

Rules

RULE

Department of Economic Development Board of Architectural Examiners

Limited Liability Company (LAC 46:I.1335)

Under the authority of R.S. 37:144 and in accordance with the provisions of R.S. 49:950 et seq., the Board of Architectural Examiners amended LAC 46:I.1335 pertaining to the name of a limited liability company practicing architecture. The amended rule provides that the name of a limited liability company practicing architecture shall contain the words "limited liability company"; the abbreviation "L.L.C."; or the abbreviation "L.C."

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part I. Architects

Chapter 13. Titles, Firm Names, and Assumed Names

§1335. Limited Liability Company

The name of a limited liability company must comply with R.S. 12:1306 and shall include the words "limited liability company"; the abbreviation "L.L.C."; or the abbreviation "L.C."

Allowed	Not Allowed
Smith and Jones, Architects, A Limited Liability Company	Smith and Jones, Architects (if the entity is a limited liability company)
Smith and Jones, Architects, L.L.C.	
Smith and Jones, Architects, L.C.	

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:145-146.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Architectural Examiners, LR 20:996 (September 1994), amended LR 24:18 (January 1998).

Mary "Teeny" Simmons
Executive Director

9801#002

RULE

Department of Economic Development Board of Architectural Examiners

Prepared Documents (LAC 46:I.1115)

Under the authority of R.S. 37:144(C) and in accordance with the provisions of R.S. 49:950 et seq., the Board of Architectural Examiners amended LAC 46:I.1115 pertaining

to when specifications, drawings, or other related documents will be deemed to have been prepared either by the architect or under the architect's responsible supervision, as required by R.S. 37:152(B). The board clarified the existing rule and provided that if the documents are prepared outside the architect's office then the architect shall maintain all evidence of the architect's responsible control; otherwise, the architect shall be considered to be in violation of the architects' licensing law and subject to disciplinary penalties.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part I. Architects

Chapter 11. Administration

§1115. Interpretation of R.S. 37:152(B)

Specifications, drawings, or other related documents will be deemed to have been prepared either by the architect or under the architect's responsible supervision only when:

1. the client requesting preparation of such plans, specifications, drawings, reports or other documents makes the request directly to the architect, or the architect's employee as long as the employee works in the architect's office;
2. the architect personally controls the preparation of the plans, specifications, drawings, reports or other documents and has input into their preparation prior to their completion;
3. if the plans, specifications, drawings, reports, or other such documents are prepared outside the architect's office, the architect shall maintain all evidence of the architect's responsible control including correspondence, time records, check prints, telephone logs, site visit logs, research done for the project, calculations, changes, and all written agreements with any persons preparing the documents outside of the architect's offices accepting professional responsibility for such work;
4. the architect reviews the final plans, specifications, drawings, reports or other documents; and
5. the architect has the authority to, and does, make any necessary and appropriate changes to the final plans, specifications, drawings, reports or other documents. If an architect fails to maintain written documentation of the items set forth above, when such are applicable, then the architect shall be considered to be in violation of R.S. 37:152, and the architect shall be subject to the disciplinary penalties provided in R.S. 37:153.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:144.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Architectural Examiners, LR 17:575 (June 1991), amended LR 24:18 (January 1998).

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:144.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Architectural Examiners, LR 17:575 (June 1991), amended LR 24:18 (January 1998).

Mary "Teeny" Simmons
Executive Director

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RULE

Department of Economic Development Real Estate Commission

Agency Disclosure (LAC 46:LXVII.3401-3411)

Under the authority of the Real Estate License Law, R.S. 37:1435, and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., R.S. 37:1437, and R.S. 9:3891 et seq., Agency Relations in Real Estate Transactions, the Real Estate Commission has amended LAC 46:LXVII.Chapter 34. LAC 46:LXVII.3401 is revised to reflect the statute under which agency relations in real estate transactions are now governed. LAC 46:LXVII.3403 and 3405 are revised to establish guidelines for reproduction and distribution of the agency disclosure informational pamphlet and the dual agency disclosure form the usage of which was made mandatory by Act 32 (R.S. 37:1455.A.21 and R.S. 37:1467) of the 1997 Regular Session. LAC 46:LXVII.3407-3411 is repealed.

The amendments will become effective March 1, 1998, in accordance with Chapter 4 of Code XV of Title 9 of the Louisiana Revised Statutes of 1950, comprised of R.S. 9:3891-3899.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXVII. Real Estate

Subpart 1. Real Estate

Chapter 34. Agency Disclosure

§3401. Agency Relationships in Real Estate Transactions

Effective March 1, 1998, agency relations in real estate transactions will be governed by Chapter 4 of Code XV of Title 9 of the Revised Statutes of 1950, comprised of R.S. 9:3891-3899.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1435.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Commission, LR 18:26 (January 1992), amended LR 19:1129 (September 1993), LR 24:19 (January 1998).

§3403. Agency Disclosure Informational Pamphlet

A. Licensees shall provide the agency disclosure informational pamphlet to all parties to a real estate transaction involving the sale or lease of real property.

B. The agency disclosure informational pamphlet shall be obtained from the commission in a form suitable for use by licensees in reproducing the pamphlet locally. Licensees are responsible for insuring that the pamphlets prepared and distributed are the most current version prescribed by the commission and contain the identical language prescribed by the commission.

C. Licensees will provide the agency disclosure informational pamphlet to prospective sellers/lessors and buyers/lessees at the time of the first face-to-face contact with the sellers/lessors or buyers/lessees when performing any real estate related activity involving the sale or lease of real

property, other than a ministerial act as defined in R.S. 9:3891(12).

D. Licensees providing agency disclosure informational pamphlets to prospective sellers/lessors and buyers/lessees shall insure that the recipient of the pamphlet signs and dates the receipt included in the pamphlet. The licensee providing the pamphlet will affix his/her signature to the receipt as a witness to the signature of the recipient, and the licensee will retain the signed receipt for a period of five years.

E. In any circumstance in which a seller/lessor or a buyer/lessee refuses to sign the receipt included in the agency disclosure informational pamphlet, the licensee shall prepare written documentation to include the nature of the proposed real estate transaction, the time and date the pamphlet was provided to the seller/lessor or buyer/lessee, and the reasons given by the seller/lessor or buyer/lessee for not signing the receipt. This documentation will be retained by the licensee for a period of five years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1435.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Commission, LR 18:26 (January 1992), amended LR 19:1129 (September 1993), LR 24:19 (January 1998).

§3405. Dual Agency Disclosure

A. The dual agency disclosure form will be used by licensees acting as a dual agent under R.S. 9:3897.

B. The dual agency disclosure form shall be obtained from the commission in a form suitable for use by licensees in reproducing the form locally. Licensees are responsible for insuring that the form is the most current version prescribed by the commission and that reproductions of the form contain the identical language prescribed by the commission.

C. Licensees shall insure that the dual agency disclosure form is signed by all clients at the time the brokerage agreement is entered into or at any time before the licensee acts as a dual agent; but in no event later than when a purchase agreement is entered into by the clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1435.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Commission, LR 18:26 (January 1992), amended LR 19:1129 (September 1993), LR 24:19 (January 1998).

§3407. Seller/Lessor Agency Disclosure

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1435.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Commission, LR 18:26 (January 1992), amended LR 19:1129 (September 1993), repealed LR 24:19 (January 1998).

§3409. Buyer/Lessee Agency Disclosure

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1435.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Commission, LR 18:26 (January 1992), amended LR 19:1129 (September 1993), repealed LR 24:19 (January 1998).

§3411. Dual Agent/Agency Disclosure

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1435.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Commission, LR 18:26 (January 1992), amended LR 19:1129 (September 1993), repealed LR 24:20 (January 1998).

Julius C. Willie
Executive Director

9801#034

RULE

**Department of Environmental Quality
Office of Air Quality and Radiation Protection
Air Quality Division**

**Control of Emission of Organic Compounds
(LAC 33:III.Chapter 21) (AQ149)**

Under the authority of the Louisiana Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary has amended the Air Quality Division Regulations, LAC 33:III.Chapter 21 (AQ149).

This rule revised parts of Chapter 21 to provide clarification where language may have resulted in misinterpretation of the Regulation. Because of recent and anticipated changes in area designation status in some parishes from nonattainment to attainment for ozone, clarification by parish (unless applicable statewide) of regulatory applicability was added. Compounds exempted from VOC definition were updated, as allowed by recent EPA rulemaking, to exempt HFC 43-10MEE and HCFC 225CA and CB. These compounds are solvents which could be used in electronics and precision cleaning, and are exempt on the basis that these compounds have negligible contribution to tropospheric ozone formation. Miscellaneous errors or ambiguity identified by various sources were clarified and corrected throughout Chapter 21.

This rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S. 49:953(G)(3), therefore, no report regarding environmental/health benefits and social/economic costs is required.

Title 33

ENVIRONMENTAL QUALITY

Part III. Air

Chapter 21. Control of Emission of Organic Compounds

Subchapter A. General

§2103. Storage of Volatile Organic Compounds

* * *

[See Prior Text in A-H.2.e]

3. Vapor Pressure. The maximum true vapor pressure is determined based upon the highest expected calendar-month average of the storage temperature. The true vapor pressure shall be determined from one of the following methods:

- a. from available data on the Reid vapor pressure;

b. by ASTM Test Method D323 for the measurement of Reid vapor pressure, and adjusted for actual storage temperature using the nomographs contained in API Bulletin 2517;

- c. from standard reference texts;
- d. determined by ASTM Test Method D2879; or
- e. by another method approved by the administrative authority*.

* * *

[See Prior Text in I-I.5]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 15:1065 (December 1989), repromulgated LR 16:27 (January 1990), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:360 (April 1991), LR 18:1121 (October 1992), LR 20:1376 (December 1994), LR 21:1223 (November 1995), repromulgated LR 21:1333 (December 1995), amended LR 22:453 (June 1996), LR 22:1212 (December 1996), LR 24:20 (January 1998).

§2107. Volatile Organic Compounds—Loading

* * *

[See Prior Text in A-E.2]

3. Vapor processing systems that use a combustion device designed and operated for 90 percent destruction efficiency to destroy collected VOCs will be exempt from testing.

* * *

[See Prior Text in F]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 16:116 (February 1990), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:360 (April 1991), LR 22:1212 (December 1996), LR 24:20 (January 1998).

§2108. Marine Vapor Recovery

A. Applicability. An affected facility is any marine loading operation serving ships and/or barges loading crude oil, gasoline, or volatile organic compounds (VOCs) with an uncontrolled emission of 100 tons per year (TPY) or greater of volatile organic compounds. Emissions from VOCs with a true vapor pressure of less than 1.5 psia at the loading temperature of the liquid are exempt from the control requirements of this Section.

* * *

[See Prior Text in B-C.1]

2. Affected facilities shall collect and process the vapors by a recovery and/or destruction system such that uncontrolled emissions are reduced by at least 90 percent by weight.

3. Unless exempted under Subsection A of this Section, affected facilities' emissions to the atmosphere caused by the loading of crude oil, gasoline, or volatile organic compounds into ships and/or barges are not to exceed the following:

* * *

[See Prior Text in C.3.a-H.2]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 14:704 (October 1988), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 16:959 (November 1990), LR 22:1212 (December 1996), LR 23:1678 (December 1997), LR 24:20 (January 1998).

§2115. Waste Gas Disposal

Any waste gas stream containing volatile organic compounds (VOC) from any emission source shall be controlled by one or more of the applicable methods set forth in Subsections A-G of this Section. This Section shall apply to all waste gas streams located at facilities that have the potential to emit 50 TPY or more of volatile organic compounds in the parishes of Ascension, East Baton Rouge, Iberville, Livingston, Pointe Coupee, and West Baton Rouge, or 100 TPY in any other parish. This Section does not apply to waste gas streams that must comply with a control requirement, meet an exemption, or are below an applicability threshold specified in another section of this Chapter. This Section does not apply to waste gas streams that are required by another federal or state regulation to implement controls that reduce VOCs to a more stringent standard than would be required by this Section.

A. Control Requirements for Operations that Commenced Construction Prior to January 20, 1985. Nonhalogenated hydrocarbons shall be burned at 1300EF (704EC) for 0.3 second or greater in a direct-flame afterburner or an equally effective device which achieves a removal efficiency of 95 percent or greater, as determined in accordance with Subsection J.1 of this Section, or if emissions are reduced to 50 ppm by volume, whichever is less stringent.

B. Control Requirements for Operations that Commenced Construction On or After January 20, 1985. Nonhalogenated hydrocarbons shall be burned at 1600EF (870EC) for 0.5 second or greater in a direct-flame afterburner or thermal incinerator. Other devices will be accepted provided 98 percent or greater VOC destruction or removal efficiency can be demonstrated, as determined in accordance with Subsection J.1 of this Section, or if emissions are reduced to 20 ppm by volume, whichever is less stringent.

C. Control Requirements for Existing Polypropylene Plants Using Liquid Phase Processes. All waste gas streams containing VOCs at the following sources in existing polypropylene plants using liquid phase processes shall be controlled as specified in Subsection B of this Section:

* * *

[See Prior Text in C.1-C.3]

D. Control Requirements for Existing High-Density Polyethylene Plants Using Liquid Phase Slurry Processes. All waste gas streams containing VOCs at the following sources in existing high-density polyethylene plants using liquid phase slurry processes shall be controlled as specified in Subsection B of this Section:

* * *

[See Prior Text in D.1-D.2]

E. Control Requirements for Polystyrene Plants Using Continuous Processes. The emissions from the material recovery section (e.g., product devolatilizer system) shall be limited to 0.12 kg VOC/1,000 kg of product.

F. Control Requirements for Halogenated Hydrocarbons. The halogenated hydrocarbons shall be combusted or controlled by other methods specified in Subsection G of this Section that achieve a removal efficiency of 95 percent or greater, as determined in accordance with Subsection J.1 of this Section. If combusted, the halogenated products of combustion shall be reduced to an emission level acceptable to the administrative authority.

G. Alternative Control Requirements. Other methods of control (such as, but not limited to, carbon adsorption, refrigeration, catalytic and/or thermal reaction, secondary steam stripping, recycling, or vapor recovery system) may be substituted for burning provided the substitute is acceptable to the administrative authority* and it achieves the same removal efficiency as required by this Section and determined in accordance with Subsection J.1 of this Section or it achieves a degree of control not practically or safely achieved by other means.

H. Exemptions

1. All waste gas streams containing VOCs, except those subject to Subsections C, D, and E of this Section, are exempt from the requirements of this Section if any of the following conditions are met:

a. it can be demonstrated that the waste gas stream is not a part of a facility that emits, or has the potential to emit, 50 TPY or more of volatile organic compounds in the parishes of Ascension, East Baton Rouge, Iberville, Livingston, Pointe Coupee, and West Baton Rouge, or 100 TPY in any other parish;

b. it is a waste gas stream from a low-density polyethylene plant and no more than 1.1 pounds of ethylene per 1,000 pounds (1.1 kg/1000 kg) of product are emitted from all the waste gas streams associated with the formation, handling, and storage of solidified product;

c. it is a waste gas stream having a combined weight of VOCs equal to or less than 100 pounds (45.4 kg) in any continuous 24-hour period; or

d. it is a waste gas stream with a concentration of VOCs less than 0.44 psia true partial pressure (30,000 ppm) except for the parishes of Ascension, Calcasieu, East Baton Rouge, Iberville, Livingston, Pointe Coupee, St. James, and West Baton Rouge in which the concentration of VOCs in the waste gas stream must be less than 0.044 psia true partial pressure (3,000 ppm).

2. Except for waste gas streams subject to Subsections C, D, and E of this Section, the administrative authority* may waive the requirements of this Section if one of the following conditions is met:

* * *

[See Prior Text in H.2.a-H.2.b]

3. Waste gas streams subject to Subsections C, D, and E of this Section are exempt from the requirements of this Section if it can be demonstrated that the waste gas stream has a concentration of VOCs no greater than 408 ppm by volume.

[NOTE: Paragraphs 4 and 5 are being deleted at this time to clarify confusion regarding the asterisks as printed in AQ68 published as a final Rule in March 1993.]

* * *

[See Prior Text in I-K.3]

4. records to demonstrate that the criteria are being met for any exemption claimed.

L. This Section does not apply to safety relief and vapor blowdown systems where control cannot be accomplished because of safety or economic considerations. However, the emissions from these systems shall be reported to the department as required under LAC 33:III.918. Emergency occurrences shall be reported under LAC 33:III.927.

M. Definitions. Unless specifically defined in LAC 33:III.111, the terms in this Section shall have the meanings commonly used in the field of air pollution control. Additionally, the following meanings apply:

Safety Relief and Vapor Blowdown Systems—the emergency escape of gas from a process unit through a valve or other mechanical device, in order to eliminate system overpressure or in the case of an operational emergency.

Waste Gas Stream—any gas stream, excluding fugitive emissions as defined in LAC 33:III.Chapter 5, containing VOC and discharged from a processing facility directly to the atmosphere or indirectly to the atmosphere after diversion through other process equipment. Process gaseous streams that are used as primary fuels are excluded. The streams that transfer such fuels to a plant fuel gas system are not considered to be waste gas.

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 16:960 (November 1990), LR 17:654 (July 1991), LR 18:1122 (October 1992), LR 19:317 (March 1993), LR 22:1212 (December 1996), LR 24:21 (January 1998).

§2117. Exemptions

The following compounds are considered exempt from the control requirements of this Chapter: methane; ethane; 1, 1, 1 trichloroethane (methyl chloroform); methylene chloride (dichloromethane); trichlorofluoromethane (CFC-11); dichlorodifluoromethane (CFC-12); chlorodifluoromethane (HCFC-22); 1,1,2-trichloro 1,2,2-trifluoroethane (CFC-113); trifluoromethane (HFC-23); 1,2-dichloro 1,1,2,2-tetrafluoroethane (CFC-114); chloropentafluoroethane (CFC-115); 1,1,1-trifluoro 2,2-dichloroethane (HCFC-123); 1,1,1,2-tetrafluoroethane (HFC-134a); 1,1-dichloro 1-fluoroethane (HCFC-141b); 1-chloro 1,1-difluoroethane (HCFC-142b); 2-chloro-1,1,1,2-tetrafluoroethane (HCFC-124); pentafluoroethane (HFC-125); 1,1,2,2-tetrafluoroethane (HFC-134); 1,1,1-trifluoroethane (HFC-143a); 1,1-difluoroethane (HFC-152a); acetone; parachlorobenzotrifluoride (PCBTF); perchloroethylene (tetrachloroethylene); cyclic, branched, or linear completely methylated siloxanes; 3,3-dichloro-1,1,1,2,2-pentafluoropropane (HCFC-225ca); 1,3-dichloro-1,1,2,2,3-pentafluoropropane (HCFC)-225cb); 1,1,1,2,3,4,4,5,5,5-decafluoropentane (HFC 43-10mee); difluoromethane (HFC-32); ethylfluoride (HFC-161); 1,1,1,3,3,3-hexafluoropropane (HFC-236fa); 1,1,2,2,3-pentafluoropropane (HFC-245ca); 1,1,2,3,3-pentafluoropropane (HFC-245ea); 1,1,1,2,3-pentafluoropropane (HFC-245eb); 1,1,1,3,3-entafluoropropane (HFC-245fa); 1,1,1,2,3,3-

hexafluoropropane (HFC-236ea); 1,1,1,3,3-pentafluorobutane (HFC-365mfc); chlorofluoromethane (HCFC-31); 1-chloro-1-fluoroethane (HCFC-151a); 1,2-dichloro-1,1,2-trifluoroethane (HCFC-123a); 1,1,1,2,2,3,3,4,4-nonafluoro-4-methoxy-butane (C₄F₉OCH₃); 2-(difluoromethoxymethyl)-1,1,1,2,3,3,3-heptafluoropropane ((CF₃)₂CF₂OC₂H₅); 1-ethoxy-1,1,2,2,3,3,4,4-nonafluorobutane (C₄F₉OC₂H₅); and 2-(ethoxydifluoromethyl)-1,1,1,2,3,3,3-heptafluoropropane ((CF₃)₂CF₂OC₂H₅). The following classes of perfluorocarbons are also considered exempt from the control requirements of this Chapter: cyclic, branched, or linear, completely fluorinated alkanes; cyclic, branched, or linear, completely fluorinated ethers with no unsaturations; cyclic, branched, or linear, completely fluorinated tertiary amines with no unsaturations; and sulfur containing perfluorocarbons with no unsaturations and with sulfur bonds only to carbon and fluorine.

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 16:118 (February 1990), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:289 (March 1994), LR 21:681 (July 1995), LR 21:1330 (December 1995), repromulgated LR 22:14 (January 1996), amended LR 22:703 (August 1996), LR 23:1661 (December 1997), LR 24:22 (January 1998).

§2121. Fugitive Emission Control

* * *

[See Prior Text in A-C.4.h]

i. pumps and compressors that are sealless or have a double mechanical seal;

* * *

[See Prior Text in C.4.j-G.Liquid Service]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 16:959 (November 1990), LR 17:654 (July 1991), LR 21:1330 (December 1995), LR 22:1128 (November 1996), LR 22:1212 (December 1996), LR 24:22 (January 1998).

§2122. Fugitive Emission Control for Ozone Nonattainment Areas

* * *

[See Prior Text in A-D.4.g]

h. pumps and compressors that are sealless or have a double mechanical seal;

* * *

[See Prior Text in D.4.i-G.6]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 20:1102 (October 1994), repromulgated LR 20:1279 (November 1994), amended LR 22:1129 (November 1996), LR 22:1212 (December 1996), repromulgated LR 23:197 (February 1997), amended LR 23:1678 (December 1997), LR 24:22 (January 1998).

Subchapter B. Organic Solvents

§2123. Organic Solvents

* * *

[See Prior Text in A-B.1.c]

2. Whenever any organic solvent or any constituent of an organic solvent may be classified from its chemical structure into more than one of the above groups of organic compounds, it shall be considered as a member of the most reactive chemical group, that is, that group having the least allowable percent of the total volume of solvents.

C. Surface Coating Industries. No person may cause, suffer, allow, or permit volatile organic compound (VOC) emissions from the surface coating of any materials affected by this Subsection to exceed the emission limits as specified in this Section.

Affected Facility	Daily Weighted Average VOC Emission Limitation	
	Lbs. Per Gal. of Coating as applied (minus water and exempt solvent)	Kgs. Per Liter of Coating as applied (minus water and exempt solvent)
1. Large Appliance Coating Industry. The following emission limits shall apply: Prime, single, or topcoat application area, flashoff area and oven	2.8	0.34
2. Surface Coating of Cans. The following emission limits shall apply: Sheet Basecoat (exterior and interior) and over-varnish: Two-piece can exterior (basecoat and over-varnish)	2.8	0.34
Two and three-piece can interior body spray, two-piece can exterior end (spray or roll coat)	4.2	0.51
Three-piece can side-seam spray	5.5	0.66
End sealing compound	3.7	0.44
3. Surface Coating of Coils. The following emission limits shall apply: Prime and topcoat or single coat operation	2.6	0.31
4. Surface Coating of Paper. The following emission limits shall apply: Coating Line	2.9	0.35
5. Surface Coating of Fabrics. The following emission limits shall apply: Fabric Facility	2.9	0.35
Vinyl Coating Line (except Plasticol coatings)	3.8	0.45

6. Surface Coating of Assembly Line Automobiles and Light Duty Trucks. The following emission limits shall apply: Prime application, flashoff area and oven (determined on a monthly basis)	1.2	0.14
Primer surface application flashoff area and oven	2.8	0.34
Topcoat application, flashoff area and oven	2.8	0.34
Final repair application, flashoff area and oven	4.8	0.58
As an alternative to the emission limitation of 2.8 pounds of VOC per gallon of coating applied for the primer surfacer and/or topcoat application, compliance with these emission limitations may be demonstrated by meeting a standard of 15.1 pounds of VOC per gallon of solids deposited.		
7. Surface coating-magnet wire coating. The following emission limits shall apply: Coating Line	1.7	0.20
8. Surface Coating of Metal Furniture. Volatile organic compound emissions from metal furniture coating lines shall not exceed three pounds per gallon (0.36 kg/liter) of coating (minus water and exempt solvent).		
9. Surface Coating of Miscellaneous Metal Parts and Products. The following emission limits shall apply: Clear Coat	4.3	0.52
Air or force air dried items (not oven dried)	3.5	0.42
Frequent color change and/or large numbers of colors applied, or first coat on untreated ferrous substrate	3.0	0.36
Outdoor or harsh exposure or extreme performance characteristics	3.5	0.42
No or infrequent color change, or small number of colors applied	0.4	0.05
a. Powder Coating		
b. Other	3.0	0.36
These limits do not apply to operations covered in 1-8 or 11 herein or exterior coating of fully assembled aircraft, auto refinishing, and auto customizing topcoating (processing less than 35 vehicles per day).		
10. Factory Surface Coating of Flat Wood Paneling. The following emission items shall apply:	VOC Emission Limitation	
	Lbs/1000 sq. ft. of Coated Surface	Kgs/100 sq. meter of Coated Surface
Printed interior wall panels made of hardwood plywoods and thin particleboard	6.0	2.9

Natural finish hardwood plywood panels	12.0	5.8
Class II finishes for hardboard paneling	10.0	4.8
11. Surface Coating for Marine Vessels and Oilfield Tubulars and Ancillary Oilfield Equipment.		
a. Except as otherwise provided in this Rule, a person shall not apply a marine coating with a VOC content in excess of the following limits:		
Baked Coatings	3.5	0.42
Air-Dried Single-Component Alkyd or Vinyl Flat or Semi Gloss Finish Coatings	3.5	0.42
Two Component Coatings	3.5	0.42
b. Except for the parishes of Ascension, Calcasieu, East Baton Rouge, Iberville, Livingston, Pointe Coupee, and West Baton Rouge, in which the VOC limitations in Subsection C.11.a of this Section may not be exceeded, specialty marine coatings and coatings on oilfield tubulars and ancillary oilfield equipment with a VOC content not in excess of the following limits may be applied:		
Heat Resistant	3.5	0.42
Metallic Heat Resistant	4.42	0.53
High Temperature (Fed. Spec. TT-P-28)	5.41	0.65
Pre-Treatment Wash Primer	6.5	0.78
Underwater Weapon	3.5	0.42
Elastomeric Adhesives With 15 percent Weight Natural or Synthetic Rubber	6.08	0.73
Solvent-Based Inorganic Zinc Primer	5.41	0.65
Pre-Construction and Interior Primer	3.5	0.42
Exterior Epoxy Primer	3.5	0.42
Navigational Aids	3.5	0.42
Sealant for Wire-Sprayed Aluminum	5.4	0.648
Special Marking	4.08	0.49
Tack Coat (Epoxies)	5.08	0.61
Low Activation Interior Coating	4.08	0.49
Repair and Maintenance Thermoplastic	5.41	0.65
Extreme High Gloss Coating	4.08	0.49
Antenna Coating	4.42	0.53
Antifoulant	3.66	0.44
High Gloss Alkyd	3.5	0.42

Anchor Chain Asphalt Varnish (Fed. Spec. TT-V-51)	5.2	0.62
Wood Spar Varnish (Fed. Spec. TT-V-119)	4.1	0.492
Dull Black Finish Coating (DOD-P-15146)	3.7	0.444
Tank Coatings (DOD-P-23236)	3.5	0.42
Potable Water Tank Coating (DOD-P-23236)	3.7	0.444
Flight Deck Markings (DOD-C-24667)	4.2	0.504
Vinyl Acrylic Top Coats	5.4	0.648
Antifoulant Applied to Aluminum Hulls	4.5	0.55

* * *

[See Prior Text in D-F.4]

G. Definitions

Air Dried Coating—any coating that is cured at a temperature below 90EC (194EF).

