarily ceases operations at its licensed location as a result of an evacuation order issued by the state or parish OHSEP, the nursing facility must immediately give notice to the Health Standards Section and OHSEP by facsimile or email of the following:

a. the date and approximate time of the evacuation;

b. the sheltering host site(s) to which the nursing facility is evacuating; and

c. a list of residents being evacuated, which shall indicate the evacuation site for each resident.

2. Within 48 hours, the nursing facility must notify the Health Standards Section and OHSEP of any deviations from the intended sheltering host site(s) and must provide the Health Standards Section and OHSEP with a list of all residents and their locations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2009.1-2116.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 24:49 (January 1998), amended LR 32:2261 (December 2006), LR 33:

Interested persons may submit written comments to Jerry Phillips, Department of Health and Hospitals, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.
Secretary

0706#031

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Office for Citizens with Developmental Disabilities

Home and Community Based Services Waivers
New Opportunities Waiver—Emergency Opportunities
(LAC 50:XXI.13707)

The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities proposes to amend LAC 50:XXI.13707 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. 49:95(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Appropriations Bill of the 2004 Regular Session of the Legislature allocated funds for the establishment of 66 emergency slots for the New Opportunities Waiver (NOW) program and mandated the development and enforcement of rules established under the Administrative Procedure Act to create an equitable and precise methodology for defining an emergency and the issuance of such slots. The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities promulgated an Emergency Rule that established the provisions governing emergency waiver opportunities. In addition, the bureau repealed the rules governing programmatic allocation of MR/DD Waiver slots and adopted those provisions to govern the programmatic allocation of waiver opportunities for NOW (*Louisiana Register*, Volume 30, Number 8). Subsequently, the bureau amended the August 20, 2004 Rule to clarify the provisions governing allocation of waiver opportunities for persons transitioning from publicly operated to private ICF-MR facilities (*Louisiana Register*, Volume 31, Number 11). The department by Emergency Rule amended the provisions of the November 20, 2005 Rule to create an additional 100 emergency waiver opportunities (*Louisiana Register*, Volume 33, Number 3). This Emergency Rule is being promulgated to continue the provisions of the March 1, 2007 Emergency Rule.

This action is being taken to promote the health and welfare of those individuals with developmental disabilities by facilitating access to waiver services.

Effective June 29, 2007, the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities amends the provisions governing the programmatic allocation of waiver opportunities in the New Opportunities Waiver.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE Part XXI. Home and Community Based Services Waivers

Subpart 11. New Opportunities Waiver

Chapter 137. General Provisions

§13707. Programmatic Allocation of Waiver Opportunities

A. - C.6. ...

7. One hundred and sixty-six waiver opportunities shall be used for qualifying individuals with developmental

disabilities who require emergency waiver services. In the event that a waiver opportunity is vacated, the opportunity will be returned to the emergency pool for support planning based on the process for prioritization. Once the 166 waiver opportunities are filled, then supports and services based on the priority determination system will be identified and addressed through other resources currently available for individuals with developmental disabilities.

C.8. - D. ...

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, Office for Citizens with Developmental Disabilities, LR 31:2900 (November 2005), amended LR 33:

Interested persons may submit written comments to Kathy Kliebert, Office for Citizens with Developmental Disabilities, P.O. Box 3117, Baton Rouge, LA 70821-3117. She is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.
Secretary

0706#062

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of the Secretary Office for Citizens with Developmental Disabilities

Home and Community-Based Services Waivers
Supports Waiver—Support Coordination Services
(LAC 50:XXI.5715, 5901 and 6101)

The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities adopts LAC 50:XXI.5715 and amends §§5901 and 6101 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities implemented a new home and community-based services waiver, called the supports waiver, to promote the independence of individuals with developmental disabilities by creating vocational and community inclusion options to enhance their lives (*Louisiana Register*, Volume 32, Number 9).

Waiver recipients currently receive support coordination for the supports waiver through targeted case management services provided under the Medicaid State Plan and paid from all state general funds, pending approval of the associated Medicaid State Plan amendment. The department now proposes to amend the September 20, 2006 Rule governing the services covered in the supports waiver to include support coordination as a covered service.