Baked Coating—any coating that is cured at a temperature at or above 90EC (194EF).

Extreme High Gloss Coating—any coating that achieves at least 95 percent reflectance on a 60E meter when tested by ASTM Method D-523.

Heat Resistant Coating—any coating that during normal use must withstand temperatures of at least 204EC (400EF).

High Gloss Coating—any coating that achieves at least 85 percent reflectance on a 60E meter when tested by ASTM Method D-523.

High Temperature Coating—any coating that must withstand temperatures of at least 426EC (800EF).

Marine Coating—any coating, except unsaturated polyester resin (fiberglass) coatings, containing volatile organic materials and applied by brush, spray, roller, or other means to ships, boats and their appurtenances, and to buoys and oil drilling rigs intended for the marine environment.

Metallic Heat Resistant Coating—any coating which contains more than five grams of metal particles per liter as applied and which must withstand temperatures over 80EC (175EF).

Repair and Maintenance Thermoplastic Coating—a resin-bearing coating in which the resin becomes pliable with the application of heat, such as vinyl, chlorinated rubber, or bituminous coatings.

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 16:119 (February 1990), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:654 (July 1991), LR 18:1122 (October 1992), LR 22:340 (May 1996), LR 22:1212 (December 1996), LR 23:1678 (December 1997), LR 24:23 (January 1998).

Subchapter F. Gasoline Handling

§2132. Stage II Vapor Recovery Systems for Control of Vehicle Refueling Emissions at Gasoline Dispensing Facilities

* * *

[See Prior Text in A-A. *Stage II Vapor Recovery System*]

B. Applicability

1. The provisions of this Section shall apply to motor vehicle fuel dispensing facilities in the affected parishes of Ascension, East Baton Rouge, Iberville, Livingston, Pointe Coupee, and West Baton Rouge.

* * *

[See Prior Text in B.2-I]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 18:1254 (November 1992), repromulgated LR 19:46 (January 1993), amended LR 23:1682 (December 1997), LR 24:25 (January 1998).

§2135. Bulk Gasoline Terminals

A. Areas Affected. All facilities in Ascension, Beauregard, Bossier, Caddo, Calcasieu, East Baton Rouge, Grant, Iberville, Livingston, Jefferson, Lafayette, Lafourche, Orleans, Pointe Coupee, St. Bernard, St. Charles, St. James, St. John the Baptist, St. Mary, and West Baton Rouge parishes shall be in compliance with this Section.

* * *

[See Prior Text in B-E.5.c]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended LR 16:611 (July 1990), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:654 (July 1991), LR 18:1123 (October 1992), LR 22:1212 (December 1996), LR 24:25 (January 1998).

Subchapter H. Graphic Arts

§2143. Graphic Arts (Printing) by Rotogravure and Flexographic Processes

A. Control Requirements. No person shall operate or allow the operation of a packaging rotogravure, publication rotogravure, or flexographic printing facility having a potential to emit 50 TPY or more of VOCs in the parishes of Ascension, East Baton Rouge, Iberville, Livingston, Pointe Coupee, and West Baton Rouge or having a potential to emit 100 TPY or more of VOCs in any other parish, unless volatile organic compound emissions are controlled by one of the methods in Subsection A.1-5 of this Section. Once a facility is subject to the provisions of this Section, it remains so regardless of future variations in production.

* * *

[See Prior Text in A.1-5]

B. Applicability Exemption. A rotogravure or flexographic printing facility which has a potential to emit on an uncontrolled basis at full production (8760 hours per year basis) a combined weight of volatile organic compounds less than 50 TPY calculated from historical records of actual consumption of ink is exempt from the provisions of Subsection A of this Section.

* * *

[See Prior Text in C-D.3]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 16:964 (November 1990), LR 18:1123 (October 1992), LR 22:1212 (December 1996), LR 24:25 (January 1998).

Subchapter I. Pharmaceutical Manufacturing Facilities
§2145. Pharmaceutical Manufacturing Facilities

* * *

[See Prior Text in A-F.3]

4. Test Method 25 40 CFR part 60, appendix A, (as incorporated by reference at LAC 33:III.3003) for determining total gaseous nonmethane organic emissions as carbon.

* * *

[See Prior Text in G-G.4]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 16:964 (November 1990), LR 22:1212 (December 1996), LR 24:25 (January 1998).

Subchapter L. Limiting Volatile Organic Compound Emissions from Cleanup Solvent Processing

§2151. Limiting Volatile Organic Compound Emissions from Cleanup Solvent Processing

A. Applicability. The provisions of this Subchapter apply to stationary sources that emit, or have the potential to emit, 50 TPY or more of volatile organic compounds and conduct one or more of the affected cleaning operations in the parishes of Ascension, Calcasieu, East Baton Rouge, Iberville, Livingston, Pointe Coupee, and West Baton Rouge. Once a source is subject to this Subchapter, it shall be so, ad infinitum. Affected cleaning operations are ones that use solvents in the following operations:

* * *

[See Prior Text in A.1-9]

B. Definitions. Unless specifically defined in LAC 33:III.111, the terms in this Subchapter shall have the meanings commonly used in the field of air pollution control. Additionally, the following meanings apply, unless the context clearly indicates otherwise.

* * *

[See Prior Text]

Cleaning of Removable Parts—solvent engulfs the entire surface of the part as it is dipped into a container of solvent or the part is cleaned above the container by a cleaning activity such as spraying or wiping. Equipment or the unit operation where this might take place includes part washers, batch-loaded cold cleaners, ultrasonic cleaners, and spray gun washers.

* * *

[See Prior Text]

Closed-Loop Recycling (In-Process Recycling)—reuse or recirculation of a chemical material within the boundaries used

o develop a material balance around a unit operation system. A recovery or regeneration (R and R) unit operation may be within the boundaries selected for the primary unit operation system if it is:

- a. solely dedicated. The chemical is reused only for cleaning the primary unit operation; or
- b. physically integrated. The R and R unit operation is connected to the primary unit operation by means of piping, so that it is not possible to perform the material balance around the primary unit operation system without including it.

* * *

[See Prior Text]

C. Control Requirements. Sources specified in Subsection A of this Section shall implement the following actions, per EPA publication number EPA-453/R-94-015, February 1994:

* * *

[See Prior Text in C.1]

- 2. utilize accounting on a unit operation system; and
- 3. submit plans to the administrative authority, to reduce VOC emissions from solvent usage, within 12 months after promulgation of these Regulations. Any increases in VOC emissions due to the substitution of a nonhazardous air pollutant for a hazardous one shall require approval of the administrative authority*. To satisfy all requirements of this Subsection, the owner or operator of an affected facility may alternatively report the controls and/or work practices deemed to be MACT that have been adopted to reduce VOC emissions from solvent cleanup operations. These plans or submissions become enforceable upon approval.

D. Testing. ASTM Method D-4828, "Standard Test Method for Practical Washability of Organic Coatings", is a method adaptable for comparing the cleaning effectiveness of solvents and other cleaners. Minor modifications of this method may be approved by the administrative authority. Alternative methods may be approved only by the administrator.

E. Monitoring, Reporting, and Recordkeeping. Reporting and recordkeeping shall be used to monitor VOC emissions from solvent use for cleanup purposes. Affected facilities shall calculate and record the net VOC emissions from usage of solvents monthly and report the net VOC emissions from solvent usage annually. In addition, solvent reduction progress shall be reported annually, based on product output or other suitable basis approved by the administrative authority*. To satisfy all requirements of this Subsection, the owner or operator of an affected facility may alternatively report the controls and/or work practices deemed to be MACT that have been adopted to reduce VOC emissions from solvent cleanup operations.

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 21:391 (April 1995), amended LR 24:25 (January 1998).

Subchapter M. Limiting Volatile Organic Compound Emissions From Industrial Wastewater

§2153. Limiting Volatile Organic Compound Emissions from Industrial Wastewater

A. Definitions. Unless specifically defined in LAC 33:III.111, the terms in this Chapter shall have the meanings normally used in the field of air pollution control. Additionally the following meanings apply, unless the context clearly indicates otherwise.

Affected Source Category—any facilities of the following source categories located in Ascension, Calcasieu, East Baton Rouge, Iberville, Livingston, Pointe Coupee, and West Baton Rouge parishes and having the potential to emit 50 TPY or more of VOCs:

- a. organic chemicals, plastics, and synthetic fibers manufacturing industry under Standard Industrial Classification (SIC) codes 2821, 2823, 2824, 2865, and 2869;
- b. pesticides manufacturing industry under SIC code 2879;
- c. pharmaceutical manufacturing industry under SIC codes 2833, 2834, and 2836; and
- d. hazardous waste treatment, storage, and disposal facilities industry under SIC codes 4952, 4953, and 4959.

* * *

[See Prior Text in A. *Affected Volatile Organic Compounds (VOC) Wastewater-1*]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 21:936 (September 1995), LR 22:1212 (December 1996), amended LR 24:26 (January 1998).

Gus Von Bodungen
Assistant Secretary

9801#068

RULE

Department of Environmental Quality Office of Air Quality and Radiation Protection Air Quality Division

Emission Standard for Asbestos
(LAC 33:III.5151)(AQ163)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary has amended the Air Quality Division regulations, LAC 33:III.5151.J.1 (AQ163).

This rule revision will require the regulated community to follow methods and procedures to prevent emissions to the outside air from the handling of asbestos-containing waste

material. The department originally promulgated the rule essentially verbatim from the federal *Asbestos NESHAP Standard*. However, there was an inherent weakness in the logic of the rule, in that the regulated community has the option of discharging no visible emission or implementing some emission control procedures to prevent emissions, but if emission control procedures are not followed, there will be emissions. The emission control procedures, specifically LAC 33:III.5151.J.1.a, are the industry standard for controlling emissions. The basis and rationale for this rule are to eliminate the contradictory language so that the *Asbestos NESHAP Standard* and LAC 33:III.5151.J.1 are consistent.

This rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

Title 33
ENVIRONMENTAL QUALITY

Part III. Air

**Chapter 51. Comprehensive Toxic Air Pollutant
Emission Control Program**

Subchapter M. Asbestos

§5151. Emission Standard for Asbestos

* * *

[See Prior Text in A-J]

1. Discharge no visible emissions to the outside air during collection, processing (including incineration), packaging, or transporting or deposition of any asbestos-containing waste material generated by the source, and use one of the emission control and waste treatment methods specified in Subsection J.1.a-d of this Section.

* * *

[See Prior Text in J.1.a-P.2.b]

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 17:1204 (December 1991), repealed and repromulgated in LR 18:1121 (October 1992), amended LR 20:1277 (November 1994), LR 24:27 (January 1998).

Gus Von Bodungen
Assistant Secretary

9801#067

RULE

**Department of Environmental Quality
Office of the Secretary**

Credit for Recycling Equipment
(LAC 33:VII.10407)(OS024)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary has amended the Solid Waste Division regulations, LAC 33:VII.10407 (OS024).

The rule amends the tax credit for qualified recycling equipment to define costs allowed under the recycling credit

program to include installation costs. This action is required to clarify that installation costs are included for recycling credit. The basis and rationale for this rule are to provide incentives for recycling nonhazardous solid waste by offering the credit for the recycling equipment program mandated in R.S. 47:6005.

This rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

Title 33

ENVIRONMENTAL QUALITY

Part VII. Solid Waste

Subpart 2. Recycling

Chapter 104. Credit for Recycling Equipment
**§10407. Technical Specifications for Qualified
Recycling Equipment**

* * *

[See Prior Text in A - A.3]

B. The following categories of equipment will be excluded from certification as qualified recycling equipment:

1. vehicles as defined in LAC 33:VII.10405;
2. in-kind replacement of parts for machinery or apparatus;
3. structures, machinery, equipment, or devices used to store or incinerate waste materials; and
4. used equipment.

C. The department shall determine the costs to obtain and construct the qualified equipment that may be allowed for the credit. When the equipment is built from components and assembled at the installation site or a site separate from the installation site, and subsequently transported and installed at the installation site, the costs of the components, the costs to assemble the components, and the costs to install the components shall be considered the allowed costs.

D. The costs of material and labor to construct a building or other structure necessary to support the equipment or to protect the equipment and operators from the elements while they operate the equipment shall be allowed costs, provided that the building or structure is used exclusively in connection with the recycling operations.

E. Under no circumstances shall any of the following be considered allowed costs:

1. financial charges;
2. the costs of acquiring land or rights in land and any costs incidental thereto, including recording fees; and
3. the costs to construct a building or structure to store raw material or finished products.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6005.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of the Secretary, LR 18:841 (August 1992), amended LR 24:27 (January 1998).

Herman Robinson
Assistant Secretary

9801#071

RULE

Department of Environmental Quality Office of Water Resources Municipal Facilities Division

Drinking Water Revolving Loan Fund
(LAC 33:IX.2201-2213)(WP027)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary has amended the Municipal Facilities Division regulations, LAC 33:IX.Chapter 22 (WP027).

This rule establishes requirements for participation in the Drinking Water Revolving Loan Fund program as authorized by the Safe Drinking Water Amendments of 1996 and Act 480 of the 1997 Regular Session of the Louisiana Legislature. The Drinking Water Revolving Loan Fund will provide financial assistance to qualified borrowers for the construction of eligible drinking water facilities. The rule provides information relating to eligibility of projects, application requirements, environmental reviews, and loan conditions. The basis and rationale for this proposed rule are to implement the Drinking Water Revolving Loan Fund program as authorized by the Safe Drinking Water Amendments of 1996 and Act 480 of the 1997 Regular Session of the Louisiana Legislature and to provide the mechanism for the state to qualify for federal funds that will provide financial assistance to water systems for the construction of eligible drinking water facilities.

This rule meets the exceptions listed in R.S. 30:2019(D)(3) and R.S. 49:953(G)(3); therefore, no report regarding environmental/health benefits and social/economic costs is required.

Title 33

ENVIRONMENTAL QUALITY

Part IX. Water Quality

Chapter 22. Drinking Water Revolving Loan Fund

§2201. Introduction

A. The Department of Health and Hospitals, Office of Public Health (OPH), is the state agency within Louisiana granted primary enforcement responsibility from the EPA to ensure that public drinking water systems within the state are in compliance with state regulations that are no less stringent than federal drinking water regulations adopted in accordance with the Safe Drinking Water Act (SDWA) (42 U.S.C. 300f et seq.). The SDWA Amendments of 1996 authorized a state revolving loan fund program and grants to assist water systems in financing the costs of infrastructure improvements to achieve compliance with the SDWA.

B. In accordance with the Louisiana Constitution and authorizing legislation, the Department of Environmental Quality (the department) is assisting OPH in the financial administration of the Drinking Water Revolving Loan Fund (the fund). Regulations governing the fund program are promulgated by both OPH and the department.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, Municipal Facilities Division, LR 24:28 (January 1998).

§2203. Authority

These regulations provide for the Drinking Water Revolving Loan Fund as required by R.S. 30:2011 et seq. and in particular R.S. 30:2011(A)(3), (D)(1); 2074(A)(4), (B)(8); R.S. 40:2824(A); 2826(A), (B), (E), and (F).

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, Municipal Facilities Division, LR 24:28 (January 1998).

§2205. Definitions

The following terms used in these regulations shall have the following meanings:

Administrative Fee—the fee due from a borrower to the department at the origination of a loan and/or on the outstanding principal amount of a loan payable in installments at such rate or rates and at such time or times as may be established by the secretary.

Applicant—any person, as defined, that submits an application for financial assistance in accordance with these regulations.

Binding Commitment Agreement—an instrument evidencing a legal obligation by the department, acting on behalf of the state, to a person that sets forth terms for making a loan from the fund and/or providing such other financial assistance as may be authorized in connection with the program.

Borrower—any person receiving financial assistance for the construction of a drinking water facility.

Completion Date—the date the operation of a completed project receiving financial assistance from the fund is initiated or capable of being initiated, whichever is earlier.

Construction—includes preliminary planning, engineering, architectural, legal, fiscal, and economic investigations and/or studies, surveys, designs, plans, working drawings, specifications, erection, building, acquisition, alteration, remodeling, improvement, or extension of the project.

Department—the Louisiana Department of Environmental Quality.

Drinking Water Facilities—facilities for the purpose of collecting, transporting, treating, storing, distributing, or holding drinking water.

Environmental Review—an assessment by the department of the environmental impact of a proposed project and assurances that the project will comply with all environmental laws and executive orders applicable to the project area.

Financial Assistance—loans, credit enhancement devices, guarantees, pledges, interest rate swap agreements, linked deposit agreements, and other financial subsidies authorized by law.

Fund—the Drinking Water Revolving Loan Fund established by the department in accordance with the Safe Drinking Water Act (SDWA) Amendments of 1996 and Act 480 of the 1997 Regular Session of the Louisiana Legislature.

Letter of Intent—a written notification of the intent of the applicant to participate in the fund program. The notification must include a request for financial assistance, the estimated amount of financial assistance, and an estimated construction schedule and document the authority of the applicant.

Loan or Loans—a disbursement of money made by the department from the fund to a person in accordance with a loan and pledge agreement.

Loan and Pledge Agreement—a contractual arrangement by and between a person and the state acting by and through the department, providing for a loan or loans to such person for the purpose of paying the eligible cost of a project or projects.

Operation, Maintenance, and Replacement (O, M, and R)—those functions that result in expenditures during the useful life of the drinking water facilities for materials, labor, utilities, and other items that are necessary for managing and maintaining the drinking water facilities to achieve the capacity and performance for which such works were designed and constructed, including replacement.

Person—any individual, partnership, firm, corporation, company, cooperative, association, society, trust, or any other business unit or entity, including any municipality, or state agency.

Project or Projects—the activities or tasks identified in a loan and pledge agreement for which a person has made a loan and may expend, obligate, or commit loan proceeds.

Secretary—the secretary of the Department of Environmental Quality.

State—the state of Louisiana or any agency or instrumentality thereof.

System Improvement Plan—the necessary plans and studies relating to the construction of a complete project of drinking water facilities.

User Charge—a charge or fee levied on users of drinking water facilities for the cost of operation, maintenance, and replacement. User charges may include other costs such as the repayment of debt incurred for the construction of the drinking water facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, Municipal Facilities Division, LR 24:28 (January 1998).

§2207. Eligibility for Participation

A. Letter of Intent. An applicant shall send a letter of intent to the department and OPH.

B. Eligible Projects. Financial assistance may be provided only for the construction of drinking water facilities as described in a system improvement plan approved by OPH. The department may consider criteria such as ownership, ability to repay, managerial capability, or other such criteria to determine the amount and type of financial assistance for a project.

C. Allowable/Eligible Costs. Allowable cost determinations, based on applicable law and regulations, may be made by OPH or the department, on a project-by-project basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, Municipal Facilities Division, LR 24:29 (January 1998).

§2209. Application Requirements and Loan Conditions

A. Limitation on Applications. An application shall only be funded after authorization from OPH and after meeting all of the department's requirements.

B. Application Package. The contents of the application package must contain all applicable information required by the department including, but not limited to, the following:

1. System Improvement Plan. The applicant will submit, through OPH, a system improvement plan consisting of those necessary plans and studies that directly relate to construction of drinking water facilities. The system improvement plan must contain enough information to allow the department to perform an environmental review.

2. Financial Information. The applicant is required to submit sufficient information to demonstrate its legal, institutional, managerial, and financial capability to ensure the construction, operation, and maintenance of the drinking water facilities and repayment of the loan, interest, and administrative fees.

3. Site Certificate. The applicant must submit a certificate executed by an attorney certifying that the applicant has acquired all property sites, easements, rights-of-way, or specific use permits necessary for construction, operation, and maintenance of the project described in the approved system improvement plan.

C. Loan Conditions. Loans for projects will be made only to eligible applicants that:

1. provide a fair and equitable user charge system that generates revenues sufficient to cover the costs of O, M, and R for the system;

2. agree to own, operate, and maintain the drinking water facilities so that such drinking water facilities will function properly as long as the loan and pledge agreement is in effect;

3. agree to properly maintain financial records, have periodic audits, and make these records available to the department, OPH, EPA, or their designees upon request;

4. commit to undertake the expenditure of loan proceeds for construction or other eligible project costs within six months after entering into a binding commitment agreement or such time frame as may be required by the department, provided that failure to start the expenditure of funds within one year after entering into a binding commitment agreement may result in the withdrawal by the department of all financial assistance;

5. agree to evidence the loan by a bond, note, or other form of evidence of indebtedness prescribed or approved by the department; and

6. agree to pay administrative fees imposed by the department to defray long term administrative costs associated with the fund program.

D. Loan Period. Loans shall be made for a period of time not to exceed 20 years from the completion date of the construction of a project, except for loans for projects for disadvantaged communities as defined by OPH that may have loan periods up to 30 years with approval of the department.

interim construction financing shall not exceed two years without written approval from the department and from OPH.

E. Loan Repayment. Loan repayments of the principal, administrative fees, and interest installments will be set by the department, with the first installment due no later than one year following the project's completion date. The department will establish the loan repayment schedule in the terms of the loan and pledge agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, Municipal Facilities Division, LR 24:29 (January 1998).

§2211. Events of Default and Remedies

The provisions for events of default and remedies will be specified in the loan and pledge agreement for each borrower receiving a loan from the fund. The secretary or the undersecretary of the department must approve all remedies for events of default.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, Municipal Facilities Division, LR 24:30 (January 1998).

§2213. Miscellaneous

The department may take certain actions and require a borrower to take actions necessary to assure compliance by such borrower with requirements of the *Internal Revenue Code* of 1986, as amended, in connection with a loan from the fund. The borrower shall reimburse the department for any cost incurred by the department in connection with any such actions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2011 et seq.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, Municipal Facilities Division, LR 24:30 (January 1998).

Linda Korn Levy
Assistant Secretary

9801#065

RULE

Office of the Governor Division of Administration Property Assistance Agency

Federal Property Assistance Program
(LAC 34:IX.Chapters 1-31)

The Office of the Governor, Division of Administration, Property Assistance Agency in accordance with R.S. 49:950 et seq., in order to be in conformity with law, has amended the following rules governing the Federal Property Assistance Program.

Executive Order MJF 97-19, dated January 1, 1997, authorizes the name of the program to be the Louisiana Federal Property Assistance Program, a unit of the Louisiana Property Assistance Agency, a section of the Division of Administration

in the Executive Branch of the Office of the Governor. This executive order authorizes the director of the agency, acting through the program manager, to possess all power and authority necessary to exercise and perform all the functions, duties, and responsibilities cited in the plan of operation, so as to comply with all applicable state and federal laws and regulations. The following changes are designed to accommodate the executive order.

Title 34

GOVERNMENT CONTRACTS, PROCUREMENT AND PROPERTY CONTROL

Part IX. Federal Property Assistance Program

Chapter 1. Legal Authority

§101. Executive Order

Executive Order MJF 97-19, dated January 1, 1997, authorizes the name of the program to be the Louisiana Federal Property Assistance Program, a unit of the Louisiana Property Assistance Agency, a section of the Division of Administration in the Executive Branch of the Office of the Governor. This executive order authorizes the director of the agency, acting through the program manager, to possess all power and authority necessary to exercise and perform all the functions, duties and responsibilities cited in the plan of operation, so as to comply with all applicable state and federal laws and regulations.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:411 (October 1977), repromulgated LR 9:839 (December 1983), amended by the Property Assistance Agency, LR 24:30 (January 1998).

§103. Attorney General's Ruling

Repealed.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 104-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:411 (October 1977), repromulgated LR 9:839 (December 1983), repealed by the Property Assistance Agency, LR 24:30 (January 1998).

§105. Appropriations Bill

The ancillary budget identifies the revolving fund of the program which is used as the means of financing for the program's operations.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:411 (October 1977), repromulgated LR 9:839 (December 1983), amended by the Property Assistance Agency, LR 24:30 (January 1998).

Chapter 3. Designation of State Agency

§301. Agency Responsible

The Federal Property Assistance Program, a unit of the Louisiana Property Assistance Agency, a section of the Division of Administration, which is in the Executive Branch of the Office of the Governor, is designated as the agency responsible for administering the federal surplus property program in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:411 (October 1977), repromulgated LR 9:839 (December 1983), amended by the Property Assistance Agency, LR 24:30 (January 1998).

§303. Organization of the Program

The program is under the supervision of the program manager, who directs the implementation of this plan of operation, which fully outlines the provisions of P.L. 94-519. This is a permanent plan of operation that is in compliance with 41 CFR 101-44 and P.L. 94-519. The program manager, with a staff of 16 employees, directs the operation of the program through inspection, selection, acquisition, transportation, storage, and issuance of federal surplus property to eligible donees in the state of Louisiana. The main segments of the organization are:

1. program management;
2. administration;
3. procurement, compliance, and utilization;
4. operations and property distribution.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:411 (October 1977), amended LR 9:839 (December 1983), amended by the Property Assistance Agency, LR 24:31 (January 1998).

§305. Facilities

The program offices are located at 1635 Foss Drive, Baton Rouge, Louisiana. The central facilities are at this location, which includes approximately 29,000 square feet of covered space, 200,000 square feet of outside storage space, and 900 square feet of parking. This facility is owned by the state of Louisiana and is rent-free.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:412 (October 1977), repromulgated LR 9:840 (December 1983), amended by the Property Assistance Agency, LR 24:31 (January 1998).

Chapter 5. Inventory Control and Accounting System

§501. Inventory Control

A. Scope of Accountability System. The program shall maintain accurate accountability records of all donable property approved for transfer to the program and donable property received, warehoused, distributed, and disposed of by the program. Accountability records of all passenger motor vehicles and single items having an acquisition cost of \$5,000 or more, on which restrictions are imposed, shall be maintained in order to identify the items.

B. Checking Property into Program Custody

1. All property received shall be checked in promptly, as soon as full identification can be completed.

2. The approved copy of the Standard Form 123 (SF-123) is used as the basis for checking property into the program facility. The inventory adjustment voucher shall be used for property received without the SF-123. To supplement

these, available shipping documents, invoices, trucking bills of lading, donee reports, etc. will be used.

3. Exceptions or differences in a line item on the SF-123 are noted when the item(s) are received to reflect any increase or decrease as it affects the line item. This action will be documented to report any change in the amount initially allocated on a report of overages/shortages. This action is subsequently posted to the Property Receipts Register.

4. The SF-123 is considered as an order; therefore, any differences, over or short, are recorded on the Shortage/Overage Report Form. Copies of this form in every case are forwarded to the General Services Administration (GSA) regional office involved. A copy is also mailed to the holding agency when the record of receipt shows a variance from the quantities and items shown on shipping documents.

5. In accordance with the requirements of Federal Property Management Regulations (FPMR) 101-44.115 concerning overages, when the estimated fair value or acquisition cost of a line item of property is over \$500, it will be listed on the SF-123 and sent to the GSA regional office for approval.

C. All issues of property to eligible donees are recorded on a distribution document (invoice) with provisions made for recording the name of the item, state serial number, quantity, government acquisition cost, and service charges.

D. Periodic Verification of Property on Hand

1. A financial verification of the property on hand at the end of each month at the state agency is made and reconciled with the books, in accordance with accepted accounting practices.

2. A physical inventory will be completed each fiscal year. This physical inventory will be compared with a unit-generated computer printout as each segment is completed. All differences will be properly noted, recorded, and will become a part of the regular accounting system. Any adjustments on items shall be reported to the manager for approval and any necessary follow-up and corrective action.

E. Tracing Property from Receiving Document to Issue Document

1. Each line item on the receiving report (Form 123) must be entered on the computer including noun nomenclature, federal supply classification code (group code), government acquisition cost, condition code, receipt date, and quantity received. Each receiving document is recorded in a register, and a file folder is maintained for each receiving document.

2. Each warehouse write-up document is numbered and filed numerically by month.

3. Every issue document (invoice) that is generated from the warehouse write-up documents must be entered on the computer so that the computer reports accurately reflect the federal property inventory. Each issue document is filed numerically by month. These documents are also filed by donee organization and are grouped by parish.

F. Means of Determining Quantity of Various Types of Property Donated to Individual Donees

1. A file folder is maintained in the program offices for each eligible donee. This folder will hold a copy of each

distribution document (invoice), monthly status of account, correspondence, reports, and other items involving transactions with the donee.

2. A separate compliance record is maintained for each donee on items with a unit acquisition cost of \$5,000 or more and on all passenger motor vehicles on which restrictions are imposed.

3. A summary of distribution to record the acquisition cost of property transferred to each eligible unit is prepared monthly.

G. Disposal of Property of No Value to Program. Property will be reported to GSA for transfer to another state agency or disposed of by public sale, dumping, or abandonment, as authorized. Appropriate records are maintained to cover such disposals, in accordance with the procedures and requirements of FPMR 101-44.205.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:411 (October 1977), amended LR 9:840 (December 1983), amended by the Property Assistance Agency, LR 24:31 (January 1998).

§503. Financial Accounting

Scope. A double entry financial accounting system provides a full accounting of all property requested, screened, received, issued, and disposed of, plus income, expenses, and status of the revolving fund. The system includes:

1. distribution documents (invoices);
2. accounts payable;
3. accounts receivable;
4. sale register (issues);
5. property receipts register;
6. deposit slips and vouchers;
7. cost center responsibility report (budget control);
8. general ledger;
9. payment of bills and expenses;
10. monthly financial report;
11. in-use inventory;
12. State Property Inventory Control Report;
13. record of disposals;
14. statistical analysis reports.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:413 (October 1977), amended LR 9:840 (December 1983), repromulgated by the Property Assistance Agency, LR 24:32 (January 1998).

Chapter 7. Return of Donated Property

§701. Return of Property by Donee

A. When a determination has been made that property has not been put in use by a donee within one year from the date of receipt of the property, or when the donee has not used the property for one year thereafter under the terms and conditions of the Application, Certification, and Agreement Form signed by the chief executive officer or other authorized representative of the donee as a condition of eligibility (and repeated on the reverse side of each distribution document), the donee, if property is still usable, as determined by the program office, must either:

1. return the property, at its own expense, to the program warehouse;

2. transfer the property to another eligible donee within the state or to a federal agency, as directed by the program manager;

3. make such other disposal of the property, as the program manager may direct.

B. The program manager will periodically emphasize this requirement when corresponding and meeting with donees and when surveying and auditing utilization of donated property at donee facilities.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:413 (October 1977), repromulgated LR 9:540 (December 1983), amended by the Property Assistance Agency, LR 24:32 (January 1998).

Chapter 9. Financing and Service Charges

§901. Financing

A. The state legislature approves the budget for the program, and an appropriation bill is signed into law by the governor each fiscal year which allows the program to operate a revolving fund. This allows the program to receive service charges from donees in order to defray the costs of the operating within the approved budget.

B. Funds expended or advanced, or commitments made or incurred shall be paid or provided for from the receipts of the program's revolving fund prior to the close of the fiscal year.

C. The revolving fund is established with the state treasurer to maintain the revenues from service charges which cover the costs of administering and operating this program. Monies deposited to the revolving fund must be used only for such purposes and for the short- and long-term benefit of the donees.

D. All income from service charges and other monies received by the program are deposited to the revolving fund. Payments covering all expenses are made by state check. All remittances must be in the form of checks drawn on the account of the donee and made payable to the program. All expenditures made from the revolving fund will be in accordance with federal regulations as per FPMR 101-44.202(c)(5).

E. Any evident surplus in the revolving fund shall be passed directly to the donees' benefit through reduction in the service charges for the current inventory during the fiscal year. Surpluses during the fiscal year may be utilized by the manager to acquire additional distribution facilities, improve existing facilities, or other capital expenditures deemed by the manager to be in the best overall interests of the donees. In the event the program is to be terminated, service charges will be reduced to the extent that any surplus will be passed on to the donees on the usable inventory.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:413 (October 1977), repromulgated LR 9:841 (December 1983), amended by the Property Assistance Agency, LR 24:32 (January 1998).

§903. Service Charges

A. Service charges are established for items at the time of receipt of the property and are designed to effect full recovery of the cost of operations of the program. The service charges shall be clearly marked on each item or lot. The service charges are based on the prorated expenses incurred annually by the program including, but not limited to, the following major cost areas: personnel, transportation, utilities, fuels, telephone, warehousing, storage, compliance, insurance, printing, supplies, and travel.

B. The service charges assessed each item shall be reasonable and fair in relation to the cost incurred and the services performed by the program. Emphasis will be placed on keeping the service charges to a minimum, but at the same time, providing the necessary service. Other factors considered in determining service charges are original acquisition cost, present value, screening cost, quantity, condition, desirability of property, transportation, loading and unloading cost, packing and crating, administrative cost, utilization and compliance, and delivery to donee when required.

C. The service and handling charge will be determined by applying zero to 50 percent of original acquisition cost or fair market value, taking into consideration factors listed in §903.B, D, and E and §907.C. The total of the service charges for all property donated by the program during any given fiscal year shall not exceed 15 percent of the original government acquisition cost of the property.

D. Special or extraordinary costs may be added to the service charges as follows.

1. Rehabilitated Property. Direct costs for rehabilitating property will be added to the service charge.

2. Overseas Property. Additional direct costs for returning the property may be added.

3. Long-Haul Property. Charges for major items with unusual costs may be added. Any such costs which are anticipated will be discussed with the donee prior to shipment.

4. Special Handling. An additional charge may be made for dismantling, packing, crating, shipping, delivery, and other extraordinary handling charges.

5. Screening. Extraordinary costs incurred in screening property may be added.

6. Homeless. Property provided to homeless activities (P.L. 110-77, Stewart B. McKinney Homeless Assistance Act enacted July 22, 1987) will be provided at a nominal fee.

E. The manager has the authority to reduce the service charges due to property condition. The manager may request, from the GSA regional office, a reduction on high-acquisition cost items when in poor condition, or when the item is to be used for secondary purposes.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:413 (October 1977), repromulgated LR 9:841 (December 1983), amended LR 16:690 (August 1990), amended by the Property Assistance Agency, LR 24:33 (January 1998).

§905. Minimal Charges

A. Service charges for items requested by a donee and which are shipped directly from the federal holding agency to

the donee shall be based on a percentage of the acquisition cost of the item, which is derived from the percentage of the cost for each of the functions performed by the program.

B. Transportation costs, if transportation is provided by the program, shall be based on the cost per mile, cost of loading, unloading, crating, and packing. Transportation arranged by the donee shall be paid direct by the donee and must be provided in a timely manner in order not to lose the priority for the item.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:414 (October 1977), amended LR 9:841 (December 1983), amended by the Property Assistance Agency, LR 24:33 (January 1998).

§907. Special Donations

A. In cases involving major items of property or otherwise where unusual expenses may be incurred, the program may negotiate the service charge with the donee.

B. The State Agency Quarterly Donation Report of Surplus Personal Property will be used to measure performance.

C. The manager has the authority to reduce the service charge when he believes that an element of the charge is not applicable, or when he deems it to be in the best interests of the program.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:414 (October 1977), repromulgated LR 9:841 (December 1983), amended by the Property Assistance Agency, LR 24:33 (January 1998).

Chapter 11. Terms and Conditions on Donable Property

§1101. Restrictions on Property

A. The program will require each eligible donee, as a condition of eligibility, to file with the program office an Application, Certification and Agreement form outlining the certifications, and agreements, and the terms, conditions, reservations, and restrictions under which all federal surplus personal property will be donated. Each form must be signed by the chief executive officer of the donee agreeing to these requirements prior to the donation of any surplus property. The donee shall be defined as the unit which is authorized to pay for the item(s) and which otherwise meets the qualification requirements. The certifications and agreements, and the terms, conditions, and reservations and restrictions, will be printed on the reverse side of each program distribution document (invoice), which shall be signed by the chief executive officer of the donee or his certified designee, whose name must be provided to the program office, in writing, over the signature of the chief executive officer of the donee.

B. The following periods of restriction are established by the program on all items of property with a unit acquisition cost of \$5,000 or more, and on all passenger motor vehicles.

1. Passenger motor vehicles—18 months from the date the property is placed in use.

2. Items with a unit acquisition cost of \$5,000 to \$10,000—18 months from the date the property is placed in use.

3. Items with a unit acquisition cost of over \$10,000—30 months from the date the property is placed in use.

4. Aircraft (except combat type) and vessels (50 feet or more in length) with a unit acquisition cost of \$5,000 or more—60 months from the date the property is placed in use. Such donations shall be subject to the requirements of a conditional transfer document.

5. Aircraft (combat type)—restricted in perpetuity. Donation of combat type aircraft shall be subject to the requirements of a conditional transfer document.

C. For good and sufficient reasons, such as the condition of the property, or the proposed use (secondary utilization, cannibalization, etc.), the program office may reduce the period of restriction on items of property falling within the provisions of §1101.B.3 and 4, at the time of donation, but no less than for a period of 18 months from the date the property is placed in use.

D. The program office, at its discretion, may impose such terms, conditions, reservations, and restrictions as it deems reasonable, on the use of donable property other than items with a unit acquisition cost of \$5,000 or more, and passenger motor vehicles.

E. The program office has imposed the following terms and conditions which shall be applicable during the period of compliance:

1. each passenger motor vehicle and any motorized heavy equipment (such as bulldozers, tractors, etc.) shall bear the official decal of the donee or the name of the donee in letters no less than 3 inches in height on each side of the item during the period of compliance;

2. donees which are defined as state agencies shall maintain those items which are movable, nonconsumable, and have a fair market value of \$250 or more and have been obtained from the federal surplus property program on the inventory control system defined in the State Property Control regulations of August 20, 1976;

3. donees which are not defined as state agencies shall maintain those items which are movable, nonconsumable, and have a fair market value of \$250 or more and have been obtained from the federal surplus property program on an inventory control system during the period of compliance. That inventory control system shall show the location of the items.

F. Failure to comply with the provisions of §1101.E will cause the program office to impose the following penalties on the donee:

1. return of the item to the program at the donee's expense;

2. a fine of 1 percent per day of the acquisition cost of the item shall be imposed on the donee for each day the restriction is not met;

3. the donee shall be declared ineligible as a participant in the program for a period of 90 days;

4. the manager may set aside the condition and penalties in §1101.E and F.1-3, in writing, for good and sufficient reasons.

G. Whenever information is obtained by the manager of the program from utilization reports, periodic surveys, or from other sources which indicate that a donee has failed to place property into use for the benefit acquired or within the prescribed period of time, or that there has been a loss or theft, or related acquisition, use, or disposal of property during the compliance period, the manager shall immediately initiate the appropriate investigative and compliance action as prescribed in §1903.D. When an investigation proves failure by the donee to comply with this Chapter, the manager shall impose the penalties listed in §1101.F.1-3.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:414 (October 1977), amended LR 9:841 (December 1983), amended by the Property Assistance Agency, LR 24:33 (January 1998).

§1103. Restrictions of Donations

A. The program may amend, modify, or grant release of any term, condition, reservation, or restriction it has imposed on donated items of personal property, in accordance with the standards prescribed in this plan, provided that the conditions pertinent to each situation have been affirmatively demonstrated to the satisfaction of the program manager and made a matter of public record.

B. The program office will impose on the donation of any surplus item of property, regardless of unit acquisition cost, such conditions involving special handling or use limitations as GSA may determine necessary because of the characteristics of the property.

C. The program office will impose on all donees the statutory requirement that all items donated must be placed in use within one year of donation and be used for the purpose for which it was donated for one year after being placed in use or otherwise returned to the program while the property is still usable.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:415 (October 1977), amended LR 9:842 (December 1983), amended by the Property Assistance Agency, LR 24:34 (January 1998).

Chapter 13. Nonutilized Donable Property

§1301. Methods of Disposal

A. All property in the possession of the program office which cannot be utilized by eligible donees shall be reported to GSA for disposal authorization, in accordance with FPMR 101-44.205. In accordance with this regulation, the program office shall either:

1. transfer the property to the program of another state or to a federal agency;

2. sell the property by public sale;

3. abandon or destroy the property.

B. In the event of disposal by transfer to an agency in another state or by public sale, the program office may seek such reimbursement as is authorized in accordance with FPMR 101-44.205.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:415 (October 1977), amended LR 9:842 (December 1983), amended by the Property Assistance Agency, LR 24:34 (January 1998).

Chapter 15. Fair and Equitable Distribution

§1501. Methods for Distribution and Utilization

A. General Policy. The program office shall arrange for a fair and equitable offering of available surplus property to the eligible units in the state, based upon their relative needs and resources and their ability to utilize the property in their program.

B. Determinations

1. The following criteria shall be used by the manager of the program in determining the relative needs and resources of donees and their ability to utilize the property:

a. the population of the parish of the donee, based on the current Preliminary Population Estimates for Louisiana by Parish. Source: Louisiana Tech University, official depository of U.S. Bureau of Census materials;

b. the per capita income of the parish of the donee. Source: current Bureau of Economic Analysis, Department of Commerce;

c. the percent of the average employed persons to the population of the parish of the donee. Source: Research and Statistics Unit, Department of Employment Security, current; and Louisiana Tech University, current Preliminary Population Estimates by Parish;

d. the daily average school attendance of the parish of the donee. Source: Louisiana Department of Education, current;

e. the number of hospital beds (short-term general hospitals) of the parish of the donee. Source: current Louisiana Hospitals Statistics of the State Office of Comprehensive Health Planning;

f. details on the scope of the donees' program, financial information, and specific items of property needed.

2. Other factors to be taken into consideration will include:

a. critical need on the part of the applicant due to a state of emergency or emergency, such as fire, flood, hurricane, etc.;

b. quantity and/or value of surplus property received by donee to date, and specific major items of equipment previously received;

c. interest and expressions of need on the part of the donee in the property available;

d. ability and willingness demonstrated by donee to inspect and select property, timeliness in removing property

from warehouse, or a request for direct shipment from a federal holding agency;

e. financial ability of donee to acquire property, repair or renovate property (if necessary), and maintain the property.

C. Applications for Surplus Property not in Inventory

1. A request for a specific item of property may be submitted by the chief executive officer, or his designee, of the donee to the manager of the program on a Request for Property form when the specific item is not in the inventory of the program.

2. The Request for Property form shall be the only means of requesting property by the donee, in order that the manager may use the same information in determining priority on competing requests for items. Priority ratings by the manager shall be made, utilizing the formula based on the criteria shown in §1501.D, and shall be based on the information submitted by the donee on the Request for Property form.

3. Falsification of any information on the Request for Property form submitted by the donee shall cause the donee's eligibility to participate in the program to be revoked for a period of 12 months.

D. Formula for Determining the Property Request Priorities

1. The program office shall use this formula for determining which donee shall receive an item for which there are competing requests. The information submitted by the donee on the Request for Property form shall be the main basis for the rating. The manager of the program shall have the authority to modify the rating formula on a quarterly basis and to delete and/or add categories, as are necessary to maintain fair and equitable distribution among the donees. The higher the donee rating, the higher the priority the donee will have for the item utilizing the formula.

2. Population by parish of the donee:

Under 10,000	10	50,001-100,000	5
10,001-20,000	9	100,001-150,000	4
20,001-30,000	8	150,001-200,000	3
30,001-40,000	7	Over 200,001	2
40,001-50,000	6		

3. Per capita income by parish of the donee:

Under \$3,000	10	\$3,901-\$4,100	5
\$3,001-\$3,300	9	\$4,101-\$4,300	4
\$3,301-\$3,500	8	\$4,301-\$4,500	3
\$3,501-\$3,700	7	Over \$4,501	2
\$3,701-\$3,900	6		

4. Percentage of average employed persons to the population by parish of the donee:

Less than 10%	10	30%-35%	5
10%-15%	9	35%-40%	4
15%-20%	8	40%-45%	3
20%-25%	7	Over 45%	2
25%-30%	6		

5. Daily school attendance by parish of the donee:

Under 5,000	10	40,000-60,000	5
5,001-10,000	9	60,001-80,000	4
10,001-20,000	8	80,001-100,000	3
20,001-30,000	7	over 100,000	2
30,001-40,000	8		

6. Number of hospital beds by parish of the donee:

0-25	5
26-50	4
51-200	3
201-500	2
over 500	1

7. State of emergency: 10

8. Emergency: 20

9. Unencumbered funds available to acquire property: Yes-10; No-0.

10. Unencumbered funds available to repair, renovate (if necessary), and maintain property: Yes-10; No-0.

11. Ability and willingness demonstrated by donee to inspect and select property, and timeliness in removing property from warehouse: 0-10.

12. Scope of donee's program and utilization of the item for the benefit of the residents: 0-10.

13. Interest and expressions of need on the part of the donee in the item: 0-10.

14. Direct pickup request from the federal holding agency by the donee: 5.

15. Value of surplus property received by donee to date:

Federal Acquisition Cost	Rating
0-\$10,000	10
\$10,001-\$ 25,000	8
\$25,001-\$ 50,000	6
\$50,001-\$100,000	4

16. Specific major items of equipment previously received: 0-10.

E. Selection and Shipment of Donable Property

1. The manager of the program shall recommend to GSA the certification of donee screeners, as are qualified and needed, in accordance with FPMR 101-44.116.

2. The program office shall, insofar as practical, on items requested on the Request for Property form, arrange for inspection and release of property directly from the holding

agencies by the donee at minimal service charges to cover legitimate costs, as detailed in Chapter 9 of this plan, when requested by the donee.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:415 (October 1977), amended LR 9:842 (December 1983), amended by the Property Assistance Agency, LR 24:35 (January 1998).

Chapter 17. Eligibility

§1701. Potential Donees

The program office will contact and instruct all known potential donees in the state on the procedures to follow to establish their eligibility to participate in the surplus property program. A listing of the potential donees in the state shall be established by using the standards and guidelines in FPMR 101-44.207, as well as the following guidelines:

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:417 (October 1977), repromulgated LR 9:843 (December 1983), amended by the Property Assistance Agency, LR 24:36 (January 1998).

§1703. Public Agencies

A. The Louisiana Secretary of State's *Roster of Officials*, which lists cities, towns, parishes, the judiciary, state departments, divisions, councils, boards, commissions, institutions, Indian tribes, etc.

B. The executive officers of the above units will be contacted for a listing of local departments, divisions, commissions, and councils, indicating their different activities and functions.

C. The Economic Development and Planning Commissions will be contacted for lists of their recipients who might be qualified.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:417 (October 1977), repromulgated LR 9:843 (December 1983), repromulgated by the Property Assistance Agency, LR 24:36 (January 1998).

§1705. Nonprofit, Tax-Exempt Units

A. State departments of education, higher education, public health, mental health, community affairs, youth services, and others will be asked for listings of all local units approved or licensed by their departments.

B. Existing listings of units now eligible to participate in the surplus property program.

C. National, regional, and state organizations and associations.

D. Inquiries, letters, telephone calls, etc., received relative to eligibility.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:417 (October 1977), amended LR 9:844 (December 1983), repromulgated by the Property Assistance Agency, LR 24:36 (January 1998).

§1707. Promulgating the Program

Contacts will be made by letter, telephone calls, general meetings, and conferences with the groups in §1703 and §1705, supplemented when necessary by news releases, informational bulletins, and attendance at conferences and meetings to discuss the surplus property program.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:417 (October 1977), amended LR 9:844 (December 1983), repromulgated by the Property Assistance Agency, LR 24:37 (January 1998).

§1709. Requirements for Eligibility

Each unit will be required to file with the program office, as a condition of eligibility:

1. an Application, Certification, and Agreement form, signed by the chief executive officer of the donee, accepting the terms and conditions under which property will be transferred;

2. a written authorization, signed by the chief executive officer or executive head of the donee activity, or a resolution by the governing board or body of the donee activity, designating one or more representative to act for the applicant, obligate any necessary funds, and execute distribution documents;

3. assurance of compliance indicating acceptance of civil rights and nondiscrimination on the basis of sex or handicap in accordance with GSA regulations and requirements;

4. directory information, including the applicant's legal name, address, and telephone number, and status as a public agency or nonprofit, tax-exempt educational or public health unit;

5. program details and scope, including different activities and functions;

6. a listing of specific equipment, material, vehicles, machines, or other items in which the donee would be interested in the future;

7. financial information, if necessary, for the evaluation of relative needs and resources;

8. proof of tax-exemption under Section 501(c)(3) of the *Internal Revenue Code* of 1954 (for nonprofit units only);

9. proof that the applicant is approved, accredited, or licensed in accordance with FPMR 101-44.207.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:417 (October 1977), amended LR 9:844 (December 1983), amended by the Property Assistance Agency, LR 24:37 (January 1998).

§1711. Recertification of Eligibility

All approvals of eligibility will be updated every three years except those programs that are certified, approved, and/or licensed annually, which must be updated every year.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:417 (October 1977), repromulgated LR 9:844

(December 1983), amended by the Property Assistance Agency, LR 24:37 (January 1998).

Chapter 19. Compliance and Utilization

§1901. Scope

The program office shall conduct utilization reviews to ensure compliance by donees with the terms, conditions, reservations, and restrictions imposed on:

1. any property not placed in use within one year from the date of acquisition, and not used for a period of one year;
2. any passenger motor vehicle;
3. any item of property valued at \$5,000 or more;
4. any item having characteristics that require special handling or use limitations imposed by GSA.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:417 (October 1977), repromulgated LR 9:844 (December 1983), amended by the Property Assistance Agency, LR 24:37 (January 1998).

§1903. Methods

A. The program office will arrange to visit each donee receiving major items of property, (i.e., items with a unit acquisition cost of \$5,000 or more and passenger motor vehicles with federal and/or state restrictions on the use of the property at least once during the period of restriction. All such visits will be made by the compliance/utilization audit staff or administration of the program.

B. Written reports of utilization from the chief executive officer of the donee will be requested during the periods of restricted activity or in the event of unusually heavy work loads at the program office.

C. Each visit on compliance utilization will encompass:

1. general utilization of property, including items with an acquisition cost of under \$5,000 and items listed under §1901.D;
2. compliance with all terms, conditions, reservations, and restrictions imposed on the use of the property;
3. any evidence of oversupply or stockpiling;
4. application advice for property needed;
5. effectiveness of the surplus property program;
6. recommendations for better service.

D. A report will be prepared on each compliance visit and submitted to the manager for approval. Follow-up action on noncompliance or nonuse will be taken, as necessary. Instances of suspected fraud or misuse will be reported to the Federal Bureau of Investigation and GSA. Program personnel will assist in any subsequent investigations.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:418 (October 1977), amended LR 9:844 (December 1983), amended by the Property Assistance Agency, LR 24:37 (January 1998).