This action is being taken to secure enhanced federal funding and eliminate the reliance on state general funds for support coordination services provided to supports waiver recipients. It is estimated that implementation of this Emergency Rule will increase expenditures in the Supports Waiver Program by approximately \$69,797 for state fiscal year 2006-2007.

Effective June 20, 2007, the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities amends the provisions governing the Supports Waiver to establish support coordination as a covered service.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community Based Services
Waivers

Subpart 5. Supports Waiver

Chapter 57. Covered Services

§5715. Support Coordination

A. Support Coordination is a service that will assist recipients in gaining access to all of their necessary services, as well as medical, social, educational and other services, regardless of the funding source for the services. Support coordinators shall be responsible for on-going monitoring of the provision of services included in the recipient's approved CPOC.

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, Office for Citizens with Developmental Disabilities, LR 33:

Chapter 59. Provider Participation

§5901. General Provisions

A. - C.5. ...

6. Support Coordination. Providers must be licensed as support coordination agencies and enrolled in the Medicaid Program to deliver these services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended LR 33:

Chapter 61. Reimbursement

§6101. Reimbursement Methodology

A. - H. ...

J. Support Coordination. Support coordination shall be reimbursed at a fixed monthly rate in accordance with the terms of the established contract.

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, Office for Citizens with Developmental Disabilities, LR 32:1607 (September 2006), amended LR 33:

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 Kathy Kliebert, Office for Citizens with Developmental Disabilities, P.O. Box 3117, Baton Rouge, LA 70821-3117. She is responsible for responding to inquiries regarding this

Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.
Secretary

0706#060

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Office of the Secretary
Office for Citizens with Developmental Disabilities

Targeted Case Management
Individuals with Developmental Disabilities
(LAC 50:XV.10501, 10505 and 11701)

The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities proposes to amend LAC 50:XV.10501, 10505 and 11701 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted provisions governing case management services provided to targeted population groups and certain home and community-based services waiver recipients (*Louisiana Register*, Volume 25, Number 7). In May 2004, the bureau repromulgated the July 1999 Rule in a codified format in Title 50 of the Louisiana Administrative Code (*Louisiana Register*, Volume 30, Number 5). The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities implemented a new home and community-based services waiver for persons with developmental disabilities, called the supports waiver. The department amended the provisions governing targeted case management to include recipients receiving services in the supports waiver and to change the name of the Mentally Retarded/Developmentally Disabled Waiver (*Louisiana Register*, Volume 32, Number 9). Case management services for supports waiver recipients are currently being paid from all state general funds pending approval of the associated Medicaid State Plan Amendment. The department now proposes to amend the provisions of the September 20, 2006 Rule governing targeted case management to remove the coverage of case management services for supports waiver recipients. Case management services shall be provided as support coordination services and included as a covered service in the supports waiver program.

This action is being taken to secure enhanced federal funding and eliminate the reliance on state general funds for case management services provided to supports waiver recipients. It is anticipated that implementation of this Emergency Rule will reduce expenditures for Targeted Case Management by approximately \$69,797 for state fiscal year 2006-2007.

Effective June 20, 2007, the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with

Developmental Disabilities amends the provisions governing Targeted Case Management to remove the coverage of case management services for supports waiver recipients.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 7. Targeted Case Management

Chapter 105. Provider Participation

§10501. Participation Requirements

A. - D.7. ...

8. assure the recipient's right to elect to receive or terminate case management services (except for recipients in the New Opportunities Waiver, Elderly and Disabled Adult Waiver and Children's Choice Waiver programs). Assure that each recipient has freedom of choice in the selection of an available case management agency (every six months), a qualified case manager or other service providers and the right to change providers or case managers;

9. - 12. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1037 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 33:

§10505. Staff Education and Experience

A. - E.1.d. ...

e. Targeted EPSDT; and

f. Children's Choice Waiver

2. - 2.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 Community Supports and Services, LR 29:38 (January 2003), LR 30:1038 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 33:

Chapter 117. Individuals with Developmental Disabilities

§11701. Introduction

A. The targeted population for case management services shall consist of individuals with developmental disabilities who are participants in the new opportunities waiver.

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 30:1043 (May 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 32:1608 (September 2006), amended LR 33:

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 Kathy Kliebert, Office for Citizens with Developmental Disabilities, P.O. Box 3117, Baton Rouge, LA 70821-3117.

She is the person responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.
Secretary

0706#061

DECLARATION OF EMERGENCY

Department of Public Safety and Corrections State Uniform Construction Code Council

State Uniform Construction Code (LAC 55:VI.301)

The Louisiana Department of Public Safety and Corrections, Louisiana State Uniform Construction Code Council hereby adopts the following Emergency Rule governing the implementation of Act 12 of the 2005 First Extraordinary Session, R.S. 40:1730.21 et seq. This Rule is being adopted in accordance with the Emergency Rule provisions of R.S. 49:953(B) of the Administrative Procedure Act. This Emergency Rule becomes effective on the date of the signature, May 24, 2007, by the authorized representative of the Louisiana State Uniform Construction Council and shall remain in effect for the maximum period allowed by the APA, which is 120 days.

As a result of the widespread damage caused by Hurricanes Rita and Katrina, the Legislature enacted and mandated a state uniform construction code to promote public safety and building integrity. This new code went into effect statewide on January 1, 2007. The Louisiana State Uniform Construction Code Council ("Council") promulgated rules governing the adoption of the state uniform construction code. The council instituted, in the regular rulemaking process, a Rule pertaining to the International Residential Code, more specifically Chapter 3, Paragraph A.3. In this previous Rule, Part V-Mechanical and Part VIII-Electrical were excluded from the adoption of the International Residential Code. The International Mechanical Code and National Electrical Code, used for commercial projects, refer the user to these chapters of the International Residential Code. Without these chapters included in the International Residential Code, we do not have mechanical and electrical codes for residential construction. Therefore, the Rule is being amended to include the mechanical and electrical chapters into the International Residential Code. Immediately adopting this Rule will provide for mechanical and electrical code standards for residential structures and simplify the process for code enforcement.

Title 55

PUBLIC SAFETY

Part VI. Uniform Construction Code

Chapter 3. Adoption of the Louisiana State Uniform Construction Code

§301. Louisiana State Uniform Construction Code

A. - A.2. ...

3. International Residential Code, 2006 Edition, not including Parts I-Administrative and VII-Plumbing. The

applicable standards referenced in that code are included for regulation of construction within this state. Appendix J, Existing Buildings and Structures, is also included for mandatory regulation. For purposes of this Part, Section R301.2.1.1 of the 2003 edition of the International Residential Code is hereby specifically adopted in lieu of the 2006 edition and shall be effective until January 1, 2008. Furthermore, IRC R301.2.1.1 (Design Criteria) shall be amended as follows and shall only apply to the International Residential Code:

- a. Amendment of R301.2.1.1 (Design Criteria);
- b. Item 6, the American Concrete Institute, Guide to Concrete Masonry Residential Construction in High Winds Areas, shall be added;
- c. Item 7, Institute for Business and Home Safety, Optional Code-plus Fortified for Safer Living, shall be added;
- d. Item 8, Federal Alliance for Safe Homes, Optional Code-plus Blueprint for Safety, shall be added.

4. - 7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1730.22(C) and (D).

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, State Uniform Construction Code Council, LR 33:291 (February 2007), amended LR 33:

Jill Boudreaux
Undersecretary

0706#002

DECLARATION OF EMERGENCY

Department of Social Services Military Family Assistance Board

Military Family Assistance (LAC 67:III.Chapters 59-67)

In accordance with the Administrative Procedure Act, R.S. 49:953(B), and R.S. 46:120 et seq., the Military Family Assistance Board finds that these emergency rules regulating the eligibility, application, consideration and disbursement process under the Military Family Assistance Act are necessary to prevent imminent peril to the public health, safety and welfare.