Chapter 21. Consultation with Advisory Bodies, Public and Private Groups

§2101. Representation of the Program

A. The program office will arrange for and participate in local, regional, or statewide meetings of public and private organizations and associations which represent potential

donees to disseminate information on the program, discuss procedures and problems, and obtain recommendations on determining relative needs, resources, and the utilization of property and how the program office can provide more effective service. The program office will regularly provide information on the donation program to state and local officials, and to heads of nonprofit institutions and organizations, and will actively participate in, and, upon request, provide speakers for conferences and meetings held by public and private organizations.

B. The program office, in consultation with advisory bodies and public and private groups, will invite eligible donees to submit expressions of interest and need for property items so that the program office may advise GSA of such requirements, including requests for specific items of property.

C. A Louisiana Federal Property Assistance Program advisory board shall be established by the manager of the program. It shall be composed of one representative from each of the eight areas listed in the program Quarterly Donation Report of Surplus Personal Property. The manager shall select the representative who is felt to best represent that segment of the donees. Advisory board members shall advise the manager on means to improve the program in the areas which they represent. The representatives shall serve without pay or compensation.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:418 (October 1977), amended LR 9:844 (December 1983), amended by the Property Assistance Agency, LR 24:37 (January 1998).

Chapter 23. Audits

§2301. Reconciling Financial Records

A. At the close of each month the program office will conduct an internal audit which will reconcile the warehouse and office records on inventory value, disposals, property received, and property issued.

B. Annually, the audit staff of the program will conduct an audit which shall include, in addition to fiscal affairs, a review of the conformance of the program with the provisions of this plan of operation and the requirements of 41 CFR 101.44.

C. An external audit will be performed at least once every two years by the legislative auditor or by an independent certified public accountant or independent licensed public accountant who is certified or licensed by a regulatory authority of the state or other subdivision of the United States. It shall include an audit of all fiscal affairs and a review of the conformance of the program with the provisions of this plan of operation and the requirements of 41 CFR 101-44. A copy of the audit will be furnished by the program office, immediately upon completion, to the GSA regional office. The manager will advise the GSA regional office of all corrective actions taken, with respect to any exceptions or violations indicated by the audit. It is agreed that GSA may, for appropriate reasons, conduct its own audit of the program, following due notice to the governor of the reasons for such audit, and may visit the program office for purposes of reviewing the program's

operation, when it deems it appropriate.

D. Financial records and all other books and records of the program shall be available for inspections by representatives of GSA, the general accounting office, or other authorized federal activities.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:418 (October 1977), amended LR 9:844 (December 1983), amended by the Property Assistance Agency, LR 24:38 (January 1998).

§2303. Donee Audits

Any state or local government, nonprofit organization or educational institution that receives item(s) valued at \$25,000 or more annually from the Donation of Federal Surplus Personal Property Program shall have an audit performed in accordance with the Office of Management and Budget Circular A-133. A copy of the audit shall be sent to the program office immediately after the donee receives the audit.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Property Assistance Agency, LR 24:38 (January 1998).

Chapter 25. Cooperative Agreements

§2501. Types of Agreements

The program has the authority to enter into such cooperative agreements with federal agencies and other state agencies as may be necessary, in accordance with FPMR 101-44.206. Such agreements may involve, but not be limited to:

1. use of property by the program;
2. overseas property;
3. use of federal telecommunications system;
4. interstate transfers;
5. others, as may be necessary.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:418 (October 1977), repromulgated LR 9:845 (December 1983), amended by the Property Assistance Agency, LR 24:38 (January 1998).

Chapter 27. Liquidation

§2701. Procedures and Time Frame

A. In the event of liquidation, or at the time determination has been made by state officials to liquidate the program, a liquidation plan will be prepared in accordance with FPMR 101-44.201.c.14.

B. The liquidation plan shall include:

1. reasons for liquidation;
2. schedule and estimated date of termination;
3. method of disposal of surplus property on hand, consistent with the provisions of FPMR 101.44.205;
4. method of disposal of agency's physical and financial assets;
5. retention of books and records for a five-year period following liquidation.

C. Such plan will be submitted to GSA and its approval secured prior to the beginning of liquidation.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:419 (October 1977), amended LR 9:845 (December 1983), amended by the Property Assistance Agency, LR 24:38 (January 1998).

Chapter 29. Forms

§2901. Types and Utilization

A. The distribution document (invoice) shall be used as the standard issue document and the invoice for all issues of surplus property to eligible donees or other states. The terms and conditions shall be printed on the back of each prenumbered distribution document (invoice).

B. Certain specific items require conditional transfer documents in addition to the standard forms:

- 1. noncombat type aircraft with a unit acquisition cost of over \$5,000 require a conditional transfer document;
- 2. combat type aircraft with a unit acquisition cost of over \$5,000 require a conditional transfer document;
- 3. vessels over 50 feet in length with a unit acquisition cost of over \$5,000 require a conditional transfer document.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:419 (October 1977), amended LR 9:845 (December 1983), amended by the Property Assistance Agency, LR 24:39 (January 1998).

Chapter 31. Records

§3101. Time Frame for Retention

All official records of the program will be retained for no less than five years, except records involving property in compliance status for six years or longer will be kept for at least one year after the case is closed.

AUTHORITY NOTE: Promulgated in accordance with 41 CFR 101-44 and P.L. 94-519.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Federal Property Assistance Agency, LR 3:419 (October 1977), repromulgated LR 9:845 (December 1983), amended by the Property Assistance Agency, LR 24:39 (January 1998).

Irene C. Babin
Director

9801#019

RULE

**Department of Health and Hospitals
Board of Physical Therapy Examiners**

Licensure; Unauthorized Practice; and
Supervision (LAC 46:LIV.Chapters 1 and 3)

Notice is hereby given, in accordance with R.S. 49:950 et seq., the Administrative Procedure Act, that the Board of Physical Therapy Examiners (board), pursuant to the authority vested in the board by R.S. 2401.2A(3), has amended rules relative to the practice of physical therapy.

**Title 46
PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

**Part LIV. Physical Therapy Examiners
Subpart 1. Licensing and Certification**

Chapter 1. Physical Therapists and Physical Therapist Assistants

Subchapter A. General Provisions

§107. Qualifications for License

A. - B.5. ...

C. The burden of satisfying the board as to the qualifications and eligibility of the applicant for licensure shall be upon the applicant. An applicant shall not be deemed to possess such qualifications unless the applicant demonstrates and evidences such qualifications in the manner prescribed by and to the satisfaction of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2401.2(A)3.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Physical Therapy Examiners, LR 13:744 (December 1987), amended by the Department of Health and Hospitals, Board of Physical Therapy Examiners, LR 15:387 (May 1989), LR 17:662 (July 1991), 19:208 (February 1993), LR 22:284 (April 1996), LR 24:39 (January 1998).

Subchapter C. Graduates of Foreign Physical Therapy Schools

§115. Qualification for License

A. - A.1. ...

2. have successfully completed his education in physical therapy that is substantially equivalent to the requirements of physical therapists educated in accredited physical therapy programs in the United States as the board, upon evaluation of the applicants educational program by an approved credentials evaluation service, deems sufficient, however, such substantially equivalent education shall be no less than a total of 120 semester hour credits which includes a minimum of 60 semester hour credits for professional education and a minimum of 40 semester hours of general education as established in a course work evaluation total approved by the board;

3. - 4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2401.2(A)3.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Physical Therapy Examiners, LR 13:744 (December 1987), amended by the Department of Health and Hospitals, Board of Physical Therapy Examiners, LR 17:662 (July 1991), LR 18:962 (September 1992), LR 19:208 (February 1993), LR 22:284 (April 1996), LR 24:39 (January 1998).

Subpart 3. Practice

Chapter 3. Practice

Subchapter A. General Provisions

§303. Definitions

As used in this Chapter, the following terms and phrases shall have the meanings specified:

* * *

Student—means a person who is pursuing a course of study leading to a degree as a physical therapist (SPT) or a physical therapist assistant (SPTA) in a professional education

program approved by the board and is satisfying supervised clinical education requirements related to his physical therapy education.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2401.2(A)3.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Physical Therapy Examiners, LR 13:744 (December 1987), amended by the Department of Health and Hospitals, Board of Physical Therapy Examiners, LR 19:208 (February 1993), LR 21:394 (April 1995), LR 24:39 (January 1998).

§305. Special Definition: Practice of Physical Therapy

A. As used in the definition of *practice of physical therapy* set forth in the Physical Therapy Practice Act, and as used in this Chapter, the following terms shall have their meanings specified:

* * *

Continuous Supervision—means responsible, continuous, on-the-premises observation and supervision by a licensed physical therapist of the procedures, functions and practice rendered by a physical therapy aide/technician; student; physical therapist assistant permittee pending licensure by examination or re-examination; and physical therapist temporary permittee who has once failed the licensing examination.

* * *

Physical Therapy Supportive Personnel

a. ...

b. *Physical Therapist Assistant*—a person licensed by the board who is a graduate of an associate degree program in physical therapist assisting accredited by the American Physical Therapy Association or was granted licensure pursuant to R.S. 37:2403(D). The physical therapist assistant may not supervise physical therapy aides/technicians without a physical therapist continuously on the premises.

c. The level of responsibility assigned to *physical therapy supportive personnel* is at the discretion of the physical therapist, who is ultimately responsible for the acts or omissions of these individuals. Supportive personnel may perform only those functions for which they have documented training and skills. The prohibitions for physical therapy supportive personnel shall include, but not be limited to, interpretation of referrals; performance of evaluations; initiation or adjustment of treatment programs; assumption of the responsibility for planning patient care; or any other matters as determined by the board. The physical therapist shall only delegate portions of the treatment session to an aide/technician only after the therapist has assessed the patient's status.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2401.2(A)3.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Physical Therapy Examiners, LR 13:738 (December 1987), amended by the Department of Health and Hospitals, Board of Physical Therapy Examiners, LR 17:666 (July 1991), LR 19:208 (February 1993), LR 21:1243 (November 1995), LR 24:40 (January 1998).

Subchapter B. Prohibitions

§307. Unauthorized Practice

A. ...

B. A physical therapist shall use the letters "P.T." in connection with his name or place of business to denote licensure. A physical therapist assistant shall use the letters "P.T.A." in connection with his name to denote licensure. No person shall hold himself out to the public, an individual patient, a physician, dentist or podiatrist, or to any insurer or indemnity company or association or governmental authority as a physical therapist, physiotherapist or physical therapist assistant, nor shall any person directly or indirectly identify or designate himself as a physical therapist, physiotherapist, registered physical therapist, licensed physical therapist, physical therapist assistant, or licensed physical therapist assistant, nor use in connection with his name the letters, P.T., L.P.T., R.P.T., or P.T.A., or any other words, letters, abbreviations, insignias, or sign tending to indicate or imply that the person constitutes physical therapy, unless such person possesses a current license or temporary permit duly issued by the board.

C. A physical therapy student who is pursuing a course of study leading to a degree as a physical therapist in a professional education program approved by the board and is satisfying supervised clinical education requirements related to his physical therapy education shall use the letters "S.P.T." in connection with his name while participating in this program. A physical therapist assistant student who is pursuing a course of study leading to a degree as a physical therapist assistant in a professional education program approved by the board and is satisfying supervised clinical education requirements related to his physical therapist assisting education shall use the letters "S.P.T.A." in connection with his name while participating in this program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2401.2(A)3.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Physical Therapy Examiners, LR 13:749 (December 1987), amended by the Department of Health and Hospitals, Board of Physical Therapy Examiners, LR 21:395 (April 1995), LR 24:40 (January 1998).

§309. Exemptions

A. - B. ...

C. A student shall be exempt from licensure when pursuing a course of study leading to a degree in physical therapy or physical therapist assisting in a professional education program approved by the board and is satisfying supervised clinical education requirements related to his education.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2401.2(A)3.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Physical Therapy Examiners, LR 13:749 (December 1987), amended by the Department of Health and Hospitals, Board of Physical Therapy Examiners, LR 24:40 (January 1998).

Subchapter C. Supervised Practice

§317. General Supervision Requirements for Permittees

- A. ...
- B. - B.1. ...

2. not have been subject, within a period of three years prior to undertaking such responsibility, to administrative action or consent order by the board which resulted in sanction to his physical therapy license. The three-year period shall commence upon satisfactory completion of the sanction.

- 3. - 5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2401.2(A)3.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Physical Therapy Examiners, LR 13:749 (December 1987), amended by the Department of Health and Hospitals, Board of Physical Therapy Examiners, LR 15:388 (May 1989), LR 17:667 (July 1991), LR 24:41 (January 1998).

§319. Additional Supervision Requirements for Foreign Graduate Physical Therapists

- A. - B.1. ...

2. provide the board with a written certification, following the conclusion of a foreign graduate physical therapist's clinical training as required by §115.A.3, that the permittee has accumulated not less than 1,000 hours of actual clinical experience in the practice of physical therapy under the periodic and/or continuous supervision of the licensed physical therapist as required in §§115, 159 and 305.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2401.2(A)3.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Physical Therapy Examiners, LR 13:749 (December 1987), amended by the Department of Health and Hospitals, Board of Physical Therapy Examiners, LR 17:667 (July 1991), LR 19:208 (February 1993); LR 24:41 (January 1998).

§321. Supervision Requirements

- A. - C.2. ...
- D. Student

1. The supervising physical therapist shall provide continuous, on-the-premises supervision of a student in all practice settings.

2. A physical therapist shall supervise no more than five students at any given time.

- E. Supervision Ratio

1. A physical therapist shall not supervise:

- a. more than three physical therapist assistants and/or aides/technicians at any one time;
- b. more than two permittees at any one time; or
- c. more than five students at any one time.

2. A supervising physical therapist must comply with the supervision ratios required in §321.E.1 and shall not exceed the maximum of a 1:5 ratio in any combination of such supervised individuals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2401.2(A)3.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Physical Therapy Examiners, LR 13:750 (December 1987), amended by the Department of Health and

Hospitals, Board of Physical Therapy Examiners, LR 19:208 (February 1993), LR 24:41 (January 1998).

Sharon Toups
Chairman

9801#014

RULE

**Department of Health and Hospitals
Board of Veterinary Medicine**

Veterinary Practice Facilities (LAC 46:LXXXV.711)

(Editor's Note: The following Section of a rule, published on pages 969-970 of the August 1997 Louisiana Register, is being repromulgated to include text which was inadvertently omitted.)

**Title 46
PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part LXXXV. Veterinarians

Chapter 7. Veterinary Practice

§711. Definitions for Classification of Practice Facilities

A. In order to be classified as, advertised as, or use the word "hospital" as defined in §700 in the name of a veterinary facility, all of the following minimum standards and requirements shall be met:

- 1. - 4. ...

5. Facility shall have access to a diagnostic x-ray machine and development equipment area kept in compliance with state and federal regulations.

- 6. - 8. ...

- B. - D.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1518.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 19:1331 (October 1993), amended LR 23:969 (August 1997), repromulgated LR 24:41 (January 1998).

Charles B. Mann
Executive Director

9801#008

RULE

**Department of Health and Hospitals
Office of Public Health**

Sanitary Code—Milk and Milk Products (Chapter VII)

In accordance with the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Health and Hospitals, Office of Public Health, pursuant to the authority in R.S. 40:4A(1) and R.S. 40:5, has amended rules contained in Chapter VII pertaining to Grade A raw milk for pasteurization

certified for interstate milk shipment and Grade A pasteurized milk certified for interstate milk shipment, by adding two new sections as set forth below:

Add Section 7:091.1 to read:

7:091.1 Grade A Raw Milk for Pasteurization Certified for Interstate Milk Shipment. Grade A raw milk for pasteurization certified for interstate milk shipment is raw milk produced on dairy farms in Louisiana that meets all requirements of the Sanitary Code, State of Louisiana, as well as the requirements for Grade A as set forth by the National Conference on Interstate Milk Shipments (NCIMS). In cases of "conflicting provisions," the stricter codal requirement must be met.

Raw milk produced in Louisiana in substantial compliance with the provisions in this Section may be certified by the state health officer for inclusion in the U.S. Food and Drug Administration Interstate Milk Shippers List.

* * *

Change 7:094 to correct a typographical error pertaining to the grade of milk:

7:094 Grade A Pasteurized Milk. Grade A pasteurized milk is Grade A raw milk for pasteurization which has been pasteurized, cooled, and placed in the final container in a milk plant conforming with all of the sections of sanitation in this Chapter. In all cases, milk shall show efficient pasteurization as evidenced by a satisfactory phosphatase test. At no time after pasteurization and until delivery shall milk have a bacterial plate count exceeding 20,000 per milliliter or a coliform count exceeding 10 per milliliter in more than one of the last four samples.

* * *

Add Section 7:094.1 to read:

7:094.1 Grade A Pasteurized Milk Certified for Interstate Milk Shipment. Grade A pasteurized milk certified for interstate milk shipment is pasteurized milk certified for interstate milk shipment that meets all Grade A requirements of the Sanitary Code, State of Louisiana as well as the requirements for Grade A as set forth by the National Conference on Interstate Milk Shipments (NCIMS). In cases of "conflicting provisions," the stricter codal requirement must be met.

Pasteurized milk processed in Louisiana in substantial compliance with the provisions in this Section may be certified by the state health officer for inclusion in the U.S. Food and Drug Administration Interstate Milk Shippers List.

* * *

Bobby P. Jindal
Secretary

9801#061

RULE

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

Home and Community
Based Services—Elderly
and Disabled Adults Waiver

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This rule is adopted in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following regulations governing the Home Care for the Elderly waiver program to:

- 1) redefine the target population served by the waiver and rename the waiver;
- 2) establish an average cost per day limit each participant of the waiver;
- 3) establish and define new services;
- 4) establish methodology for the assignment of slots; and
- 5) clarify admission and discharge criteria, mandatory reporting requirements and the reimbursement requirement for the prior approval of the plan of care.

The total number of slots assigned shall not exceed the maximum number of slots approved by the Health Care Financing Administration. The assignment of vacated and previously unoccupied waiver slots; admission and discharge criteria; the array of services; calculation of waiver costs; mandatory reporting requirements and reimbursement for services provided prior to the approval of the plan of care shall be determined in accordance with the following guidelines.

Definition of Targeted Population for the Waiver

This home and community based services waiver is targeted at persons who qualify for admission to a nursing facility and are over age 65 or adults, age 21 or over, who are disabled according to Medicaid standards. It shall be called the Elderly and Disabled Adult waiver.

Guarantee of Waiver Costs

In order to assure the cost effectiveness of this entire home and community based services waiver each participant shall be limited to an array of services whose average cost per day shall not exceed a limit set by the bureau. This figure shall be

set annually at a percentage of the average costs borne by the Medicaid program for the equivalent population receiving nursing facility services, with an allowance for temporary, brief periods of excess costs in order to maintain a participant in the community. Case managers shall complete a budget analysis form as part of each care plan which shall list the types and number of services necessary to maintain the waiver participant safely in the community, the cost of those services and the average cost per day covered by the care plan.

Programmatic Allocation of Waiver Slots

The waiting list shall be used to protect the individual's right to be evaluated for waiver eligibility. Each waiver slot may be filled only once during each waiver year. When funding becomes available for a new waiver slot or a slot that has been vacated in the previous waiver year, staff of the Intake Offices at the local Councils on Aging shall notify the next individual in order of application on the waiting list in writing that a slot is available and that they are next in line to be evaluated for possible waiver slot assignment. A copy of the notification letter shall be forwarded to the Health Standards Section of BHSF. A case manager assists in the gathering of the documents needed for both the financial and medical certification eligibility process. If the individual is determined to be ineligible either financially or medically, that individual is notified in writing and a copy of the notice is forwarded to the Council on Aging office. The next person on the waiting list is notified as stated above and the process continues until an eligible person is encountered. A waiver slot is assigned to an individual when eligibility is established and the individual is certified.

Waiver Admission Criteria

Admission to this Waiver Program shall be determined in accordance with the following criteria.

1. initial and continued Medicaid eligibility as determined by the parish BHSF Office;
2. initial and continued eligibility for a nursing facility level of care as determined by the Health Standards Section of BHSF;
3. the plan of care must provide justification that the waiver services are appropriate, cost effective and represent the least restrictive treatment alternative for the individual; and
4. assurance that the health and safety of the individual can be maintained in the community with the provision of reasonable amounts of waiver services as determined by the Health Standards Section of BHSF.

Waiver Discharge Criteria

Participants shall be discharged from this Waiver Program if one of the following criteria is met:

1. loss of Medicaid eligibility as determined by the parish BHSF Office;
2. loss of eligibility for a nursing facility level of care as determined by the Health Standards Section of BHSF;
3. incarceration or placement under the jurisdiction of penal authorities, or courts;
4. change of residence to another state with the intent to become a resident of that state;

5. admission to a nursing facility or any other long term care institutional setting;

6. the health and welfare of the waiver participant cannot be assured in the community through the provision of amounts of waiver services within the cost cap as determined by the Health Standards Section of BHSF, i.e., the waiver participant presents a danger to himself or others;

7. failure to cooperate in either the eligibility determination process or the performance of the care plan; or

8. continuity of services is interrupted as a result of the participant not receiving waiver services during a period of 14 or more consecutive days. This does not include interruptions in services because of hospitalization.

Mandatory Reporting Requirements

Case managers and waiver service providers are obligated to report changes that could affect the waiver participant's eligibility, including but not limited to those changes cited in the discharge criteria, to either the parish BHSF Office or the Health Standards Section of BHSF within five working days. In addition, case managers and waiver service providers are responsible for documenting the occurrence of incidents or accidents that affect the health, safety and well-being of the waiver participant and completing an incident report. The incident report shall be submitted to the Health Standards Section of BHSF within five working days of the incident.

Definition of Services

The following services will be made available to participants in this waiver by employees of Personal Attendant Provider agencies in half hour increments:

1. *Personal Care Attendant*—assistance with eating, bathing, dressing, personal hygiene, or activities of daily living.
2. *Household Supports*—services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
3. *Personal Supervision (day)*—non-medical care, supervision and socialization, provided to a functionally impaired adult. Personal supervisors may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services as the household support worker does. The provision of this service does not entail hands-on nursing care.
4. *Personal Supervision (night)*—this type of supervision is to provide for the safety of individuals living alone who are limited in mobility or cognitive function to such an extent that they may not be able to preserve their own safety in dangerous situations.

Reimbursement of Waiver Services

Reimbursement shall not be made for waiver services provided prior to the BHSF approval of the care plan.

Bobby P. Jindal
Secretary

9801#052

RULE

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

Nursing Homes—Minimum Licensure
Standards (LAC 48:I.Chapters 97, 98, and 99)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, adopts the following rule as authorized by R.S. 40:2009.1-2116.4. This rule is in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The purpose of the nursing home licensing law and requirements is to provide for development, establishment, and enforcement of standards of care of individuals in nursing homes and for the construction, maintenance, and operation of nursing homes which will promote safe and adequate treatment of such individuals in nursing homes. Minimum standards for the licensing of nursing homes were last adopted in 1987 with the publication of these regulations as identified above under the *Louisiana Administrative Code*. Since that time there has been a tremendous expansion of federal regulations governing long-term care. Therefore, the department is now proposing to repeal current nursing home licensing regulations and establish new licensing regulations in order to assure that a high quality of care is provided to persons residing in nursing homes.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing repeals current licensing regulations for all nursing homes in Louisiana and adopts the following regulations which are to be contained in LAC 48:I, Subpart 3, Chapters 97, 98, and 99.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensure

Chapter 97. Nursing Homes

Subchapter A. General Provisions

§9701. Definitions

Abuse—the willful infliction of physical or mental injury or the causing of the deterioration of a resident by means including, but not limited to, sexual abuse, exploitation, or extortion of funds or other things of value to such an extent that his health, moral, or emotional well-being is endangered.

Administrator—any individual who is, or may be charged with, the general administration of a nursing home, and who has been licensed and registered by the Board of Examiners of Nursing Home Administrators in accordance with the provisions of R.S. 37:2501.

Advanced-Practice Registered Nurse (APRN)—a licensed registered nurse who is certified by a nationally-recognized certifying body as having an advanced nursing specialty, and who meets the criteria for an advanced-practice registered nurse as established by the Louisiana State Board of Nursing. An advanced-practice registered nurse shall include certified

nurse midwife, certified registered nurse anesthetist, clinical nurse specialist, or nurse practitioner.

Ancillary Service—a service such as, but not limited to, podiatry, dental, audiology, vision, physical therapy, speech pathology, occupational therapy, psychological, and social services.

Applicant—the legal entity that applies for the license to open, conduct, manage, or maintain a nursing home.

Biological—a preparation used in the treatment or prevention of disease that is derived from living organisms or their by-product.

Change of Ownership—any change in the legal entity responsible for the operation of the facility. Management agreements are generally not changes of ownership if the former owner continues to retain policy responsibility and approve or concur in decisions involving the nursing home's operation. However, if these ultimate legal responsibilities, authorities, and liabilities are surrendered and transferred from the former owner to the new manager, then a change of ownership has occurred.

Charge Nurse—an individual who is licensed by the state of Louisiana to practice as an RN or LPN and designated as a charge nurse by the nursing home.

Chemical Restraint—a psychopharmacologic drug that is used for discipline or convenience and not required to treat medical symptoms.

Controlled Dangerous Substance—a drug, substance, or immediate precursor in Schedule I through V of R.S. 40:964.

Dietary Manager—a person who:

1. is a licensed dietitian; or
2. is a graduate of a dietetic technician program; or
3. has successfully completed a course of study, by correspondence or classroom, which meets the eligibility requirements for certification by the Dietary Manager's Association; or
4. has successfully completed a training course at a state approved school (vocational or university) which includes coursework in foods, food service supervision, and diet therapy. Documentation of an eight-hour course of formalized instruction in diet therapy, conducted by the employing facility's qualified dietitian, is permissible if the course meets only the foods, and food service supervision requirements; or
5. is currently enrolled in an acceptable course of not more than 12 months which will qualify an individual upon completion.