In 2005, the Louisiana legislature created the Military Family Assistance Program ("Program") as a payer of last resort to provide emergency financial assistance to military families with direct and immediate financial needs as the result of the military service of a family member. The Program is currently funded solely through donations and began its existence with no funds to disburse. Over the past almost two years, donations have been made to the Program such that the program now has, according to the State Treasurer's Office, approximately \$158,900.00 on deposit.

Now that the program has sufficient funds on hand to begin disbursements, it is necessary that these rules be adopted on an emergency basis in order to begin accepting and processing program applications without further delay.

These rules are hereby adopted, May 24, 2007, and shall remain in effect for 120 days.

Title 67

SOCIAL SERVICES

Part III. Family Support

Subpart 17. Military Family Assistance

Chapter 59. Authority, Construction and Definitions

§5901. Authority

A. Rules and regulations are hereby established by the Military Family Assistance Board by order of the Military Family Assistance Act, R.S. 46: 120, et seq., Act 151 of the 2005 Louisiana Legislature.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

§5903. Construction of Regulations; Severability

A. Nothing contained in these rules shall be so construed as to conflict with any provision of the Act or any other applicable statute. If any provision of any rule or regulation is held invalid by any state or federal court in Louisiana, such provision shall be deemed severed from the rule and the court's finding shall not be construed to invalidate any of the other provisions of the rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

§5905. Definitions

A. The following terms as used in these regulations, unless the context otherwise requires or unless redefined by a particular part hereof, shall have the following meanings:

Activated Military Personnel or *Activated Military Person*—a person domiciled in Louisiana for civilian purposes, names Louisiana as Home of Residence (HOR) for military purposes, and who is a member of a reserve component of the United States Army, Navy, Air Force, Marine Corps, or Coast Guard, including the Louisiana National Guard, and called to active federal service in excess of thirty days or who is a member of the Louisiana National Guard and called to active state service pursuant to R.S. 29:7.

Application—a written request for financial assistance from the Military Family Assistance Program made on the form captioned Military Family Assistance Program Request Form, together with documents related thereto.

Approval Authority—the third party administrator for all need-based claims of \$1500 or less; the Fund Committee for all need-based claims of greater than \$1500 up to \$2500; and the board for all need-based claims of greater than \$2500. The Fund Committee and the board are the approval authority for all claims for one-time lump sum payments and all claims appealed by an eligible applicant.

Board—the Louisiana Military Family Assistance Board.

Claimant—an eligible applicant.

Eligible Applicant—activated military personnel or a family member of activated military personnel.

Family Member of Activated Military Personnel—the primary next of kin or an immediate family member.

Final Appeal—an appeal to the Louisiana Military Family Assistance Board.

Fund Committee—the committee comprised of three board members appointed by the Chairman of the board to assist in administering the Louisiana Military Family Assistance Program which committee shall also serve as an appellate body for all claims of \$1500.00 or less before a final appeal is made to the full board.

Immediate Family Member—with respect to an activated military person:

- a. a spouse;
- b. a natural child, adopted child, step child, or illegitimate child, if acknowledged by the person or parenthood has been established by a court of competent jurisdiction, except that if such child has not attained the age of 18 years, the term means a surviving parent or legal guardian of such child;
- c. any other person claimed as a dependent on the federal income tax of the activated military person;
- d. a biological or adoptive parent, unless legal custody of the person by the parent has been previously terminated by reason of a court decree or otherwise under law and not restored;
- e. a brother or sister of the person, if such brother or sister has attained the age of 18 years; or
- f. any other person, if such person was given sole legal custody of the person by a court decree or otherwise under law before the person attained the age of 18 years and such custody was not subsequently terminated before that time.

Third Party Administrator—the Louisiana Office of the Attorney General.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

Chapter 61. Eligibility and Application Process

§6101. Eligibility

A. To be eligible for a grant from the Louisiana Military Family Assistance Program, an individual must be either an activated military person or the family member of an activated military person.

B. The activated military person must have served in excess of 30 consecutive days of active duty since September 11, 2001 before the activated military person or any family member may submit an application for assistance to the Louisiana Military Family Assistance Program.