Director of Nursing (DON)—a registered nurse, licensed by the state of Louisiana, who directs and coordinates nursing services in a nursing home.

Drug Administration—an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container); verifying it with the physician's orders; giving the individual dose to the proper resident; monitoring the ingestion of the dose; and promptly recording the time and dose given.

Drug Dispensing—an act which entails the interpretation of an order for a drug or biological and, pursuant to the order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological for a resident or for a service unit of the facility by a licensed pharmacist, physician, or dentist.

Fees—remittance required by rules published by the department in *Louisiana Register*, June 20, 1989 (Volume 15, Number 6).

Licensed Bed—a bed set up, or capable of being set up, within 24 hours in a nursing home for the use of one resident.

Licensed Dietitian—a dietitian who is licensed to practice by the Louisiana Board of Examiners in Dietetics and Nutrition.

Licensed Practical Nurse (LPN)—an individual currently licensed by the Louisiana State Board of Practical Nurse Examiners to practice practical nursing in Louisiana.

Major Alteration—any repair or replacement of building materials and equipment which does not meet the definition of minor alteration.

Medical Director—a physician licensed in Louisiana who directs and coordinates medical care in a nursing home.

Minor Alteration—repair or replacement of building materials and equipment with materials and equipment of a similar type that does not diminish the level of construction below that which existed prior to the alteration. This does not include any alteration to the function or original design of the construction.

Neglect—the failure to provide the proper or necessary medical care, nutrition, or other care necessary for a resident's well-being.

Nurses' Call System—a system that audibly registers calls electronically from its place of origin (which means the resident's bed, toilet, or bathing facility) to the place of receivership (which means the nurses' station).

Nursing Home—any private home, institution, building, residence, or other place, serving two or more persons who are not related by blood or marriage to the operator, whether operated for profit or not, and including those places operated by a political subdivision of the state of Louisiana which undertakes, through its ownership or management, to provide maintenance, personal care, or nursing for persons who, by reason of illness or physical infirmity or age, are unable to properly care for themselves. The term does not include the following:

1. a home, institution, or other place operated by the federal government or agency thereof, or by the state of Louisiana;

2. a hospital, sanitarium, or other institution whose principal activity or business is the care and treatment of persons suffering from tuberculosis or from mental diseases;

3. a hospital, sanitarium, or other medical institution whose principal activity or business is the diagnosis, care, and treatment of human illness through the maintenance and operation of organized facilities therefore;

4. any municipal, parish, or private child welfare agency, maternity hospital, or lying-in home required by law to be licensed by some department or agency;

5. any sanitarium or institution conducted by and for Christian Scientists who rely on the practice of Christian Science for treatment and healing;

6. any nonprofit congregate housing program which promotes independent living by providing assistance with daily living activities such as cooking, eating, dressing, getting out of bed, and the like to persons living in a shared group environment who do not require the medical supervision and nursing assistance provided by nursing homes. No congregate housing program, except those licensed or operated by the state of Louisiana, shall:

- a. use the term "nursing home" or any other term implying that it is a licensed health care facility; or

- b. administer medications or otherwise provide any other nursing or medical service.

Physical Restraint—any physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.

Physician—an individual currently licensed by the Louisiana State Board of Medical Examiners to practice medicine and/or surgery in Louisiana.

Physician Assistant—a person who is a graduate of a program accredited by the Council on Medical Education of the American Medical Association or its successors, or who has successfully passed the national certificate examination administered by the National Commission on the Certification of Physicians' Assistants, or its predecessors, and who is approved and licensed by the Louisiana State Board of Medical Examiners to perform protocol services under the supervision of a physician or group of physicians approved by the board to supervise such assistant.

Registered Nurse (RN)—an individual currently licensed by the Louisiana State Board of Nursing to practice professional nursing in Louisiana.

Registered Pharmacist—an individual currently licensed by the Louisiana State Board of Pharmacy to practice pharmacy in Louisiana.

Resident—an individual admitted to the nursing home by and upon the recommendation of a physician, and who is to receive the medical and nursing care ordered by the physician.

Resident Activities Director—an individual responsible for directing or providing the activity services of a nursing home.

Restorative Nursing Care—activities designed to resolve, diminish, or prevent the needs that are inferred from the resident's problem; including the planning, implementation and evaluation of said activities in accordance with the Louisiana State Board of Nursing Legal Standards of Nursing Practice.

Social Service Designee—an individual responsible for arranging or directly providing medically-related social services.

Sponsor—an adult relative, friend, or guardian of a resident who has an interest or responsibility in the resident's welfare.

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 24:44 (January 1998).

§9703. Licensing Process

A. No application for a nursing home license, renewal of a license, or change in the existing license will be considered unless such application is in writing, on a form supplied by the department, containing the name(s) and address(es) of the owner(s), and signed by either the applicant or his representative.

1. It shall be accompanied by the fees and documentary evidence required by these licensing requirements.

2. When the secretary finds that an application is in proper order, he/she will cause whatever investigations are necessary to be made.

3. He/She may also cause routine, periodic inspections to be made of licensed nursing homes and such special inspections and investigations as he/she may consider necessary.

B. The applicant or applicant's designee shall disclose to the department the name and address of all individuals with 5 percent or more ownership interest, and, in the instance where the nursing home is a corporation or partnership, the name and address of each officer or director, and board members.

C. If the nursing home is operated by a management company, or leased in whole or in part by another organization, the applicant or applicant's designee shall disclose to the department the name of the management firm and employer identification number, or the name of the leasing organization.

D. The nursing home shall complete the licensing application form and return it to the department at least 15 days prior to the initial licensing survey or expiration date of the current license, accompanied by a nonrefundable, per annum licensing fee as provided by law. All fees shall be submitted only by certified or company check, or U.S. postal money order, made payable to DHH. All state-owned facilities are exempt from fees. The nursing home shall reapply for licensing on an annual basis.

E. The nursing home shall only accept that number of residents for which it is licensed, unless prior written approval has been secured from the department.

F. If a nursing home is in substantial compliance with the licensing requirements for nursing homes and the nursing home licensing law, a license shall be issued by the department for a period of not more than 12 months, determined by the department. If a nursing home is not in substantial compliance with the licensing requirements for nursing homes and the nursing home licensing law, the department may issue a provisional license for a period of up to six months if there is no immediate and serious threat to the health and safety of residents.

G. For an increase in bed capacity as a result of new construction, renovations or alterations, a fee as provided by law shall be remitted to the department. Approval shall be granted after an on-site survey or through the submission of a signed and dated attestation to the compliance with these licensing requirements.

H. For a replacement license, when changes such as name change, address change, or bed reduction are requested, in

writing, by the nursing home, a fee as provided by law shall be remitted.

I. For a change in licensee or premises, the buyer(s) shall submit to the department a completed application for nursing home licensing with a licensing fee, as provided by law. Nursing home licensing is not transferable from one entity or owner(s) to another.

J. A processing fee, as provided by law, shall be submitted by the nursing home for issuing a duplicate facility license with no changes.

K. The license shall be conspicuously posted in the nursing home.

L. Licensing inspection visits should be a source of help and guidance to the management. During these inspection visits the representatives of the department, in addition to checking compliance by the home with fire, sanitation, diet and health regulations, will review with the management the overall plan for the care of residents and the personnel needs of the home and will also offer recommendations designed to improve the service of the home, unless contraindicated by a more stringent rule, regulation, or policy.

M. Exceptions to these Licensing Requirements

1. Where any requirement on an existing nursing home would impose a financial hardship but would not adversely affect the health and safety of any resident, the existing nursing home may submit a request for exception (waiver) to the department.

2. Where a more stringent requirement on an existing nursing home would impose an unreasonable hardship, the existing nursing home may submit a written request for exception, along with supporting documentation, to the department.

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 24:46 (January 1998).

§9705. License Denial, Revocation; or Nonrenewal of License

The department also may deny, suspend, or revoke a license where there has been substantial noncompliance with these requirements in accordance with the nursing home licensing law. If a license is denied, suspended, or revoked, an appeal may be requested as outlined in the nursing home licensing law.

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 24:46 (January 1998).

§9707. Approval of Plans

A. All new construction, other than minor alterations, shall be done in accordance with the specific requirements of the Office of the State Fire Marshal and the Bureau of Engineering and Consulting Services of the Department of Health and Hospitals, covering new construction in nursing homes, including submission of preliminary plans and the submission of final work drawings and specifications to each of these agencies.

B. No new nursing home shall hereafter be constructed, nor shall major alterations be made to existing nursing homes, without prior written approval, and unless in accordance with plans and specifications approved in advance by the Bureau of Engineering and Consulting Services of the Department of Health and Hospitals and the Office of the State Fire Marshal. The review and approval of plans and specifications shall be made in accordance with these licensing requirements for nursing homes and the *State of Louisiana Sanitary Code*.

C. Before any new nursing home is licensed, or before any alteration or expansion of a licensed nursing home can be approved, the applicant must furnish one complete set of plans and specifications to the Bureau of Engineering and Consulting Services of the Department of Health and Hospitals and one complete set of plans and specifications to the Office of the State Fire Marshal, together with fees and other information as may be required.

1. Plans and specifications for new construction, other than minor alterations, shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer.

2. No residential conversions will be considered for a nursing home license.

D. In the event that submitted materials do not satisfactorily comply with the aforementioned publications, the Department of Health and Hospitals shall furnish a letter to the party submitting the plans which shall list the particular items in question and request further explanation and/or confirmation of necessary modifications.

E. Notice of satisfactory review from the Department of Health and Hospitals and the Office of the State Fire Marshal constitutes compliance with this requirement, if construction begins within 180 days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes, or rules of any responsible agency.

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 24:46 (January 1998).

§9709. Fire Protection

All nursing homes required to be licensed by the law shall comply with the rules, established fire protection standards, and enforcement policies as promulgated by the Office of the State Fire Marshal.

1. It shall be the primary responsibility of the Office of the State Fire Marshal to determine if applicants are complying with those requirements.

2. No initial license shall be issued without the applicant furnishing a certificate from the Office of the State Fire Marshal that such applicant is complying with their provisions.

3. A provisional license may be issued to the applicant if the Office of the State Fire Marshal issues the applicant a conditional certificate.

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 24:47 (January 1998).

§9711. Sanitation and Patient Safety

All nursing facilities required to be licensed by the law shall comply with the rules, sanitary code and enforcement policies as promulgated by the Office of Public Health.

1. It shall be the primary responsibility of the Office of Public Health to determine if applicants are complying with those requirements.

2. No initial license shall be issued without the applicant furnishing a certificate from the Office of Public Health that such applicant is complying with their provisions.

3. A provisional license may be issued to the applicant if the Office of Public Health issues the applicant a conditional certificate.

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 24:47 (January 1998).

Subchapter B. Organization and General Services

§9713. Delivery of Services

A nursing home shall be administered in a manner that promotes the highest level of functioning and well-being of each resident.

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 24:47 (January 1998).

§9715. Governing Body

A. The nursing home shall have a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the nursing home. The governing body shall develop and approve policies and procedures which define and describe the scope of services offered. They shall be revised as necessary and reviewed at least annually.

B. The governing body shall be responsible for the operation of the nursing home.

C. The governing body shall appoint, in writing, a licensed administrator responsible for the management of the nursing home.

D. The governing body shall notify the department, in writing by certified mail, when a change occurs in the administrator position within 30 calendar days after the change occurs. The notice shall include the identity of the individual and the specific date the change occurred.

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 24:47 (January 1998).

§9717. Administration

A. There shall be a full-time Louisiana licensed nursing facility administrator. The administrator shall be engaged in the act of administration, and the activity shall be the major function of the person performing the act.

B. Another full-time employee shall be authorized, in writing, to act in the administrator's behalf when he/she is absent.

C. The administrator shall notify the department in writing when a change occurs in the director of nursing position within 30 calendar days after the change occurs. The notice shall include the identity of the individual and the specific date the change occurred.

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 24:47 (January 1998).

§9719. Personnel

A. There shall be sufficient qualified personnel to properly operate each department of the nursing home to assure the health, safety, proper care, and treatment of the residents.

1. Time schedules shall be maintained indicating the numbers and classification of all personnel, including relief personnel, who work on each tour of duty. The time schedules shall reflect all changes so as to indicate who actually worked.

2. Should there be a need to commingle the nursing service staff with other personnel:

a. nurse aides shall not work in food preparation after having provided personal care to residents;

b. laundry and housekeeping personnel shall not provide nursing care functions to residents;

c. nursing service personnel may perform housekeeping duties only after normal duty hours of the housekeeping staff or when a situation arises that may cause an unsafe situation.

B. Personnel records shall be current and available for each employee and shall contain sufficient information to assure that they are assigned duties consistent with his or her job description and level of competence, education, preparation, and experience.

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 24:48 (January 1998).

§9721. Criminal History Provisions; Screening

A. Nursing homes shall have criminal history checks performed on nonlicensed personnel to include CNAs, housekeeping staff, activity workers, and social service personnel in accordance with R.S. 40:1300.5 et seq.

B. All personnel requiring licensure to provide care shall be licensed to practice in the state of Louisiana. Credentials of all licensed full-time, part-time, and consultant personnel shall be verified on an annual basis, in writing, by a designated staff member.

C. TB Testing. All personnel, including volunteer workers, involved in direct resident care, shall adhere to Section 3, Chapter II of the *State of Louisiana Sanitary Code*, Sections 2:022-2:025-1 and 2:026.

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 24:48 (January 1998).

§9723. Policies and Procedures

A. There shall be written policies and procedures:

1. available to staff, residents, and/or sponsors governing all areas of care and services provided by the nursing home;

2. ensuring that each resident receives the necessary care and services to promote the highest level of functioning and well-being of each resident;

3. developed with the advice of a group of professional personnel consisting of at least a licensed physician, the administrator, and the director of nursing service;

4. approved by the governing body;

5. revised, as necessary, but reviewed by the professional group at least annually;

6. available to admitting physicians; and

7. reflecting awareness of, and provision for, meeting the total medical and psychosocial needs of residents, including admission, transfer, and discharge planning; and the range of services available to residents, including frequency of physician visits by each category of residents admitted.

B. The administrator, or his designee, is responsible, in writing, for the execution of such policies.

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 24:48 (January 1998).

§9725. Assessments and Care Plans

A. An initial assessment of the resident's needs/problems shall be performed and documented in each resident's clinical record by a representative of the appropriate discipline.

B. The assessment shall be used to develop the resident's plan of care.

C. The assessment and care plan shall be completed within 21 days of admission.

D. The care plan shall be revised, as necessary, and reviewed, at least annually, by the personnel involved in the care of the resident.

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 24:48 (January 1998).

§9727. Staff Orientation, Training and Education

A. New employees shall have an orientation program of sufficient scope and duration to inform the individual about his/her responsibilities and how to fulfill them.

B. The orientation program shall include at least a review of policies and procedures, job description, and performance expectations prior to the employee performing his/her responsibilities.

C. A staff development program shall be conducted by competent staff and/or consultants and planned based upon employee performance appraisals, resident population served by the nursing home, and as determined by facility staff. All employees shall participate in in-service education programs which are planned and conducted for the development and improvement of their skills.

D. The in-service training shall include at least problems and needs common to the age of those being served; prevention

and control of infections; fire prevention and safety; emergency preparedness; accident prevention; confidentiality of resident information; and preservation of resident dignity and respect, including protection of privacy and personal and property rights.

E. The facility's in-service training shall be sufficient to ensure the continuing competence of the staff but must be provided no less than 12 hours per year.

F. Records of in-service training shall be maintained indicating the content, time, names of employees in attendance, and the name of the presenter.

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 24:48 (January 1998).

§9729. Emergency Preparedness

A. The nursing home shall have an emergency preparedness plan (which conforms to the Office of Emergency Preparedness model plan) designed to manage the consequences of natural disasters or other emergencies that disrupt the nursing home's ability to provide care and treatment or threaten the lives or safety of the nursing home residents.

B. As a minimum, the program shall have a written plan that describes:

1. the evacuation of residents to a safe place, either within the nursing home or to another location;
2. the delivery of essential care and services to nursing home residents, whether residents are housed off-site or when additional residents are housed in the nursing home during an emergency;
3. the provisions for the management of staff, including distribution and assignment of responsibilities and functions, either within the nursing home or at another location;
4. a plan for coordinating transportation services required for evacuating residents to another location; and
5. assurance that the resident's family or sponsor is notified if resident is evacuated to another location.

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

D. The nursing home's plan shall be reviewed and approved by the parish Office of Emergency Preparedness, utilizing appropriate community-wide resources.

E. The plan shall be available to representatives of the Office of the State Fire Marshal.

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).

§9731. Complaint Process

A. Provisions for Complaints. In accordance with R.S. 40:2009.13 et seq., the following requirements are established for receiving, evaluating, investigating, and correcting grievances pertaining to resident care in licensed nursing

homes. They also provide for mandatory reporting of abuse and neglect in nursing homes.

B. Nursing Home Complaints, Procedure, Immunity

1. Any person having knowledge of the alleged abuse or neglect of a resident of a nursing home; or who has knowledge that a state law, licensing requirement, rule, or regulation, or correction order promulgated by the department, or any federal certification rule pertaining to a nursing home has been violated; or who otherwise has knowledge that a nursing home resident is not receiving care and treatment to which he is entitled under state or federal laws, may submit a complaint regarding such matter to the secretary (Department of Health and Hospitals). The complaint shall be submitted to the Health Standards Section of DHH in writing, by telephone, or by personal visit where the complainant will complete and sign a form furnished by the member of the secretary's staff receiving the complaint.

2. The secretary shall designate a staff member whose responsibility shall be to assure that all complaints received are referred to the appropriate office of the department (Health Standards Section).

3. If the complaint involves an alleged violation of any criminal law pertaining to nursing homes, the secretary shall refer the complaint to the appropriate office.

4. If the complaint involves any other matter, the secretary shall refer the complaint to the appropriate office for investigation in accordance with this Section.

5. Any person who, in good faith, submits a complaint pursuant to this Section shall have immunity from any civil liability that otherwise might be incurred or imposed because of such complaint. Such immunity shall extend to participation in any judicial proceeding resulting from the complaint.

C. Procedure for Investigation by the Office; Confidentiality of Complaints

1. The office of the department which has received the complaint from the secretary shall review the complaint and determine whether there are reasonable grounds for an investigation. No complaint shall be investigated if:

- a. in the opinion of the office, it is trivial or not made in good faith;
- b. it is too out dated and delayed to justify present investigation; or
- c. the complaint is not within the investigating authority of the office.

2. If the office determines that grounds for an investigation do not exist, it shall notify the complainant of its decision and the reasons within 15 work days after receipt of such complaint.

3. If grounds for an investigation do exist, the office shall initiate an investigation of such complaint and make a report to the complainant on its findings within 30 work days after completion of the complaint investigation.

4. The substance of the complaint shall be given to the nursing home no earlier than at the commencement of the investigation of the complaint.

5. When the substance of the complaint is furnished the nursing home, it shall not identify the complainant or the patient unless he/she consents, in writing or in a documented

telephone conversation with an employee, to the disclosure. If the disclosure is considered essential to the investigation or if the investigation results in a judicial proceeding, the complainant shall be given the opportunity to withdraw the complaint.

D. Investigation Report

1. The investigation report of the department shall state whether any nursing home licensing law, or any licensing requirement, rule, regulation, or correction order of the Department of Health and Hospitals, or any standard relating to the health, safety, care, or treatment of residents in nursing homes has been violated.

a. If such violation is found to exist, the appropriate departmental staff shall immediately provide notice of such violation to the secretary.

b. The report shall also contain a deficiency statement to the nursing home. A copy of the report shall be sent by certified mail or hand-delivered to the complainant and to the nursing home.

2. The deficiency statement shall describe the violation; list the rule or law violated; and solicit corrective actions to be taken by the nursing home.

3. A nursing home which is ordered to correct deficiencies may file a written request that the department review the corrective action taken by the home and, if necessary, reinspect the home.

a. The department shall comply with the request in a timely manner.

b. If no such request is received, the department shall review the steps taken by the home in order to comply with the corrective order and, if necessary, reinspect the home on the final date fixed for completion of the correction of the violation.

4. If the violation is found to continue to exist on the correction date, the office shall notify the appropriate department to take further action as indicated applicable by state regulations.

E. Hearing

1. A complainant or nursing home who is dissatisfied with the department's determination or investigation may request a hearing.

2. A request for a hearing shall be submitted, in writing, to the secretary within 30 days after the department's report has been mailed in accordance with the provisions of R.S. 40:2009.15A(1).

3. Notice of the time and place fixed for the hearing shall be sent to the complainant and the nursing home.

4. All appeal procedures shall be conducted in accordance with the Administrative Procedure Act.

F. Prohibition Against Retaliation. No discriminatory or retaliatory action shall be taken by any health care facility or government agency against any person or client by whom or for whom any communication was made to the department or unit, provided the communication is made in good faith for the purpose of aiding the office or unit to carry out its duties and responsibilities.

G. Notice of the Complaint Procedure. Notice of the complaint procedure, complete with the name, address, and telephone number of the Health Standards Section of the Office

of the Secretary of the Department of Health and Hospitals, shall be posted conspicuously in the nursing home at places where residents gather.

H. In accordance with R.S. 14:403.2, 14:93.3, 14:93.4, and 14:93.5, all nursing homes shall adhere to the adult protective services laws.

I. Duty to Make Complaints; Penalty; Immunity

1. Any person who is engaged in the practice of medicine, social services, facility administration, psychological or psychiatric treatment; or any registered nurse, licensed practical nurse, or nurse's aid, who has actual knowledge of the abuse or neglect of a resident of a health care facility shall, within 24 hours, submit a complaint to the secretary or inform the unit or local law enforcement agency of such abuse or neglect.

2. Any person who knowingly or willfully violates the provisions of this Section shall be fined not more than \$500; or imprisoned for not more than two months; or both.

3. Any person who, in good faith, submits a complaint pursuant to this Section shall have immunity from any civil liability that otherwise might be incurred or imposed because of such complaint. Such immunity shall extend to participation in any judicial proceeding resulting from the complaint.

4. Any person, other than the person alleged to be responsible for the abuse or neglect, reporting pursuant to this Section in good faith, shall have immunity from any civil liability that otherwise might be incurred or imposed because of such report. Such immunity shall extend to participation in any judicial proceeding resulting from such report.

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).

Subchapter C. Resident Rights

§9733. Statement of Rights and Responsibilities

A. In accordance with R.S. 40:2010.8 et seq., all nursing homes shall adopt and make public a statement of the rights and responsibilities of the residents residing therein and shall treat such residents in accordance with the provisions of the statement. The statement shall assure each resident the following:

1. the right to civil and religious liberties including, but not limited to, knowledge of available choices; the right to independent personal decision; and the right to encouragement and assistance from the staff of the facility in the fullest possible exercise of these civil and religious rights;

2. the right to private and uncensored communications including, but not limited to, receiving and sending unopened correspondence; access to a telephone; visitation with any person of the resident's choice; and overnight visitation outside the facility with family and friends in accordance with nursing home policies and physician's orders without the loss of his bed;

a. nursing home visiting hours shall be flexible, taking into consideration special circumstances such as out-of-town visitors and working relatives or friends;

b. with the consent of the resident and in accordance with the policies approved by the Department of Health and

Hospitals, the home shall permit recognized volunteer groups, representatives of community-based legal, social, mental health, and leisure and planning programs, and members of the clergy access to the home during visiting hours for the purpose of visiting with and providing services to any resident;

3. the right to present grievances on behalf of himself or others to the nursing home's staff or administrator, to governmental officials, or to any other person; to recommend changes in policies and services to nursing home personnel; and to join with other residents or individuals within or outside the home to work for improvements in resident care, free from restraint, interference, coercion, discrimination or reprisal. This right includes access to the resident's sponsor and the Department of Health and Hospitals; and the right to be a member of, to be active in, and to associate with advocacy or special interest groups;

4. the right to manage his own financial affairs or to delegate such responsibility to the nursing home, but this delegation may be only to the extent of the funds held in trust for the resident by the home. A quarterly accounting of any transactions made on behalf of the resident shall be furnished to the resident and his sponsor, if requested. A copy shall be retained in the resident's records on file in the home;

5. the right to be fully informed, in writing and orally, prior to or at time of admission and during his stay, of services not covered by the basic per diem rates and of bed reservation and refund policies of the home;

6. the right to be adequately informed of his medical condition and proposed treatment, unless otherwise indicated by the resident's physician; to participate in the planning of all medical treatment, including the right to refuse medication and treatment, unless otherwise indicated by the resident's physician; and to be informed of the consequences of such actions;

7. the right to receive adequate and appropriate health care and protective and support services, including services consistent with the resident care plan, with established and recognized practice standards within the community and with rules promulgated by the Department of Health and Hospitals;

8. the right to have privacy in treatment and in caring for personal needs:

a. to have closed room doors, and to have facility personnel knock before entering the room, except in case of an emergency or unless medically contraindicated;

b. to have confidentiality in the treatment of personal and medical records;

c. to be secure in storing and using personal possessions, subject to applicable state and federal health and safety regulations and the rights of other residents; and

d. privacy of the resident's body shall be maintained during, but not limited to, toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance;

9. the right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and oral explanations of the services provided by the home, including statements and explanations required to be offered on an as-needed basis;

10. the right to be free from mental and physical abuse and from physical and chemical restraints, except those restraints authorized by the attending physician for a specified and limited period of time or those necessitated by an emergency:

a. in case of an emergency, restraint may only be applied by a qualified licensed nurse, who shall set forth, in writing, the circumstances requiring the use of the restraint, and, in case of a chemical restraint, the attending physician shall be consulted immediately thereafter;

b. restraints shall not be used in lieu of staff supervision or merely for staff convenience or resident punishment, or for any reason other than resident protection or safety;

11. the right to be transferred or discharged:

a. a resident can be transferred or discharged only if necessary for his welfare and if his needs cannot be met in the facility; his health has improved sufficiently so that he no longer needs the services provided by the facility; the safety of individuals in the facility is endangered; the health of individuals in the facility would otherwise be endangered; he has failed, after reasonable and appropriate notice, to pay or have paid for a stay at the facility; or the facility ceases to operate;

b. both the resident and his legal representative or interested family member, if known and available, have the right to be notified, in writing, in a language and manner they understand, of the transfer and discharge. The notice must be given no less than 30 days in advance of the proposed action, except that the notice may be given as soon as is practicable prior to the action in the case of an emergency. In facilities not certified to provide services under Title XVIII or Title XIX of the Social Security Act, the advance notice period may be shortened to 15 days for nonpayment of a bill for a stay at the facility;

c. the resident, or his legal representative or interested family member, if known and available, has the right to appeal any transfer or discharge to the Department of Health and Hospitals, which shall provide a fair hearing in all such appeals;

d. the facility must ensure that the transfer or discharge is effectuated in a safe and orderly manner. The resident and his legal representative or interested family member, if known and available, shall be consulted in choosing another facility if facility placement is required;

12. the right to select a personal physician; to obtain pharmaceutical supplies and services from a pharmacy of the resident's choice, at the resident's own expense; and to obtain information about, and to participate in, community-based activities and programs, unless medically contraindicated, as documented by the attending physician in the resident's medical record, and such participation would violate infection control laws or regulations;

13. the right to retain and use personal clothing and possessions, as space permits, unless to do so would infringe upon the rights of other residents or unless medically contraindicated, as documented by the attending physician in the resident's medical record. Clothing need not be provided

to the resident by the home, except in emergency situations. If provided, it shall be of reasonable fit;

14. the right to have copies of the nursing home's rules and regulations and an explanation of the resident's responsibility to obey all reasonable rules and regulations of the nursing home and of his responsibility to respect the personal rights and private property of other residents;

15. the right to be informed of the bed reservation policy for a hospitalization:

a. the nursing home shall inform a private pay resident and his sponsor that his bed shall be reserved for any single hospitalization for a period up to 30 days, provided the nursing home receives reimbursement;

b. notice shall be provided within 24 hours of the hospitalization;

16. the right to receive a prompt response to all reasonable requests and inquiries;

17. the right of the resident to withhold payment for physician visitation if the physician did not examine the resident;

18. the right to refuse to serve as a medical research subject without jeopardizing access to appropriate medical care;

19. the right to use tobacco, at his own expense, under the home's safety rules and under applicable laws and rules of the state, unless the facility's written policies preclude smoking in designated areas;

20. the right to consume a reasonable amount of alcoholic beverages, at his own expense, unless:

a. not medically advisable, as documented in his medical record by the attending physician; or

b. unless alcohol is contraindicated with any of the medications in the resident's current regime; or

c. unless expressly prohibited by published rules and regulations of a nursing home owned and operated by a religious denomination which has abstinence from the consumption of alcoholic beverages as a part of its religious belief;

21. the right to retire and rise in accordance with his reasonable requests, if he does not disturb others and does not disrupt the posted meal schedules and, upon the home's request, if he remains in a supervised area unless retiring and rising in accordance with the resident's request is not medically advisable, as documented in his medical record by the attending physician;

22. the right to have any significant change in his health status immediately reported to him and his legal representative or interested family member, if known and available, as soon as such a change is known to the home's staff.

B. A sponsor may act on a resident's behalf to assure that the nursing home does not deny the resident's rights under the provisions of R.S. 40:2010.6 et seq., and no right enumerated therein may be waived for any reason whatsoever.

C. Each nursing home shall provide a copy of the statement required by R.S. 40:2010.8(A) to each resident and sponsor upon or before the resident's admission to the home and to each staff member of the home. The statement shall also advise the resident and his sponsor that the nursing home is not

responsible for the actions or inactions of other persons or entities not employed by the facility, such as the resident's treating physician, pharmacists, sitter, or other such persons or entities employed or selected by the resident or his sponsor. Each home shall prepare a written plan and provide appropriate staff training to implement the provisions of R.S. 40:2010.6 et seq., including but not limited to, an explanation of the following:

1. the residents' rights and the staff's responsibilities in the implementation of those rights;

2. the staff's obligation to provide all residents who have similar needs with comparable services, as required by state licensing standards.

D. Any violations of the residents' rights set forth in R.S. 40:2010.6 et seq. shall constitute grounds for appropriate action by the Department of Health and Hospitals.

1. Residents shall have a private right of action to enforce these rights, as set forth in R.S. 40:2010.9. The state courts shall have jurisdiction to enjoin a violation of resident's rights and to assess fines for violations, not to exceed \$100 per individual violation.

2. In order to determine whether a home is adequately protecting residents' rights, inspection of the home by the Department of Health and Hospitals shall include private, informal conversations with a sample of residents to discuss residents' experiences within the home with respect to the rights specified in R.S. 40:2010.6 et seq., and with respect to compliance with departmental standards.

E. Any person who submits or reports a complaint concerning a suspected violation of residents' rights or concerning services or conditions in a home or health care facility or who testifies in any administrative or judicial proceedings arising from such complaint shall have immunity from any criminal or civil liability therefor, unless that person has acted in bad faith with malicious purpose, or if the court finds that there was an absence of a justiciable issue of either law or fact raised by the complaining party.

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 24:50 (January 1998).

Subchapter D. Sanctions and Appeal Procedures

§9735. Authority and Scope

Any person or entity found to be in violation of any provision of R.S. 40:2009.1 through 40:2009.11 may be sanctioned by revocation of license, nonrenewal of license, or by civil fines as mandated by state law.

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 24:52 (January 1998).

§9737. Considerations

The secretary shall impose the sanction(s) which will bring the nursing home into compliance in the most efficient and effective manner, with the care and well-being of the residents being the paramount consideration. The secretary's decision shall be based on an assessment of some or all of the following factors:

1. whether the violations pose an immediate threat to the health or safety of the residents;
2. the duration of the violations;
3. whether the violation (or one that is substantially similar) has previously occurred during the last three consecutive surveys.

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 24:52 (January 1998).

§9739. Repeat Violations

The Department of Health and Hospitals shall have the authority to determine whether a violation is a repeat violation and shall inform the facility in its notice of that determination. Violations may be considered repeat violations by the Department of Health and Hospitals if the one or more of the following conditions are found to exist.

1. Where the Department of Health and Hospitals has established the existence of a violation as of a particular date, and the violation is one that may be reasonably expected to continue until corrective action is taken, the department may elect to treat said continuing violation as a repeat violation subject to appropriate fines for each day following the date on which the initial violation is established, until such time as there is evidence establishing a date by which the violation was corrected.

2. Where the Department of Health and Hospitals has established the existence of a violation, and another violation which is the same or substantially similar to the previous violation occurs within 18 months, the subsequent violation and all other violations thereafter shall be considered repeat violations subject to fines and other sanctions appropriate for repeat violations.

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 24:53 (January 1998).

§9741. Notice and Appeal Procedure

A. Unless otherwise indicated, any sanction may be administratively appealed in the manner described in the nursing home law in Section 2009.11.

B. Notice to Facility of Violation. When the Department of Health and Hospitals has reasonable cause to believe, through an on-site survey, a complaint investigation, or other means that there exists or has existed a threat to the health, safety, welfare, or rights of a nursing facility resident, the department shall give notice of the violation(s) in the following manner.

1. The head of the survey team shall conduct an exit conference and give the facility administrator or his designee the preliminary finding of fact and the possible violations before leaving the facility.

2. The department shall follow the discussion with confirmed written notice, given by certified mail or hand delivery, to the facility administrator.

3. The department's written notice of deficiencies shall be consistent with the findings delineated at the conference and shall:

- a. specify the violation(s);
- b. cite the legal authority which established such violation(s);
- c. cite any sanctions assessed for each violation;
- d. inform the administrator that the facility has 10 days from receipt of notice, sent by certified mail or hand delivery, within which to request a reconsideration of the proposed agency action;
- e. inform the administrator of the facility that the consequences of failing to timely request an administrative appeal will be that the departmental determination will be considered final, and that no further administrative or judicial review will be had;
- f. inform the administrator of the facility if the department has elected to regard the violation(s) as repeat violation(s) or as continuing violation(s) and the manner in which sanctions will be imposed.

C. The facility may request administrative reconsideration of the department's findings. This request must be made, in writing, within 10 days after receipt of the initial notice from the state survey agency. This reconsideration of findings shall be conducted by designated employees of the department who did not participate in the initial decision to cite the deficiencies. Reconsideration shall be made on the basis of documents before the designated employees and shall include the survey report and statement of deficiencies and all documentation the facility submits to the department at the time of its request for reconsideration. Correction of a deficiency shall not be a basis for reconsideration. Oral presentations can be made by department spokesmen and facility spokesmen. This process is not in lieu of the appeals process. The designated employees shall have authority only to affirm the survey findings; revoke some or all of the cited deficiencies; or request additional information from either the department or the facility. The department shall notify the facility of its decision within three working days after the oral presentation and receipt of all requested documentation. Participation in the reconsideration does not delay the imposition of recommended remedies.

D. If the facility requests an administrative appeal, such request shall:

1. state which violation(s) the facility contests and the specific reasons for disagreement;
2. be submitted to the Department of Health and Hospitals within 30 days of receipt of the secretary's decision on the final agency action by certified mail or hand delivery;

E. The administrative hearing shall be limited to those issues specifically contested and shall not include any claim or argument that the violation(s) have been corrected. Any violations not specifically contested shall become final, and sanctions shall be enforced at the expiration of the time for appeal. All violations/sanctions not contested shall become final at the expiration of the appeal request time period.

F. If the facility does not request an administrative appeal in a timely manner or does not submit satisfactory evidence to rebut the department's findings of a violation, the decision to impose sanctions will be final and the secretary shall have the authority to enforce sanctions, as provided in these regulations.

G. The department may institute all necessary civil court action to collect fines imposed and not timely appealed. No nursing facility may claim fines as reimbursable costs, nor increase charges to residents as a result of such fines. Interest shall begin to accrue at the current judicial rate on the day following the date on which any fines become due and payable.

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 24:53 (January 1998).

§9743. Civil Money Penalties (Fines)

A. The following listed civil fines pertaining to classified violations may be assessed by the secretary against nursing homes. In the case of class "A" violations, the following civil fines shall be assessed. In the cases of class "B," "C," "D," or "E" violations, the secretary, in his discretion, may elect to assess the following civil fines or may allow a specified period of time for correction of said violation. For class "D" and "E" violations, the facility will be given notice of the fine at the time of the first violation and may be given an opportunity to demonstrate compliance before the fine becomes final.

1. If compliance is demonstrated on the follow-up visit, payment of the fine may be waived. In all instances the violation is counted and recorded.

2. If compliance is not demonstrated at the next visit, the penalty for a repeat violation will be assessed. No facility shall be penalized because of a physician's or consultant's nonperformance beyond the facility's control or if the violation is beyond the facility's control, if the situation and the efforts to correct it are clearly documented.

3. It is not the intent that every violation found on a survey, inspection, or related visit should be accompanied by an administrative penalty.

B. Class "A" violations are subject to a civil fine which shall not exceed \$2,500 for the first violation. A second class "A" violation occurring within an 18-month period from the first violation shall not exceed \$5,000 per day.

C. Class "B" violations are subject to a civil fine which shall not exceed \$1,500 for the first violation. A second Class "B" violation occurring within an 18-month period from the first violation shall not exceed \$3,000 per day.

D. Class "C" violations are subject to a civil fine which shall not exceed \$1,000 for the first violation. A second Class "C" violation occurring within an 18-month period from the first violation shall not exceed \$2,000 per day.

E. Class "D" violations are subject to a civil fine which shall not exceed \$100 for the first violation. Each subsequent Class "D" violation within an 18-month period from the first violation shall not exceed \$250 per day.

F. Class "E" violations are subject to a civil fine which shall not exceed \$50 for the first violation. Each subsequent Class "E" violation occurring within an 18-month period from the first violation shall not exceed \$100 per day.

G. The total amount of fines assessed for violations determined in any one month shall not exceed \$5,000, except that the aggregate fines assessed for Class "A" or "B" violations shall not exceed \$10,000 in any one month.

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 24:54 (January 1998).

§9745. Classes of Violations Defined

A. *Class "A" Violations*—those violations which create a condition or occurrence relating to the operation and maintenance of a nursing home which result in death or serious harm to a resident.

B. *Class "B" Violations*—those violations which create a condition or occurrence relating to the operation and maintenance of a nursing home which create a substantial probability that death or serious physical harm to a resident will result from the violation.

C. *Class "C" Violations*—conduct, acts, or omissions which do not result in death or serious physical harm to a resident or the substantial probability thereof but create a condition or occurrence relating to the operation and maintenance of a nursing home that create a potential for harm by directly threatening the health, safety, rights or welfare of a resident are Class "C" violations.

D. *Class "D" Violations*—those violations which are related to administrative and reporting requirements that do not directly threaten the health, safety, rights, or welfare of a resident.

E. *Class "E" Violations*—Class "E" violations are defined as the failure of any nursing home to submit a statistical or financial report in a timely manner as required by regulations. The failure to timely submit a statistical or financial report shall be considered a separate Class "E" violation during any month or part thereof in noncompliance.

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 24:54 (January 1998).

§9747. Collection of Civil Fines Assessed

A. Civil fines assessed shall be final if:

1. no timely or proper appeal was requested;
2. the facility admits the violations and agrees to pay; and
3. the administrative hearing is concluded with findings of violations and time for seeking judicial review has expired.

B. When civil fines become final, they shall be paid in full within 10 days of their commencement unless the department allows a payment schedule in light of a documented financial hardship. Such documentation shall be submitted within the 10-day period.

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 24:54 (January 1998).

§9749. Revocation of License

A. The secretary of the Department of Health and Hospitals may deny an application for a license or refuse to renew a license or may revoke an outstanding license when an investigation reveals that the applicant or licensee is in nonconformance with or in violation of the provisions of R.S. 40:2009.6, provided that in all such cases, the secretary shall

furnish the applicant or licensee 30 calendar days written notice specifying reasons for the action.

B. The secretary, in a written notice of denial, nonrenewal, or revocation of a license, shall notify the applicant or licensee of his right to file a suspensive appeal with the Office of the Secretary within 30 calendar days from the date the notice, as described in this Subchapter, is received by him. This appeal or request for a hearing shall specify, in detail, reasons why the appeal is lodged and why the appellant feels aggrieved by the action of the secretary.

C. When any appeal, as described in this Subchapter, is received by the secretary, if timely filed, he shall appoint an impartial three-member board to conduct a hearing on the appeal, at such time and place as such members deem proper, and after such hearing, to render a written opinion on the issues presented at the hearing. The written decision or opinion of a majority of the members conducting the hearing shall constitute final administrative action on the appeal.

D. Any member of said board or the secretary shall have power to administer oaths and to subpoena witnesses on behalf of the board or any party in interest and compel the production of books and papers pertinent to any investigation or hearing authorized by this Subchapter, provided that in all cases witness fees and transportation and similar hearing costs shall be paid by the appellant or by the Department of Health and Hospitals if the appellant is found innocent of charges. Any person, having been served with a subpoena, who shall fail to appear in response to the subpoena or fail or refuse to answer any question or fail to produce any books or papers pertinent to any investigation or hearing or who shall knowingly give false testimony therein shall be guilty of a misdemeanor and shall, upon conviction, be punished by a fine of not less than \$100, nor more than \$500, or by imprisonment of not less than one month nor more than six months, or by both such fine and imprisonment.

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 24:54 (January 1998).

Chapter 98. Nursing Homes

Subchapter A. Physician Services

§9801. Medical Director

A. The nursing home shall designate, pursuant to a written agreement, a physician currently holding an unrestricted license to practice medicine by the Louisiana State Board of Medical Examiners to serve as medical director.

B. The medical director shall serve as consultant regarding medical care policies and procedures.

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 24:55 (January 1998).

§9803. Physician Supervision

A. A resident shall be admitted to the nursing home only with an order from a physician licensed to practice in Louisiana.

1. Each resident shall remain under the care of a physician licensed to practice in Louisiana and shall have freedom of choice in selecting his/her attending physician.

2. The nursing home shall be responsible for assisting in obtaining an attending physician, with the resident's or sponsor's approval, when the resident or sponsor is unable to find one.

B. Another physician supervises the medical care of residents when their attending physician is unavailable.

C. Any required physician task may also be satisfied when performed by an advanced-practice registered nurse or physician assistant who is not an employee of the nursing home, but who is working under the direction and supervision of a physician.

D. The nursing home shall provide or arrange for the provision of physician services 24 hours a day, in case of emergency.

E. The name and telephone numbers of the attending physicians and the physicians to be called in case of emergency, when the attending physician is not available, shall be posted at each nursing station. Upon request, the telephone numbers of the attending physician or his/her replacement in case of emergency shall be provided to the resident, guardian, or sponsor.

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 24:55 (January 1998).

§9805. Physician Visits and Responsibilities

A. At the time each resident is admitted, the nursing home shall have attending physician's orders for the resident's immediate care. At a minimum, these orders shall consist of dietary, drugs (if necessary), and routine care to maintain or improve the resident's functional abilities.

B. If the orders are from a physician other than the resident's attending physician, they shall be communicated to the attending physician and verification entered into the resident's clinical record by the nurse who took the orders.

C. A physical examination shall be performed by the attending physician within 72 hours after admission, unless such examination was performed within 30 days prior to admission, with the following exceptions:

1. if the physical examination was performed by another physician, the attending physician may attest to its accuracy by countersigning it and placing a copy in the resident's record; or

2. if the resident is transferring from another nursing home with the same attending physician, a copy of the previous physical examination may be obtained from the transferring facility with the attending physician initialing its new date. The clinical history and physical examination, together with diagnoses shall be in the resident's medical record.

D. Each resident shall be seen by his/her attending physician at intervals to meet the medical needs of the resident, but at least annually.

E. At each visit, the attending physician shall write, date and sign progress notes.

F. The physician's treatment plan (physician's orders) shall be reviewed by the attending physician at least once annually.

G. Physician telephone/verbal orders shall be received only by physicians, pharmacists, or licensed nurses. These orders shall be reduced to writing in the resident's clinical record and signed and dated by the authorized individual receiving the order. Telephone/verbal orders shall be countersigned by the physician within seven days.

H. Use of signature stamps by physicians is allowed when the signature stamp is authorized by the individual whose signature the stamp represents. The administrative office of the nursing home shall have on file a signed statement to the effect that the physician is the only one who has the stamp and uses it. There shall be no delegation of signature stamps to another individual.

I. At the option of the nursing home attending physician, any required physician task in a nursing home may also be satisfied when performed by an advanced-practice registered nurse when these tasks are within their realm of education and practice, or physician assistant when these tasks are so identified within their protocols, and who is not an employee of the nursing home, but who is working under the direction and supervision of an attending physician.

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 24:55 (January 1998).

§9807. Standing Orders

A. Physician's standing orders are permissible but shall be individualized, taking into consideration such things as drug allergies, sex-specific orders, and the pertinent physical condition of the resident.

B. Over-the-counter drugs are to be utilized on a physician's standing orders. Controlled or prescription drugs except those commonly used in routine situations, should not be on standing orders and must be an individual order reduced to writing on the physician's order sheet as either a routine or pro re nata (prn) order. Each order shall include the following:

1. name of the medication;
2. strength of the medication;
3. specific dose of the medication (not a dose range);
4. route of administration;
5. reason for administration;
6. time interval between doses for administering the medication;
7. maximum dosage or number of times to be administered in a specific time frame; and
8. when to notify the attending physician if the medication is not effective.

C. Standing orders shall be signed and dated by the attending physician initially and at least annually thereafter.

D. A copy of the standing orders shall be maintained in the resident's active clinical record.

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 24:56 (January 1998).

Subchapter B. Nursing Services

§9809. General Provisions

The nursing home shall have sufficient nursing staff to provide nursing and related services that meet the needs of each resident. The nursing home shall assure that each resident receives treatments, medications, diets, and other health services as prescribed and planned, all hours of each day.

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 24:56 (January 1998).

§9811. Nursing Service Personnel

A. The nursing home shall provide a sufficient number of nursing service personnel consisting of registered nurses, licensed practical nurses, and nurse aides to provide nursing care to all residents in accordance with resident care plans 24 hours per day.

1. As a minimum, the nursing home shall provide 1.5 hours of care per patient each day.

2. Nursing service personnel shall be assigned duties consistent with their education and experience, and based on the characteristics of the resident load and the kinds of nursing skills needed to provide care to the residents.

3. Nursing service personnel shall be actively on duty. Licensed nurse coverage shall be provided 24 hours per day.

B. The nursing home shall designate a registered nurse to serve as the director of nursing services on a full-time basis during the day-tour of duty. The director of nursing services may serve as charge nurse only when the nursing home has an average daily occupancy of 60 or fewer residents.

C. If the director of nursing services has non-nursing administrative responsibility for the nursing home on a regular basis, there shall be another registered nurse assistant to provide direction of care-delivery to residents.

D. There shall be on duty, at all times, at least one licensed nurse to serve as charge nurse responsible for the supervision of the total nursing activities in the nursing home or assigned nursing unit.

E. Nurse aides shall be assigned duties consistent with their training and successful demonstration of competencies.

F. In building complexes or multistory buildings, each building or floor housing residents shall be considered a separate nursing unit and staffed separate, exclusive of the director of nursing.

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 24:56 (January 1998).

§9813. Nursing Care

A. Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. Residents

unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

B. Each resident shall be kept clean, dry, well-groomed and dressed appropriately to the time of day and the environment; and good body and oral hygiene shall be maintained. Skin care shall be provided to each resident as needed to prevent dryness, scaling, irritation, itching, and/or pressure sores.

C. Restorative nursing care shall be provided to each resident to achieve and maintain the highest possible degree of function, self-care, and independence. Restorative nursing care shall be provided for the residents requiring such care.

D. Residents requiring assistance at mealtimes shall be assisted when necessary.

E. The nursing home shall endeavor to keep residents free from pressure sores with measures taken toward their prevention.

F. Residents requiring restraints shall be restrained with standard types of devices, applied in a manner consistent with manufacturer's specifications, and that permits speedy removal in the event of an emergency. Each restrained resident shall be monitored every 30 minutes and released for 10 minutes every two hours. Restraints shall not be used for punishment nor convenience of staff.

G. The nursing home shall promptly inform the resident; consult with the resident's attending physician; notify the resident's legal representative or interested family member, if known; and maintain documentation when there is an accident which results in injury and requires physician intervention, or significant change in the resident's physical, mental, or psychosocial status.

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 24:56 (January 1998).

Subchapter C. Dietetic Services

§9815. General Provisions

The nursing home shall provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

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 24:57 (January 1998).

§9817. Dietary Service Personnel

A. The nursing home shall employ a licensed dietitian either full-time, part-time or on a consultant basis. A minimum consultation time shall be not less than eight hours per month to ensure nutritional needs of residents are addressed timely. There shall be documentation to support that the consultation time was given.

B. If a licensed dietitian is not employed full-time, the nursing home shall designate a full-time person to serve as the dietary manager.

C. Residents at nutritional risk shall have an in-depth nutritional assessment conducted by the consulting dietitian.

D. The nursing home shall employ sufficient support

personnel competent to carry out the functions of the dietary services.

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 24:57 (January 1998).

§9819. Menus and Nutritional Adequacy

A. Menus shall be planned, approved, signed and dated by a licensed dietitian prior to use in the nursing home to meet the nutritional needs of the residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council and the National Academy of Sciences, taking into account the cultural background and food habits of residents, or as modified in accordance with the orders of the practitioner(s) responsible for the care of the resident:

1. menus shall be written for each therapeutic diet ordered;

2. if cycle menus are used, the cycle shall cover a minimum of three weeks and shall be different each day of the week;

3. each day's menu shall show the actual date served and shall be retained for six months;

4. menus for the current week shall be available to the residents and posted where food is prepared and served for dietary personnel. Portion sizes shall be reflected either on the menu or within the recipe used to prepare the meal.

B. Therapeutic diets shall be prescribed by the medical practitioner responsible for the care of the resident. Each resident's diet order shall be documented in the resident's clinical record. There shall be a procedure for the accurate transmittal of dietary orders to the dietary service and informing the dietary service when the resident does not receive the ordered diet or is unable to consume the diet, with action taken as appropriate.

1. The nursing home shall maintain a current list of residents identified by name, room number, and diet order, and such identification shall accompany each resident's meal when it is served.

2. A current therapeutic diet manual, approved by a registered dietitian, shall be readily available to attending physicians, nursing staff, and dietetic service personnel and shall be the guide used for ordering and serving diets.

C. Each resident shall receive and the nursing home shall provide:

1. at least three meals daily, at regular times comparable to normal mealtimes in the community;

2. food prepared by methods that conserve nutritive value, flavor, and appearance;

3. food that is palatable, attractive, and at the proper temperature;

4. food prepared in a form designed to meet individual needs; and

5. substitutes offered of similar nutritional value to residents who refuse food or beverages served.

D. A list of all menu substitutions shall be kept for 30 days.

E. There shall be no more than 14 hours between a substantial evening meal and breakfast the following day. A

substantial evening meal is defined as an offering of three or more menu items at one time, one of which includes a high-quality protein such as meat, fish, eggs, or cheese.

F. There shall be no more than 16 hours between a substantial evening meal and breakfast the following day when a nourishing snack is offered at bedtime. A nourishing snack is defined as a verbal offering of items, single or in combination, from the basic food groups.

G. Bedtime nourishments shall be offered nightly to all residents, unless contraindicated by the resident's medical practitioner, as documented in the resident's clinical record.

H. If residents require assistance in eating, food shall be maintained at appropriate serving temperatures until assistance is provided. Feeder trays shall be delivered at the time staff is immediately available for feeding.

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 24:57 (January 1998).

§9821. Equipment and Supplies

A. Special eating equipment and utensils shall be provided for residents who need them. At least a one week supply of staple food with a three-day supply of perishable food conforming to the approved menu shall be maintained on the premises.

B. An approved lavatory shall be convenient and properly equipped for dietary services staff use.

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 24:58 (January 1998).

§9823. Sanitary Conditions

A. All food shall be procured, stored, prepared, distributed, and served under sanitary conditions to prevent food borne illness. This includes keeping all readily perishable food and drink according to *State Sanitary Code*.