C. The Military Family Assistance Program is a payer of last resort. All applicants shall seek assistance from other available sources prior to making application to the Military Family Assistance Program. Other available sources include, but are not limited to, Army Emergency Relief, Air Force Aid Society, Navy-Marine Corps Relief Society, Coast Guard Mutual Assistance, Salvation Army, American Red Cross, and Veterans' Emergency Assistance.

D. The approval authority may, in its sole discretion, waive the requirement to seek assistance from other available sources when unusual or exigent circumstances make such application impractical or unlikely to produce results in a timely manner or when the applicant shows that the circumstances are such that other potential sources of funds are inapplicable to the particular circumstances.

E. Requests for assistance from the Military Family Assistance Fund shall not be bifurcated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

§6103. Application Process

A. Eligible Applicant Responsibilities

1. All requests for assistance shall be made through a completed Louisiana Military Family Relief Assistance Program Request Form.

2. An application is not complete unless it is signed by the applicant and contains all information requested by the form.

3. All applicants shall provide all additional information requested by the Military Family Assistance Board, the Fund Committee, or the third party administrator. Failure to provide additional requested information may result in the denial of the application.

4. Applications for assistance from the Military Family Assistance Program shall include copies of applications for other types of assistance filed by the applicant.

5. Applications, together with all supporting documents, shall be mailed to: Office of the Attorney General, Attn: MFA Third Party Administrator, 1885 North Third Street, Baton Rouge, LA 70801.

6. To expedite the application process, applications and supporting documents may be sent by facsimile transmission to MFA third party administrator. If the application and supporting documents are faxed, an application with the applicant's original signature must also be mailed, along with all supporting documents, to the third party administrator. The approval authority shall not approve or pay a request for assistance until an original application is received.

7. An application for assistance from the Military Family Assistance Fund shall be considered made as of the date that it is received by the third party administrator, provided that for all applications received by facsimile transmission, an application with the applicant's original signature is subsequently received by the third party administrator.

8. If an individual acts on behalf of an eligible applicant in preparing and submitting the application, a copy of a fully executed power of attorney authorizing the individual preparing and submitting the application to act on the eligible applicant's behalf must be submitted as an attachment to the application.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

Chapter 63. Types of Grant Awards; Maximum Award Amounts; Minimum Level in Fund

§6301. Types of Grants; Restrictions on Awards

A. Two types of grants may be made by the Military Family Assistance Fund:

1. grants for need-based assistance; and
2. grants for one-time lump sum awards.

B. No request shall be approved by the board, the Fund Committee, or the third party administrator that does not meet the requirements of the law or the rules.

C. The request of an eligible applicant may be denied if the activated military personnel is not in good standing with

the appropriate military unit at the time the application is submitted or the time payment is made.

D. The board may disapprove a request for assistance if the board determines that the grant of an award under the facts and circumstances of a particular case is not be in the best interests of the board or the State of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

§6303. Award Amounts

A. The maximum dollar amount that may be awarded on behalf of an activated military person for a need-based claim per twelve month period is \$ 10,000.

B. The maximum dollar amount for need-based claims shall apply per active duty order.

C. One uniform maximum dollar amount that may be awarded on behalf of an activated military person for a one-time lump sum award shall be \$700. With respect to one-time lump sum awards, the following shall apply.

1. An eligible applicant may be awarded an additional one-time lump sum award for cost directly related to a service related death or an injury with a greater than fifty percent residual disability.

2. One-time lump sum awards are addition to, and not in lieu of, need-based awards.

3. A one-time lump sum award may be made only when extenuating circumstances are present. Extenuating circumstances include, but are not limited to:

a. the circumstance in which the injured military person is recuperating in a location away from home that necessitates travel by family members to visit with the injured military person. Costs associated with transportation, lodging, meals, and other related matters not covered by any other source to enable family members to visit an activated military person with a service related injury with a greater than fifty percent residual disability, whether the extent of the disability has been determined at the time application is made or is reasonably anticipated to result in a greater than fifty percent residual disability at the time application is made, may be requested;

b. the circumstance in which the funeral of an activated military person necessitates travel by family members to attend the funeral. Costs associated with transportation, lodging, meals, and other related matters not covered by any other source to enable family members to attend the funeral of an activated military person may be requested;

c. the circumstance in which the absence of family members to visit the injured activated military person or attend the funeral of the activated military person creates financial needs for the care of a home, pets, children, or others when the financial need is not covered by any other source;

d. such other extenuating circumstances as may be determined on a case-by-case basis by the Fund Committee.