B. Refrigerator temperatures shall be maintained according to *State Sanitary Code*.

C. Hot foods shall leave the kitchen or steam table according to *State Sanitary Code*.

D. In-room delivery temperatures shall be maintained according to *State Sanitary Code*.

E. Food shall be transported to residents' rooms in a manner that protects it from contamination, while maintaining required temperatures.

F. Refrigerated food which has been opened from its original package shall be covered, labeled, and dated.

G. All food shall be procured from sources that comply with all laws and regulations related to food and food labeling.

H. Food shall be in sound condition, free from spoilage, filth, or other contamination and shall be safe for human consumption.

I. All equipment and utensils used in the preparation and serving of food shall be properly cleansed, sanitized, and stored. This includes:

1. maintaining a water temperature in dishwashing machines at 140EF during the wash cycle (or according to the

manufacturer's specifications or instructions) and 180EF for the final rinse; or

2. maintaining water temperature in low temperature machines at 120EF (or according to the manufacturer's specification or instructions) with 50 ppm (parts per million) of hypochlorite (household bleach) on dish surfaces; or

3. maintaining a wash water temperature of 75EF, for manual washing in a three-compartment sink, with 25 ppm of hypochlorite or equivalent, or 12.5 ppm of iodine in the final rinse water; or a hot water immersion at 170EF for at least 30 seconds shall be maintained.

J. Dietary staff shall not store personal items within the food preparation and storage areas.

K. The kitchen shall not be used for dining of residents or unauthorized personnel.

L. Dietary staff shall use good hygienic practices.

M. Dietary employees engaged in the handling, preparation and serving of food shall use effective hair restraints to prevent the contamination of food or food contact surfaces.

N. Staff with communicable diseases or infected skin lesions shall not have contact with food if that contact will transmit the disease.

O. There shall be no use of tobacco products in the dietary department.

P. Toxic items such as insecticides, detergents, polishes, and the like shall be properly stored, labeled and used.

Q. Garbage and refuse shall be kept in durable, easily cleanable, insect and rodent-proof containers that do not leak and do not absorb liquids. Containers used in food preparation and utensil washing areas shall be kept covered when meal preparation is completed and when full.

R. All ice intended for human consumption shall be free of visible trash and sediment.

1. Ice used for cooling stored food and food containers shall not be used for human consumption.

2. Ice stored in machines outside the kitchen shall be protected from contamination.

3. Ice scoops shall be stored in a manner so as to protect them from becoming soiled or contaminated between usage.

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 24:58 (January 1998).

Subchapter D. Pharmaceutical Services

§9825. General Requirements

A. The nursing home shall provide emergency drugs and biologicals to its residents from an emergency kit licensed by the Louisiana State Board of Pharmacy and shall provide routine and emergency drugs and biologicals, ordered by a licensed practitioner, from a licensed pharmacy. Whether drugs and biologicals are obtained from the emergency kit(s) or from a community or institutional pharmacy permitted by the Louisiana State Board of Pharmacy, the nursing home is responsible for ensuring the timely availability of such drugs and biologicals for its residents and that pharmaceutical services are provided in accordance with accepted professional standards and all appropriate federal, state, and local laws and regulations.

B. The most current edition of drug reference materials shall be available.

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 24:58 (January 1998).

§9827. Consultant

A. If the nursing home does not employ a licensed pharmacist, it shall have a designated consultant pharmacist that provides services in accordance with accepted pharmacy principles and standards. The minimum consultation time shall not be less than one hour per quarter, which shall not include drug regimen review activities.

B. There shall be documentation to support that the consultation time was given.

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 24:59 (January 1998).

§9829. Labeling

A. All drug and biological containers shall be properly labeled by a licensed pharmacist following the guidelines established by the Louisiana State Board of Pharmacy.

B. The label on prepackaged (unit dose) containers shall follow the established guidelines of the Louisiana State Board of Pharmacy.

C. Over-the-counter (nonprescription) medications and biologicals, may be purchased in bulk packaging and shall be plainly labeled with the medication name and strength and any additional information in accordance with the nursing home's policies and procedures. Over-the-counter medications specifically purchased for a resident shall be labeled as previously stipulated to include the resident's name. The manufacturer's labeling information shall be present in the absence of prescription labeling.

D. The nursing home shall develop procedures to assure proper labeling for medications provided a resident for a temporary absence.

E. The nursing home shall have a procedure for the proper identification and labeling of medication brought into the nursing home from an outside source.

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 24:59 (January 1998).

§9831. Storage

A. All drugs and biologicals shall be stored in a locked area/cabinet and kept at proper temperatures and lighting. The medicine room or medication preparation area shall have an operable sink with hot and cold water, paper towels, and a soap dispenser.

B. Access to drug storage areas shall be limited to licensed nursing personnel, the licensed nursing home administrator, and the consultant pharmacist as authorized in the nursing home's policy and procedure manual. Any unlicensed, unauthorized individual (e.g., housekeepers, maintenance personnel, etc.) needing access to drug storage areas shall be

under the direct visual supervision of licensed authorized personnel.

C. Medication requiring refrigeration shall be kept separate from foods, in separate containers, within a refrigerator and stored at a temperature range of 36E to 46EF.

1. Laboratory solutions or materials awaiting laboratory pickup shall not be stored in refrigerators with food and/or medication.

2. Medication for "external use only" shall be stored separate from other medication and food.

D. Separately locked, permanently affixed compartments shall be provided for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse.

E. Medications of each resident shall be kept and stored in their originally received containers, and transferring between containers is forbidden.

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 24:59 (January 1998).

§9833. Disposition

A. Prescription and Over-The-Counter (OTC) medications and biologicals are to be disposed of in the following manner:

1. If medication(s) and/or biological are discontinued, or the resident is discharged to the hospital, the nursing home will retain the medication(s) for up to 60 days and then destroy as described in §9833.C.2. These must be stored in an appropriately secured storage area approved by the DON and consultant pharmacist. If the resident is deceased, the medication will be disposed of as described in §9833.C.2, unless a written order of the attending physician specifies otherwise. If the resident is transferred to another facility, the medication will accompany the resident to the receiving facility, on the written order of the attending physician.

2. Controlled drugs shall not be released or sent with a resident upon transfer or discharge, except on the written order of the attending physician.

B. If the resident/legal representative receives the medications or biologicals, upon written order of the physician, documentation containing the name and the amount of the medication or biological to be received shall be completed and signed by the resident or legal representative and a facility representative acknowledging their receipt. This document shall be placed in the resident's clinical record.

C. Expired medication(s) shall not be available for resident or staff use. These shall be destroyed on-site by nursing home personnel no later than 90 days from their expiration/discontinuation date utilizing the following methods:

1. Controlled drugs shall be destroyed on-site by a licensed pharmacist after receiving DEA authorization to do so on a continuing basis, and witnessed by a state or local law enforcement officer or other licensed nursing home individual, such as RN, LPN or MD. All controlled substances to be destroyed shall be inventoried and listed on a DEA Form 41, a copy of which shall be maintained on the premises, and a copy mailed to the Louisiana State Board of Pharmacy.

These drugs shall also be listed on the resident's individual accumulative drug destruction record.

2. For noncontrolled drugs, there shall be documentation of the resident's name; name, strength, and quantity of the drug destroyed; prescription number; method and date of destruction; signatures of at least two individuals (which shall be either licensed nurses who are employees of the nursing home, or the consultant pharmacist) witnessing the destruction. Medications of residents transferred to a hospital may be retained until the resident's return. Upon the resident's return, the physician's order shall dictate whether or not the resident is to continue the same drug regimen as previously ordered. Medications not reordered by the physician shall be destroyed, using the procedures outlined above.

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 24:59 (January 1998).

§9835. Administration

A. Drugs and biologicals shall not be administered to residents unless ordered by a practitioner (e.g., physician, dentist, or Doctor of Osteopathy) duly licensed to prescribe drugs. Such orders shall be in writing over the practitioner's signature. Drugs and biologicals shall be administered only by medical personnel or licensed nurses authorized to administer drugs and biologicals under their practice act.

B. Drugs and biologicals shall be administered as soon as possible after doses are prepared, not to exceed two hours. They shall be administered by the same person who prepared the doses for administration, except under unit dose package distribution systems.

C. An individual resident may self-administer drugs if permissible by the nursing home's policy and procedure, and if an interdisciplinary team has determined that this practice is safe. The team shall also determine who will be responsible for storage and documentation of the administration of drugs. The resident's care plan shall reflect approval to self-administer medications.

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 24:60 (January 1998).

§9837. Drug Regimen Review

The drug regimen of each resident shall be reviewed as often as dictated by the resident's condition. Irregularities shall be reported, in writing, to the resident's attending physician and director of nursing, and these reports shall be acted upon.

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 24:60 (January 1998).

§9839. Emergency Medication Kit

A. If an emergency medication kit is used in the nursing home, a permit shall be obtained and maintained in accordance with the Louisiana State Board of Pharmacy.

B. A separate permit is required for each emergency medication kit.

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 24:60 (January 1998).

§9841. Medication Record Keeping

A. General Records

1. Each resident shall have a Medication Administration Record (MAR) on which the dose of each drug or biological administered shall be properly recorded by the person administering the drug or biological to include:

- a. name, strength, and dosage of the medication;
- b. method of administration including site, if applicable;
- c. time of administration defined as one hour before to one hour after the ordered time of administration; and
- d. the initials of persons administering the medication along with a legend of the initials.

2. Medication errors and drug reactions shall be reported immediately to the resident's attending physician by a licensed nurse, and an entry made in the resident's record.

3. Medications not specifically prescribed as to time or number of doses shall automatically be stopped after a reasonable time that is predetermined by the nursing home's written policy and procedures. The attending physician shall be notified of an automatic stop order prior to the last dose so that he/she may decide if the administration of the medication is to be continued or altered.

B. Controlled Drugs

1. The nursing home shall establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate accounting of all controlled drugs received, administered, and destroyed or otherwise disposed. Only licensed medical personnel shall be allowed to receive and sign for delivery of controlled drugs.

2. Control records of schedule II drugs shall be maintained. The individual resident records shall list each type and strength of drug and the following information:

- a. date;
- b. time administered;
- c. name of resident;
- d. dose;
- e. physician's name;
- f. signature of person administering the dose; and
- g. the balance on hand.

C. Noncontrolled Drugs. Records of noncontrolled medication destruction shall be maintained in the resident's clinical record and shall include the following:

1. resident's name;
2. name, strength, and quantity of the medication;
3. prescription number;
4. method and date of destruction;
5. signatures of at least two individuals (which shall be either licensed nurses, who are employees of the nursing home, or the consultant pharmacist) witnessing the destruction.

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 24:60 (January 1998).

Subchapter E. Activity Services

§9843. Activities Program

A. A nursing home shall provide for an ongoing program of diverse and meaningful activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident.

B. The activities program encourages each resident's voluntary participation and choice of activities based upon his/her specific needs and interest.

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 24:61 (January 1998).

§9845. Activity Service Personnel

The activities program shall be directed by a resident activities director. The resident activities director shall be responsible to the administrator or his/her designee for administration and organization of the activities program.

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 24:61 (January 1998).

Subchapter F. Social Services

§9847. Social Services

A nursing home shall provide medically-related social services to meet the needs of each resident.

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 24:61 (January 1998).

§9851. Social Service Personnel

An employee of the facility shall be designated as responsible for meeting the social services needs of the resident.

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 24:61 (January 1998).

Subchapter G. Rehabilitation Services

§9853. Delivery of Service

Rehabilitative services, when provided in the nursing home, shall be delivered in a safe and accessible area. Rehabilitation services shall be provided under the written order of the resident's attending physician. These services shall be provided by appropriately credentialed individuals.

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 24:61 (January 1998).

§9855. Record Keeping

An initial assessment, established by the appropriate therapist, and a written rehabilitation plan of care shall be

developed. The resident's progress will be recorded by the therapist at the time of each visit. This information will be maintained in the resident's clinical record.

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 24:61 (January 1998).

Subchapter H. Resident Clinical Records

§9857. General Provisions

The nursing home shall maintain clinical records on each resident in accordance with accepted professional standards and practices. Each resident's clinical record shall be complete, accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.

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 24:61 (January 1998).

§9859. Maintenance of Records

A. The overall supervisory responsibility for the resident record service shall be assigned to a responsible employee of the facility.

B. All entries in the clinical record shall be either typewritten or legibly written in ink, dated, and signed.

C. If electronic signatures are used, the nursing home shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of any computer generated signature.

D. If a facsimile communications system (FAX) is used, the nursing home shall take precautions when thermal paper is used to ensure that a legible copy is retained as long as the clinical record is retained.

E. A nursing home record may be kept in any written, photographic, microfilm, or other similar method or may be kept by any magnetic, electronic, optical, or similar form of data compilation which is approved for such use by the department.

F. No magnetic, electronic, optical, or similar method shall be approved unless it provides reasonable safeguards against erasure or alteration.

G. A nursing home may, at its discretion, cause any nursing home record or part to be microfilmed, or similarly reproduced, in order to accomplish efficient storage and preservation of nursing home records.

H. Upon an oral or written request, the nursing home shall give the resident or his/her legal representative access to all records pertaining to himself/herself including current clinical records within 24 hours, excluding weekends and holidays. After receipt of his/her records for inspection, the nursing home shall provide, upon request and two working days notice, at a cost consistent with the provisions of R.S. 40:1299(A)(2)(b), photocopies of the records or any portions of them.

I. The nursing home shall ensure that all clinical records are completed within 90 days of discharge, transfer, or death. All information pertaining to a resident's stay is centralized in the clinical record.

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 24:61 (January 1998).

§9861. Content

A. The clinical record contains sufficient information to identify the resident clearly, to justify the diagnosis and treatment, and to document the results accurately.

B. As a minimum, each clinical record shall contain:

1. sufficient information to identify the resident;
 2. physician's orders;
 3. progress notes by all practitioners and professional personnel providing services to the resident;
 4. a record of the resident's assessments;
 5. the plan of care;
 6. entries describing treatments and services provided;
- and
7. reports of all diagnostic tests and procedures.

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 24:62 (January 1998).

§9863. Confidentiality

The nursing home shall safeguard clinical record information against loss, destruction, or unauthorized use. The nursing home shall ensure the confidentiality of resident records, including information in a computerized record system, except when release is required by transfer to another health care institution, law, third party payment contract, or the resident. Information from or copies of records may be released only to authorized individuals, and the nursing home must ensure that unauthorized individuals cannot gain access to or alter resident records.

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 24:62 (January 1998).

§9865. Retention

A. Clinical records shall be retained for a minimum of six years following a resident's discharge or death, unless the records are pertinent to a case in litigation, in which instance they shall be retained indefinitely or until the litigation is resolved.

B. A nursing home which is closing shall notify the department in writing at least 14 days prior to cessation of operation of their plan for the disposition of residents' clinical records for approval.

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 24:62 (January 1998).

Chapter 99. Nursing Homes

Subchapter A. Physical Environment

§9901. General Provisions

The nursing home shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.

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 24:62 (January 1998).

§9903. Nurses' Station

A. Each floor of a multistory nursing home shall have a nurses' station.

B. Each nurse's station shall be provided with working space and accommodations for recording and charting purposes by nursing home staff with storage space for in-house resident records.

C. The nurses' station shall be equipped to audibly receive resident calls electronically through a call system from resident rooms and toilet and bathing facilities. There shall be a medicine preparation room or area.

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 24:62 (January 1998).

§9905. Resident Rooms

A. Resident bedrooms shall be designed and equipped for adequate nursing care, comfort, and privacy of residents. Each resident bedroom shall have a floor, walls, and ceilings in good repair and so finished as to enable satisfactory cleaning.

B. Each resident's bedroom shall have a floor at or above grade level; accommodate no more than four residents; have a minimum width of not less than 10 feet; have a ceiling height of at least 7 feet; have electrical outlets in accordance with the *National Electrical Code* of which the construction plans were initially approved by DHH and the State Fire Marshal's Office; have direct access to an exit corridor; and be so situated that passage through another resident's bedroom is unnecessary.

C. A ceiling height of at least 8 feet shall be provided in nursing homes or additions to nursing homes in which construction plans were initially approved by DHH and the State Fire Marshal's Office after January 20, 1998.

D. Private resident bedrooms shall measure at least 100 square feet of bedroom area.

E. Multiple resident bedrooms shall measure at least 80 square feet of bedroom area for each resident.

F. There shall be at least three feet between the sides and foot of the bed and any wall, other fixed obstruction, or other bed, unless the furniture arrangement is the resident's preference and does not interfere with service delivery. In nursing homes or additions to nursing homes in which construction plans were initially approved by DHH and the State Fire Marshal's Office after January 20, 1998, there shall be at least 4 feet between the sides and foot of the bed and any wall, other fixed obstruction, or other bed, unless the furniture arrangement is the resident's preference and does not interfere with service delivery.

G. Each resident's bedroom shall have at least one window opening to the outside atmosphere. Windows with sills less than 30 inches from the floor shall be provided with guard rails.

H. Each resident's bedroom window shall be provided with shades, curtains, drapes, or blinds.

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 24:62 (January 1998).

§9907. Resident Room Furnishings

A. Each resident shall be provided with an individual bed of proper size and height for the convenience of the resident and equipped with:

1. a clean spring in good repair;
2. a clean, comfortable, well-constructed mattress at least 5 inches thick with waterproof ticking and correct size to fit the bed;
3. a clean, comfortable pillow shall be provided for each bed with extra pillows available to meet the needs of the residents;
4. adequate bed rails, when necessary, to meet the needs of the resident; and
5. sheets and covers appropriate to the weather and climate.

B. Screens or noncombustible ceiling-suspended privacy curtains which extend around the bed shall be provided for each bed in multiresident bedrooms to assure resident privacy. Total visual privacy without obstructing the passage of other residents either to the corridor, closet, lavatory, or adjacent toilet room nor fully encapsulating the bedroom window must be provided.

C. The nurses' call system cords, buttons, or other communication mechanisms shall be placed where they are within reach of each resident.

D. Each resident shall be provided a bedside table with at least two drawers, and an enclosed hanging space for clothing that is accessible to the resident. As appropriate to resident needs, each resident shall have a comfortable chair with armrests, waste receptacle, and access to mirror unless medically contraindicated.

E. Each resident who has tray service to his/her room shall be provided with an adjustable overbed table positioned so that the resident can eat comfortably.

F. Each resident shall be provided with a bedside light or over-the-bed light capable of being operated from the bed for nursing homes in which construction plans were initially approved by DHH and the State Fire Marshal's Office after May 1, 1997.

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 24:63 (January 1998).

§9909. Locked Units

A. Nursing homes providing locked units must develop admission criteria. There must be documentation in the resident's record to indicate the unit is the least restrictive environment possible, and placement in the unit is needed to facilitate meeting the resident's needs.

B. Guidelines for admission shall be provided to either the resident, his/her family, and his/her legal representative.

C. Locked units are designed and staffed to provide the care and services necessary for the resident's needs to be met.

D. There must be sufficient staff to respond to emergency situations in the locked unit at all times.

E. The resident on the locked unit has the right to exercise those rights which have not been limited as a result of admission to the unit.

F. Care plans shall address the reasons for the resident being in the unit and how the facility is meeting the resident's needs.

G. Admission to a locked unit must be in compliance with R.S. 40:1299.53 and 40:2010.8.

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 24:63 (January 1998).

§9911. Toilet; Hand Washing; and Bathing Facilities

A. Each floor occupied by residents shall be provided with a toilet, lavatory, and bathtub, whirlpool or shower.

B. Each bedroom shall be equipped with or conveniently located near adequate toilet and bathing facilities appropriate in number, size, and design to meet the needs of residents.

C. In nursing homes built prior to August 26, 1958, the following ratio shall be provided (whenever calculations include any fraction of a fixture, the next higher whole number of fixtures shall be installed):

Lavatories	1:10 beds
Toilets	1:10 beds
Showers or tubs	1:15 beds
Whirlpools (optional)	1:20 beds

D. In nursing homes built subsequent to August 26, 1958, the following ratio shall be provided (whenever calculations include any fraction of a fixture, the next higher whole number of fixtures shall be installed):

Lavatories	1 per bedroom or immediately adjacent thereto
Toilets	1:8 beds
Showers or tubs	1:10 beds
Whirlpools (optional)	1:20 beds

E. Bathrooms shall be easily accessible, conveniently located, well lighted, and ventilated to the outside atmosphere. Doors to bathrooms and toilet rooms used by residents shall be at least 2 feet 8 inches wide. The fixtures shall be of substantial construction, in good repair, and of such design to enable satisfactory cleaning.

F. Tub and shower bath bottoms shall be of nonslip material. Grab bars shall be provided to prevent falling and to assist in getting in and out of the tub or shower.

G. Separate toilet and lavatory facilities for use by employees shall be provided. Separate bathtubs, whirlpools, or showers shall be provided for employees who live on the premises.

H. Lights must be controlled by wall switches, which must be so placed that they cannot be reached from the bathtub, whirlpool, or shower.

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 24:63 (January 1998).

§9913. Dining and Resident Activities

A. The nursing home shall provide one or more areas designated for resident dining and activities.

B. The dining room(s) or area(s) shall seat not less than 50 percent of the licensed capacity of the nursing home at one seating where plans were initially approved by the Fire Marshall on or after January 20, 1998. No smoking shall be allowed in these areas during meal times.

C. There shall be sufficient space and equipment to comfortably accommodate the residents who participate in group and individual activities. These areas shall be well lighted and ventilated and be adequately furnished to accommodate all activities.

D. Areas used for corridor traffic or for storage of equipment shall not be considered as areas for dining or activities.

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 24:64 (January 1998).

§9915. Linen and Laundry

A. The nursing home shall have available, at all times, a quantity of bed and bath linen essential for proper care and comfort of residents.

B. All linen shall be in good condition.

C. All used linen shall be bagged or enclosed in appropriate containers for transportation to the laundry.

D. Soiled linen storage areas shall be ventilated to the outside atmosphere.

E. Linen from residents with a communicable disease shall be bagged, in readily identifiable containers distinguishable from other laundry, at the location where it was used.

F. Linen soiled with blood or body fluids shall be placed and transported in bags that prevent leakage.

G. If hot water is used, linen shall be washed with detergent in water at least 160EF for 25 minutes. If low-temperature (less than or equal to 158EF) laundry cycles are used, chemicals suitable for low-temperature washing, at proper use concentration, shall be used.

H. Provisions shall be made for laundering personal clothing of residents.

I. Clean linen shall be transported and stored in a manner to prevent its contamination.

J. Nursing homes providing in-house laundry services shall have a laundry system designed to eliminate crossing of soiled and clean linen.

K. There shall be hand washing facilities for employees in the laundry.

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 24:64 (January 1998).

§9917. Equipment and Supplies

A. The nursing home shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition.

B. Therapeutic, diagnostic, and other resident care equipment shall be maintained and serviced in accordance with the manufacturer's recommendations.

C. Wheelchairs shall be available for emergency use by residents who are not fully ambulatory.

D. Equipment for taking vital signs shall be maintained.

E. At least one oxygen tank or resource of oxygen shall be readily accessible for emergency use.

F. An adequate number of battery-generated lamps or flash lights shall be available for staff use in case of electrical power failure.

G. There shall be at least one telephone adapted for use by residents with hearing impairments at a height accessible to bound residents who use wheelchairs and be available for resident use where calls can be made without being overheard.

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 24:64 (January 1998).

§9919. Other Environmental Conditions

A. The nursing home shall provide a safe, clean, orderly, homelike environment.

B. The minimum resident capacity of a nursing home shall be 150 square feet gross area per resident. Bedroom square footage per bed is a part of this gross area.

C. There shall be a well lighted and ventilated living/community room with sufficient furniture.

D. There shall be a clean utility room designed for proper storage of nursing equipment and supplies.

E. There shall be a separate soiled utility room designed for proper cleansing, disinfecting, and sterilizing of equipment and supplies. As a minimum, it shall contain equipment to satisfactorily clean resident care equipment, a clinic service sink, and provisions for the storage of cleaning supplies (e.g., mops and pails) and chemical supplies.

F. A hard surfaced off-the-road parking area to provide parking for one car per five licensed beds shall be provided. This requirement is minimum and may be exceeded by local ordinances. Where this requirement would impose an unreasonable hardship, a written request for a lesser amount may be submitted to the department for waiver consideration.

G. The nursing home shall make arrangements for an adequate supply of safe potable water even when there is a loss of normal water supply. Service from a public water supply must be used, if available. Private water supplies, if used, must meet the requirements of the *State Sanitary Code*.

H. An adequate supply of hot water shall be provided which shall be adequate for general cleaning, washing, and sterilizing of cooking and food service dishes and other utensils, and for bathing and laundry use. Hot water supply to the hand washing and bathing faucets in the resident areas shall have automatic control to assure a temperature of not less than 100EF, nor more than 120EF, at the faucet outlet.

I. The nursing home shall be connected to the public sewerage system, if such a system is available. Where a public sewerage is not available, the sewerage disposal system shall conform to the requirements of the *State Sanitary Code*.

J. The nursing home shall maintain a comfortable sound level conducive to meeting the need of the residents.

K. All plumbing shall be properly maintained and conform to the requirements of the *State Sanitary Code*.

L. There shall be at least one toilet room for employees and the public.

M. There shall be adequate outside ventilation by means of window, or mechanical ventilation or a combination of the two.

N. All openings to the outside atmosphere shall be effectively screened. Exterior doors equipped with closers in air conditioned buildings need not have screens.

O. Each room used by residents shall be capable of being heated to not less than 71°F in the coldest weather and capable of being cooled to not more than 81°F in the warmest weather.

P. Lighting levels in all areas shall be adequate to support task performance by staff personnel and independent functioning of residents. A minimum of 6' to 10' candles over the entire stairway, corridors, and resident rooms measured at an elevation of 30 inches above the floor and a minimum of 20' to 30' candles over areas used for reading or close work shall be available.

Q. Corridors used by residents shall be equipped on each side with firmly secured handrails, affixed to the wall.

R. There shall be an effective pest control program so that the nursing home is free of pest and rodent infestation.

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 24:64 (January 1998).