4. Family members of activated military personnel who are listed as missing in action or prisoner of war by the U.S. Department of Defense shall be eligible for the lump sum award. The activated military person must be listed as missing in action or a prisoner of war on or after September 11, 2001.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

§6305. Minimum Funding Levels; Reserve Level; Calculation of Funds Available for Payment of One-Time Lump Sum Awards

A. The Military Family Assistance Fund shall have a minimum of \$150,000 on deposit for the Military Family Assistance Program to become operational.

B. At all times the fund shall have a reserve of a minimum of \$15,000.

C. For fiscal year 2006/2007, the maximum percentage of the Military Family Assistance Fund that may be directed to one-time lump sum awards shall not exceed five percent. The percentage shall be based on the amount of funds on deposit in the Military Family Assistance Fund as of the date of the approval of these emergency rules.

D. For fiscal year 2007/2008 and each succeeding fiscal year, the maximum percentage of the Military Family Assistance Fund that may be directed to one-time lump sum awards shall not exceed twenty percent. This percentage shall be based on the amount of funds on deposit in the Military Family Assistance Fund as of the first day of the fiscal year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

Chapter 65. Responsibilities of Third Party Administrator, Fund Committee, and Board

§6501. Third Party Administrator

A. The third party administrator shall receive all need-based applications and all applications for one-time lump sum assistance.

B. The third party administrator is authorized to review, process, approve and remit payment on all need-based applications of \$1500 and less. In no event shall the third party administrator remit payment on any request that exceeds \$1500 without the prior express written approval of the board or the Fund Committee.

C. The third party administrator is authorized to disapprove need-based applications for \$1500 or less if the eligible applicant fails to show that all requirements set forth in the law and the rules are met. The eligible applicant has the right to appeal such disapproval to the Fund Committee.

D. With respect to need-based applications of \$1500 and less, the third party administrator is authorized to approve the claim in part and disapprove the claim in part. The eligible applicant has the right to appeal the third party administrator's disapproval of any part of its need-based claim to the Fund Committee.

E. For all need-based applications received, regardless of the dollar amount of the request, the third party administrator shall make a determination on the following issues:

1. that all awards are on behalf of activated military personnel;

2. that all awards are made pursuant to a claim that is made by an eligible applicant;

3. that all awards are need-based. The third party administrator may consider a claim need-based if all of the following apply:

- a. the funds are requested for necessary expenses incurred or to be incurred;
- b. the necessary expenses created or will create an undue hardship on the activated military person or family member;
- c. the undue hardship is directly related to the activation of the military person;
- d. the activated military person or family member does not have reasonable and timely access to any other funding source;
- e. payment of the claim does not supplant other available public or private funds; and
- f. the Louisiana Military Family Assistance Fund is the eligible applicant's last resort.

F. For all one-time lump sum applications, the third party administrator shall make an initial determination of whether extenuating circumstances exist that support approval of the application.

G. After making the determinations set forth above, the third party administrator shall, for all need-based applications requesting assistance in an amount greater than \$1500 and for all one-time lump sum applications, forward the application together with all supporting documents and the determination to the Fund Committee for further review and processing, approval or disapproval, and payment by the third party administrator in the event of approval.

H. If the third party administrator approves a request of \$1500 or less, it shall determine when the claim shall be paid, the amount of payment, to whom the payment shall be made, and such other matters as it deems necessary and appropriate.

G. The third party administrator shall make a written determination on all applications for assistance as soon as possible.

1. In no event shall the time period between receipt of the completed application by the third party administrator and release of the written determination by the third party administrator exceed thirty calendar days.

2. The written determination shall be:

- a. to approve the claim;
- b. to disapprove the claim;
- c. to request additional information or documentation regarding the claim; or
- d. to schedule a meeting with the eligible applicant to discuss the claim.

H. If the third party administrator schedules a meeting, it shall make a determination within fifteen days following the date that such meeting actually takes place. The determination shall be to either approve or disapprove the claim.

I. If the third party administrator fails to make a written determination within the time periods set forth in these rules, the claim shall be considered disapproved. The eligible applicant may then lodge an appeal within the time delays set forth by statute.

J. The third party administrator shall determine that sufficient funds are on deposit for the payment of all approved claims.

K. The third party administrator shall notify the Fund Committee and the board in writing any time approved applications will cause the Military Family Assistance Fund's unobligated balance to drop to within \$15,000 of its minimum reserve level.

L. With respect to any application that creates a conflict of interest for the third party administrator, the third party administrator shall refer the application to the Fund Committee for consideration and action.

M. The third party administrator shall notify the board if it appears that an application is submitted in violation the law and these rules.

N. The third party administrator shall submit such reports to the Fund Committee and the board as are requested.

O. The third party administrator may refer need-based requests for assistance to the Fund Committee for determination if the third party administrator suspects that the grant of an award under the facts and circumstances of a particular case may not be in the best interests of the board or the State of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

§6503. Fund Committee

A. The Fund Committee shall receive determinations from the third party administrator and make decisions on all need-based applications of greater than \$1500 up to \$2500 and all applications for one-time lump sum assistance.

B. The Fund Committee shall sit as a board of appeals for the third party administrator's disapproval of all or any part of a need-based application for \$1500 or less. If the Fund Committee disapproves the eligible applicant's request for assistance, the eligible applicant may appeal the Fund Committee's disapproval to the Military Family Assistance Board.

C. The Board Chairman shall designate the members of the Fund Committee and shall select alternates to act on their behalf.

D. The Fund Committee shall receive the third party administrator's monthly report on applications received and claims paid. The Fund Committee shall determine the payment of claims when the Military Family Assistance Fund falls to within \$15,000 of its minimum funding level.

E. The Fund Committee shall instruct the third party administrator with respect to the receipt and processing of all applications for assistance from the fund if the fund falls to within \$15,000 of its minimum funding level.

F. The Fund Committee may refer need-based requests for assistance and requests for one-time lump sum awards to the board for determination if the Fund Committee suspects that the grant of an award under the facts and circumstances of a particular case may not be in the best interests of the board or the State of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

§6505. The Board and Chairman of the Board

A. If the board suspects that an application is submitted in violation of the provisions of the law and these rules, it shall refer such application to the appropriate district attorney's office.

B. The board shall provide an annual report to the Joint Legislative Committee on the Budget on the overall activities of the program and any recommendations for consideration.

C. The chairman of the board shall appoint three board members and alternates to serve on the Fund Committee.

D. The board shall sit as a final board of appeals for all applications disapproved by the Fund Committee. An eligible applicant shall have no right to appeal the final decision of the board to any other court, tribunal, or hearing body.

E. The board shall make determinations on requests for assistance brought before the board.

F. The board shall exercise oversight of the activities of the Third Party Administrator and the Fund Committee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

Chapter 67. Appeals; Withdrawal of Applications; Waivers

§6701. Appeals

A. An eligible applicant may appeal the Third Party Administrator's disapproval of all or any part of the request for assistance to the Fund Committee within thirty days of the receipt of the written determination disapproving the claim.

B. The Fund Committee is authorized by these rules to decline to consider any appeal that is not timely filed.

C. An eligible applicant may appeal the Fund Committee's disapproval of claim to the board within thirty days of the receipt of the written determination disapproving the claim.

D. The board is authorized by these rules to decline to consider any appeal that is not timely filed.

E. The decision of the board on a request for assistance shall be final. The Third Party Administrator, the Fund Committee, and the eligible applicant shall not have a right to appeal the final decision of the board to any court, tribunal, or hearing body of any kind.

F. The eligible applicant may request reconsideration of a disapproval of claim by the Third Party Administrator, the Fund Committee, or the board. The request for reconsideration shall be made within 30 days of the date of the eligible applicant's receipt of the written determination disapproving the claim. The request for reconsideration shall be made to the approval authority that disapproved the request for assistance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

§6703. Withdrawal of Applications

A. An eligible applicant and anyone properly acting on behalf of an eligible applicant shall have the right to withdraw the application at any time prior to final disposition of the application by the Third Party Administrator, the Fund Committee or the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

§6705. Waivers

A. Prior to the approval of a claim, applications and the identity of eligible applicants and their related military personnel shall be confidential unless expressly waived by the eligible applicant in writing. The filing of an appeal before the Fund Committee or the board shall be considered a waiver of the identity of eligible applicants and their related military personnel.

B. Once a claim is approved, the identity of the eligible applicant, related activated military personnel, and any person filing the application on behalf of the eligible applicant, and the amount approved shall be public record.

C. Applications, the identify of applicants and their related military personnel, and all records of the board, the Fund Committee and the Third Party Administrator related thereto, shall be available prior to any approval of the application, to necessary parties including but not limited to, the legislative auditor, the legislative oversight committee for rules and annual reports, and such other parties as necessary for prudent administration of the Military Family Assistance Program and verification of elements of the application.

D. The board, the Fund Committee, and the third party administrator are expressly authorized to make public data concerning the number of applications received, the amount of claims approved, the geographic areas of the state from which such applications are received and approved, the number of disapproved applications, and the amount of funds in the Louisiana Family Military Assistance Fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:120 et seq.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Military Family Assistance Board, LR 33:

Hunt Downer
Assistant Adjutant General

0706#054

DECLARATION OF EMERGENCY

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Commercial Deepwater Grouper Closure

The commercial season for the harvest of deepwater groupers in Louisiana state waters will close effective 12:01 a.m. on June 2, 2007. The deepwater grouper assemblage includes misty, snowy, yellowedge, Warsaw grouper, and speckled hind. The secretary has been informed that the commercial season for deepwater groupers in the federal

waters of the Gulf of Mexico off the coast of Louisiana will close at 12:01 a.m. on June 2, 2007, and will remain closed until 12:01 a.m., January 1, 2008.

In accordance with the emergency provisions of R.S. 49:953(B), the Administrative Procedure Act, R.S. 49:967 which allows the Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission to use emergency procedures to set finfish seasons, R.S. 56:326.3 which provides that the Wildlife and Fisheries Commission may set seasons for saltwater finfish, and the authority given to the secretary of the department by the commission in its resolution of January 4, 2007 to modify opening and closing dates of 2007 commercial reef fish seasons in Louisiana state waters when he is informed by the Regional Director of the National Marine Fisheries Service that the seasons have been closed in adjacent federal waters, and that the NMFS requests that the season be modified in Louisiana state waters, the secretary hereby declares:

The commercial fishery for deepwater groupers in Louisiana waters will close at 12:01 a.m. on June 2, 2007, and remain closed until 12:01 a.m., January 1, 2008. Effective with this closure, no person shall commercially harvest, possess, purchase, barter, trade, sell or attempt to

purchase, barter, trade or sell deepwater groupers whether within or without Louisiana waters. Effective with closure, no person shall possess deepwater grouper in excess of a daily bag limit, which may only be in possession during the open recreational season. Nothing shall prohibit the possession or sale of fish legally taken prior to the closure providing that all commercial dealers possessing deepwater grouper taken legally prior to the closure shall maintain appropriate records in accordance with R.S. 56:306.5 and R.S. 56:306.6.

The secretary has been notified by National Marine Fisheries Service that the commercial deepwater grouper season in federal waters of the Gulf of Mexico will close at 12:01 a.m. on June 2, 2007, and the season will remain closed until 12:01 a.m., January 1, 2008. Having compatible season regulations in state waters is necessary to provide effective rules and efficient enforcement for the fishery, to prevent overfishing of these species in the long term.

Bryant O. Hammett, Jr.
Secretary

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