Subchapter B. Infection Control and Sanitation

§9921. Organization

A nursing home shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.

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 24:65 (January 1998).

§9923. Infection Control Program

A. An infection control committee shall be established consisting of the medical director and representatives from at least administration, nursing, dietary, and housekeeping personnel.

B. The committee shall establish policies and procedures for investigating, controlling, and preventing infections in the nursing home, and monitor staff performance to ensure proper execution of policies and procedures.

C. The committee shall approve and implement written policies and procedures for the collection, storage, handling, and disposal of medical waste.

D. The committee shall meet at least quarterly, documenting the content of its meetings.

E. Reportable diseases as expressed in the *State Sanitary Code* shall be reported to the local parish health unit of the Office of Public Health.

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 24:65 (January 1998).

§9925. Employee Health Policies and Procedures

A. Nursing home employees with a communicable disease or infected skin lesions shall be prohibited from direct contact with residents or their food, if direct contact will transmit the disease.

B. The nursing home shall require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. An antimicrobial gel or waterless cleaner may be used between resident contact, when appropriate. The nursing home shall follow the Centers for Disease Control's *Guideline for Hand Washing and Hospital Environmental Control*, 1985 for hand washing.

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 24:65 (January 1998).

§9927. Isolation

When the infection control program determines that a resident needs isolation to prevent the spread of infection, the nursing home shall isolate the resident.

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 24:65 (January 1998).

§9929. Housekeeping

There shall be sufficient housekeeping personnel to maintain a safe, clean, and orderly interior.

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 24:65 (January 1998).

§9931. Nursing Care Equipment

A. Bedpans, urinals, emesis basins, wash basins, and other personal nursing items shall be thoroughly cleaned after each use and sanitized as necessary. Water pitchers, when provided, shall be sanitized as necessary.

B. All catheters, irrigation sets, drainage tubes, or other supplies or equipment for internal use, and as identified by the manufacturer as one-time use only, will be disposed of in accordance with the manufacturer's recommendations.

C. Disposable syringes used for feeding purposes shall be disposed of in accordance with the manufacturer's recommendations.

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 24:65 (January 1998).

§9933. Waste and Hazardous Materials Management

The nursing home shall have a written and implemented waste management program that identifies and controls wastes and hazardous materials. The program shall comply with all applicable laws and regulations governing wastes and hazardous materials.

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 24:66 (January 1998).

Bobby P. Jindal
Secretary

9801#053

RULE

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

**Private Intermediate Care Facility for the
Mentally Retarded—Qualifying Loss Review**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following rule in the Medical Assistance Program, as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This rule is in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Rule

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the rule governing the reimbursement of private Intermediate Care Facilities for the Mentally Retarded (ICF/MR) to incorporate the following qualifying loss review process for those facilities seeking an adjustment to their per diem rates.

XI. Qualifying Loss Review Process

A. Basis for Administrative Review

1. Allowable Basis. The following matters are subject to a qualifying loss review:

- a. that rate-setting methodologies or principles of reimbursement established under the reimbursement plan were incorrectly applied;
- b. that incorrect data or erroneous calculations were used;
- c. the facility demonstrates that the estimated reimbursement, based on its prospective rate, is less than 95 percent of the estimated costs to be incurred by the facility in providing Medicaid services during the period the rate is in effect in compliance with the applicable state and federal laws related to quality and safety standards.

2. Nonallowable Basis. The following matters are not subject to a qualifying loss review:

- a. the methodology used to establish the per diem;
- b. the use of audited and/or desk reviews to determine allowable costs;
- c. the economic indicators used in the rate-setting methodology;
- d. rate adjustments related to changes in federal or state laws, rules, or regulations (e.g., minimum wage adjustments);
- e. rate adjustments related to reduction or elimination of extraordinary rates.

B. Request for Administrative Review. Any intermediate care facility for the mentally retarded (hereafter referred to as facility) seeking an adjustment to the per diem rate shall submit a written request for administrative review to the director of Institutional Reimbursements (hereafter referred to as director) in the Department of Health and Hospitals (hereafter referred to as department).

1. Time Frames

a. Requests for administrative review must be received by DHH within 30 days of either receipt of notification of rate reduction or promulgation of this rule, whichever is later. The receipt of the letter notifying the facility of its rates will be deemed to be five days from the date of the letter.

b. The department shall acknowledge receipt of the written request within 30 days after actual receipt.

c. The director shall notify the facility of his decision within a reasonable time after receipt of all necessary documentation, including additional documentation or information requested after the initial request is received. Failure to provide a decision within a reasonable time does not imply approval.

d. If the facility wishes to appeal the director's decision, the appeal request must be received by the Bureau of Appeals within 30 days after receipt of the written decision of the director. The receipt of the decision is deemed to be five days from the date of the decision.

2. Content of the Request. The facility shall bear the burden of proof in establishing the facts and circumstances necessary to support a rate adjustment. Any costs that the provider cites as a basis for relief under this provision must be calculable and audit able.

a. Basis of the Request. Any facility seeking an adjustment to the per diem rate must specify all of the following:

- i. the nature of the adjustment sought;
- ii. the amount of the adjustment sought;
- iii. the reasons or factors that the facility believes justify an adjustment.

b. Financial Analysis. An analysis demonstrating the extent to which the facility is incurring, or expects to incur, a qualifying loss shall be provided by the facility unless the basis for review is one of the following:

- i. the rate setting methodology or criteria for classifying facilities were incorrectly applied; or
- ii. incorrect data or erroneous calculations were used in establishment of the facility's per diem; or
- iii. the facility has incurred additional costs because of a catastrophe.

C. Basis for Rate Adjustment

1. Factors Considered. The department shall award additional reimbursement to a facility that demonstrates by substantiating evidence that:

- a. the facility will incur a qualifying loss;
- b. the loss will impair a facility's ability to provide services in accordance with state and federal health and safety standards;
- c. the facility has satisfactorily demonstrated that it has taken all appropriate steps to eliminate management practices resulting in unnecessary expenditures; and
- d. the facility has demonstrated that its nonreimbursed costs are generated by factors generally not shared by other facilities in the facility's bed size Level of Care (LOC).

2. Determination to Award Relief. In determining whether to award additional reimbursement to a facility that has made the showing required, the director shall consider one or more of the factors and may take any of the following actions:

- a. the director shall consider whether the facility has demonstrated that its nonreimbursed costs are generated by factors generally not shared by other facilities in the facility's bed size LOC. Such factors may include, but are not limited to, extraordinary circumstances beyond the control of the facility; or
- b. the director may consider, and may require the facility to provide financial data, including but not limited to, financial ratio data indicative of the facility's performance quality in particular areas of operations; or
- c. the director shall consider whether the facility has taken every reasonable action to contain costs on a facility-wide basis. In making such a determination, the director may require the facility to provide audited cost data or other quantitative data and information about actions that the facility has taken to contain costs.

D. Awarding Relief. The director shall make notification of the decision to award or not award relief in writing.

1. Basis of Adverse Decision

- a. The director may determine that the review request is not within the scope of the purpose for qualifying loss review.
- b. The director may determine that the information presented does not support the request for rate adjustment.

2. Adverse Decision Appeal. Averse decisions may be appealed to the Office of the Secretary, Bureau of Appeals for the Department of Health and Hospitals, Box 4183, Baton Rouge, LA 70821-4183 within 30 days of receipt of the decision.

3. Awarding Relief

- a. Action by Director. In awarding relief under this provision, the director shall:
 - i. make any necessary adjustment so as to correctly apply the reimbursement methodology to the facility submitting the appeal, or to correct calculations, data errors, or omissions; or
 - ii. increase the facility's per diem rate by an amount that can reasonably be expected to ensure continuing access

to sufficient services of adequate quality for Title XIX Medicaid recipients served by the facility.

b. Scope of Decisions. Decisions by the director to recognize omitted, additional, or increased costs incurred by any facility; to adjust the facility rates; or to otherwise award additional reimbursement to any facility shall not result in any change in the bed size LOC per diem for the remaining facilities in the bed size LOC, except that the department may adjust the per diem if the facilities receiving adjustment comprise over 10 percent of total utilization for that bed size LOC, based on the latest audited and/or desk reviewed cost reports.

c. Effective Date. The effective date of the adjustment shall be the later of:

- i. the date of occurrence of the rate change upon which the rate appeal is in response; or
- ii. the effective date of this rule.

d. Limitations. The director shall not award relief to a provider in excess of 95 percent of appellant facility's cost coverage determined by inflationary trending of the year on which rates are based. The rate adjustment shall also be limited to no more than the amount of the rate for the previous rate year. Any facility awarded relief shall be audited and cost settled up to, but not over, the amount of the adjusted rate. Should a single facility that is an entity under common ownership or control with another facility or group of facilities be awarded relief, all facilities under common ownership or control with the facility awarded relief will be subject to audit and cost settlement up to, but not over, the amount of their rates.

Bobby P. Jindal
Secretary

9801#060

RULE

**Department of Insurance
Office of the Commissioner**

Regulation 28—Variable Contract

Under the authority of R.S. 22:1500 and the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Insurance has amended Regulation 28.

Rule

Regulation 28. Variable Contract

Section 1. Authority

This regulation is adopted and promulgated by the Department of Insurance pursuant to the authority granted by R.S. 22:1500 and the Administrative Procedure Act, R.S. 49:950 et seq. This regulation replaces and repeals the regulation of similar purpose which took effect on January 1, 1969.

Section 2. Definitions

Agent—any person, corporation, partnership, or other legal entity which, under the laws of this state, is licensed as an insurance agent.

Company—any insurer which possesses a certificate of authority to conduct life insurance business or annuity business in the state of Louisiana.

Contract on a Variable Basis or Variable Contract—any policy or contract which provides for annuity benefits which may vary according to the investment experience of any separate account or accounts maintained by the insurer as to such policy or contract, as provided for in R.S. 22:1500.

Variable Contract Agent—an agent who shall sell or offer to sell any contract on a variable basis.

Section 3. Qualifications of Insurance Companies to Issue Variable Contracts

A. No company shall deliver or issue for delivery variable contracts within this state unless the commissioner is satisfied that its condition and method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. The commissioner shall consider the following in making such a determination:

1. the history and financial condition of the company;
2. the character, responsibility, and fitness of the officers and directors of the company; and
3. the law and regulation under which the company is authorized in the state of domicile to issue variable contracts.

B. A company's subsidiary or affiliate, by common management or ownership, may be deemed by the commissioner to have satisfied the provisions of Subsection A.2 of this Section if either the company or its subsidiary or affiliate satisfies the provisions of Subsection A.2 of this Section, provided, further, that companies having a satisfactory record of doing business in this state for a period of at least three years may be deemed to have satisfied the commissioner with respect to Subsection A.2 of this Section.

C. Before any company shall deliver or issue for delivery variable contracts, it shall submit to the commissioner:

1. a general description of the kinds of variable contracts it intends to issue;
2. if requested by the commissioner, a copy of the statutes and regulations of its state of domicile under which it is authorized to issue variable contracts; and
3. if requested by the commissioner, biographical data with respect to officers and directors of the company.

Section 4. Separate Account or Separate Accounts

A. A domestic company issuing variable contracts shall establish one or more separate accounts pursuant to R.S. 22:1500.

1. Unless otherwise approved by the commissioner, assets allocated to a separate account shall be valued at their market value on the date of valuation or, if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account, provided that the portion of the assets of such separate account equal to the company's reserve liability with regard to the benefits guaranteed as to amount and duration, and funds guaranteed as to principal amount or stated rate of interest shall be valued in accordance with the rules otherwise applicable to the company's asset.

2. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate

account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

3.a. Notwithstanding any other provision of law, a company may:

i. with respect to any separate account registered with the Securities and Exchange Commission as a unit investment trust, exercise voting rights in connection with any securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate accounts in accordance with instructions from persons having interests in such accounts ratably, as determined by the company; or

ii. with respect to any separate account registered with the Securities and Exchange Commission as a management investment company, establish for such account a committee, board, or other body, the members of which may or may not be otherwise affiliated with such company and may be elected to such membership by the vote of persons having interests in such account ratably, as determined by the company. Such committee, board, or other body may have the power, exercisable alone or in conjunction with others, to manage such separate account and the investment of its assets.

b. A company, committee, board, or other body may make such other provisions in respect to any such separate account as may be deemed appropriate to facilitate compliance with requirements of any federal or state law now or hereafter in effect, provided that the commissioner approves such provisions as not hazardous to the public or the company's policyholders in this state.

4. No sale, exchange, or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made:

- a. by a transfer of cash; or
- b. by a transfer of securities having a valuation which could be readily determined in the marketplace, and provided that such transfer of securities is approved by the commissioner. The commissioner may authorize other transfers among such accounts if, in his opinion, such transfers would not be inequitable.

5. The company shall maintain in each such separate account assets with a value at least equal to the reserves and other contract liabilities with respect to such account, except as may otherwise be approved by the commissioner.

6. Rules under any provision of R.S. 22:1500 or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee, board, or other similar body. No officers or directors of such company nor any member of the committee, board, or separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account.

Section 5. Filing of Contracts

The filing requirements applicable to variable contracts shall be those filing requirements otherwise applicable under existing statutes and regulations of this state with respect to individual and group life insurance and annuity contract form filings, to the extent appropriate.

Section 6. Contracts Providing for Variable Benefits

A. Any variable contract delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of benefits. Any such contract providing benefits which vary during the payment period, including a group contract and any certificate issued thereunder, shall state that the periodic payments will vary to reflect investment experience and shall contain, on its first page, a clear statement to the effect that the periodic payments thereunder are on a variable basis. Any such contract which provides values which are vested in an annuitant under an individual contract or in the holder of a certificate under a group contract prior to the commencement of the payment period, which values will vary to reflect investment experience, shall state that such values are on the variable basis. Any certificate issued under a group contract providing such variable values shall also contain the statements required by the preceding sentence. If any such contract provides such variable periodic payments, as well as such variable values, the statements required by the preceding sentences may be combined.

B. Illustrations of benefits payable under any variable contract shall not include projections of past investment experience into the future or attempted predictions of future investment experience, provided that nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of annuity payments.

C.1. Any individual variable annuity contract delivered or issued for delivery in this state shall stipulate the investment increment factors to be used in computing the dollar amount of variable benefits or other contractual payments or values thereunder, and may guarantee that expenses and/or mortality results shall not adversely affect such dollar amounts. If not guaranteed, the expense and mortality factors shall also be stipulated in the contract.

2. In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

a. the annual net investment increment assumption shall not exceed 5 percent, except with the approval of the commissioner;

b. to the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a higher mortality rate at any age, or, if approved by the commissioner, from another table.

3. *Expense*, as used in this Subsection, may exclude some or all taxes, as stipulated in the contract.

4. Variable annuity contracts delivered or issued for delivery in this state may include as an incidental benefits provision for payment on death during the deferred period of

an amount not in excess of the greater of the sum of the premiums or stipulated payments paid under the contract or the value of the contract at the time of death; such provisions will not be deemed to be contracts of life insurance and therefore not subject to the provisions of the Insurance Law governing life insurance. Provision for any other benefit on death during the deferred period will be subject to such insurance provisions.

5. The reserve liability for variable annuities shall be established pursuant to the requirements of the standard valuation law, in accordance with actuarial procedures that recognize the variable nature of the benefits provided.

Section 7. Required Reports

A. Any company issuing individual variable contracts providing benefits in variable amounts shall mail to the contract holder, at least once in each contract year after the first, at his last address known to the company, a statement or statements reporting the investments held in the separate account, and in the case of contracts under which payments have not yet commenced, a statement reporting as of a date not more than four months previous to the date of mailing:

1. the number of accumulation units credited to such contracts and the dollar value of a unit; or

2. the value of the contract holder's account.

B. The company shall submit annually to the insurance commissioner a statement of the business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners.

Section 8. Foreign Companies

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially equal to that provided by these regulations, the commissioner, to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with these regulations.

Section 9. Licensing of Agents and Other Persons

A.1. No agent shall be eligible to sell or offer for sale a contract on a variable basis unless, prior to making any solicitation or sale of such a contract, that agent is licensed to sell life insurance in this state and presents evidence of satisfactorily passing one of the following written examinations upon securities and variable contracts:

a. any state securities examination accepted by the Securities and Exchange Commission;

b. the National Association of Securities Dealers, Inc. examination for principals or examination for qualification as a registered representative;

c. the various securities examinations required by the New York Stock Exchange, the American Stock Exchange, the Pacific Stock Exchange, or any other registered national securities exchange;

d. the Securities and Exchange Commission test given pursuant to Section 15(b)(8) of the Securities Exchange Act of 1934.

2. Any agent who participates only in the sale or offering for sale of variable contracts that are not registered under the Federal Securities Act of 1933 need not be licensed as a variable contract agent.

3. Any agent applying for a license as a variable contract agent shall do so by filing an application. All applications for a license shall be in writing on uniform forms prescribed by the commissioner of Insurance.

B. Any applicant for license as a variable contract agent shall present evidence that the applicant is currently registered with the Federal Securities and Exchange Commission as a broker-dealer or is currently associated with a broker-dealer and has met qualification requirements with respect to such association.

C. Except as modified by this regulation, refer to Part XXIV and Insurance Regulations of this department governing the licensing of life insurance agents.

D. Any person licensed in this state as a variable contract agent shall immediately report to the commissioner:

1. any suspension or revocation of the agent's variable contract license or life insurance license in any other state or territory of the United States;

2. the imposition of any disciplinary sanctions (including the suspension or expulsion from membership, suspension or revocation of or denial of registration) imposed upon him/her by the National Securities Exchange, The National Securities Association, or any federal, state, or territorial agency with jurisdiction over securities or contracts on a variable basis;

3. any judgment or injunction entered against him/her on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

E. The commissioner may reject any application or suspend, revoke, or refuse to renew any agent's variable contract license upon any ground that would bar such applicant or such agent from being licensed to sell life insurance contracts in this state. The rules governing any proceeding relating to the suspension or revocation of an agent's life insurance license shall also govern any proceeding for suspension or revocation of an agent's variable contract license.

F. An agent's variable contract license shall be renewed annually upon the approval of a variable contract agent appointment. A certificate of license status dated within 90 days must be submitted with the appointment for any nonresident agent.

James H. "Jim" Brown
Commissioner

9801#009

RULE

Department of Insurance Office of the Commissioner

Regulation 33—Medicare Supplement Insurance Minimum Standards

Pursuant to the provisions of R.S. 49:950 et seq. and R.S. 22:224, the commissioner of Insurance has amended Regulation 33. This action is necessary to bring the Medicare Supplement Insurance Minimum Standards regulation in line with the provisions mandated by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), 42 U.S.C. 1395 et seq., as amended, and with Act 633 of the 1997 Regular Legislative Session.

Rule

Section 1. Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under R.S. 49:950 et seq., the Administrative Procedure Act, and R.S. 22:224 of the *Insurance Code*.

Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 12, 13, 16, and 21, this regulation shall apply to:

(1) all Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

(2) all certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Section 4. Definitions

For purpose of this regulation:

A. *Applicant*—

(1) in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(2) in the case of a group Medicare supplement policy, the proposed certificate holder.

B. *Certificate*—any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

C. *Certificate Form*—the form on which the certificate is delivered or issued for delivery by the issuer.

D. *Issuer*—includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

E. *Medicare*—the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

F. *Medicare Supplement Policy*—a group or individual policy of health insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. Also, it includes those plans commonly known as health care prepayment plans (HCPPs).

G. *Policy Form*—the form on which the policy is delivered or issued for delivery by the issuer.

H. *Qualified Actuary*—an actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

Section 5. Policy Definitions and Terms

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this Section.

A. *Accident, Accidental Injury, or Accidental Means*—shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words or description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or

similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. *Benefit Period or Medicare Benefit Period*—shall not be defined more restrictively than as defined in the Medicare program.

C. *Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility*—shall not be defined more restrictively than as defined in the Medicare program.

D. *Health Care Expenses*—expenses of health maintenance organizations associated with the delivery of health care services which expenses are analogous to incurred losses of insurers. Expenses shall not include:

- (1) home office and overhead costs;
- (2) advertising costs;
- (3) commissions and other acquisition costs;
- (4) taxes;
- (5) capital costs;
- (6) administrative costs; and
- (7) claims processing costs.

E. *Hospital*—may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

F. *Medicare*—shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. *Medicare Eligible Expenses*—expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

H. *Physician*—shall not be defined more restrictively than as defined in the Medicare program.

I. *Sickness*—shall not be defined to be more restrictive than the following:

Sickness—illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 6. Policy Provisions

A. Except for permitted pre-existing condition clauses as described in Section 7A(1) and Section 8A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

Section 7. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to July 20, 1992

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a pre-existing condition. The policy or certificate shall not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(5)(a) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(i) an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8B of this regulation;

(iii) group contracts in force prior to the effective date of the Omnibus Budget Reconciliation Act (OBRA) of 1990 may have existing contractual obligations to continue benefits contained in the group contract. This Section is not intended to impair those obligations.

(c) If membership in a group is terminated, the issuer shall:

(i) offer the certificate holder the conversion opportunities described in Subparagraph (b); or

(ii) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

B. Minimum Benefit Standards

(1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth in any Medicare benefit period;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [\$100];

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Section 8. Benefit Standards for Policies or Certificates Issued or Delivered on or After July 20, 1992

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 20, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a pre-existing condition. The policy or certificate may not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) the issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(b) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;

(c) if the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8A(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

(i) provides for continuation of the benefits contained in the group policy; or

(ii) provides for benefits that otherwise meet the requirements of this Subsection.

(d) if an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(i) offer the certificate holder the conversion opportunity described in Section 8A(5)(c); or

(ii) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(e) if a group Medicare supplement policy is replaced by another group Medicare supplement policy

purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced.

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(7)(a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) Reinstitution of coverages:

(i) shall not provide for any waiting period with respect to treatment of pre-existing conditions;

(ii) shall provide for coverage which is substantially equivalent to coverage in effect before the date of suspension; and

(iii) shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

B. Standards for Basic ("Core") Benefits Common to All Benefit Plans. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu of it.

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

(2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

(5) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this regulation:

(1) Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one-hundredth day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty percent of the Medicare Part B Excess Charges: Coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One-hundred percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit. Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar-year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(7) Extended Outpatient Prescription Drug Benefit. Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar-year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(8) Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar-year deductible of \$250, and a lifetime

maximum benefit of \$50,000. For purposes of this benefit, *emergency care* shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) Preventive Medical Care Benefit. Coverage for the following preventive health services:

(a) an annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures;

(b) any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(i) fecal occult blood test or digital rectal examination, or both;

(ii) mammogram;

(iii) dipstick urinalysis for hematuria, bacteriuria and proteinuria;

(iv) pure tone (air only) hearing screening test, administered or ordered by a physician;

(v) serum cholesterol screening (every five years);

(vi) thyroid function test;

(vii) diabetes screening.

(c) influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every 10 years);

(d) any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) *Activities of Daily Living*—include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) *Care Provider*—a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) *Home*—any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) *At-home Recovery Visit*—the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) the actual charges for each visit up to a maximum reimbursement of \$40 per visit;

(III) \$1,600 per calendar year;

(IV) seven visits in any one week;

(V) care furnished on a visiting basis in the insured's home;

(VI) services provided by a care provider as defined in this Section;

(VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) home care visits paid for by Medicare or other government programs; and

(ii) care provided by family members, unpaid volunteers or providers who are not care providers.

(11) New or Innovated Benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

Section 9. Standard Medicare Supplement Benefit Plans

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "core" benefits, as defined in Section 8B of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in Section 8C(11) and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this Subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections

8B and 8C and list the benefits in the order shown in this Subsection. For purposes of this Section, *Structure, Language, and Format* means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. Make-up of Benefit Plans

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in Section 8B of this regulation.

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: the Core Benefit as defined in Section 8B of this regulation plus the Medicare Part A Deductible as defined in Section 8C(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: the Core Benefit as defined in Section 8B of this regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8C(1), (2), (3) and (8), respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: the Core Benefit as defined in Section 8B of this regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Sections 8C(1), (2), (8) and (10), respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: the Core Benefit as defined in Section 8B of this regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Sections 8C(1), (2), (8) and (9), respectively.

(6) Standardized Medical supplement benefit plan "F" shall include only the following: the Core Benefit as defined in Section 8B of this regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, the Part B Deductible, 100 percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8C(1), (2), (3), (5) and (8), respectively.

(7) Standardized Medicare supplement benefit plan "G" shall include only the following: the Core Benefit as defined in Section 8B of this regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80 percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefits as defined in Sections 8C(1), (2), (4), (8) and (10), respectively.

(8) Standardized Medicare supplement benefit plan "H" shall consist of only the following: the Core Benefit as defined in Section 8B of this regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Sections 8C(1), (2), (6) and (8), respectively.

(9) Standardized Medicare supplement benefit plan "I" shall consist of only the following: the Core Benefit as defined in Section 8B of this regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 percent of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10), respectively.

(10) Standardized Medicare supplement benefit plan "J" shall consist of only the following: the Core Benefit as defined in Section 8B of this regulation plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10), respectively.

Section 10. Medicare Select Policies and Certificates

A.(1) This Section shall apply to Medicare Select policies and certificates, as defined in this Section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Section.

B. For the purposes of this Section:

(1) *Complaint*—any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) *Grievance*—dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or provision of services concerning a Medicare Select issuer or its network providers.

(3) *Medicare Select Issuer*—an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) *Medicare Select Policy or Select Certificate*—means respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) *Network Provider*—a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) *Restricted Network Provision*—any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) *Service Area*—the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

E. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the

commissioner. The plan of operation shall contain at least the following information:

(1) evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community;

(b) the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals;

(c) there are written agreements with network providers describing specific responsibilities;

(d) emergency care is available 24 hours per day and seven days per week;

(e) in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This Paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) a statement or map providing a clear description of the service area.

(3) a description of the grievance procedure to be utilized.

(4) a description of the quality assurance program, including:

(a) the formal organizational structure;

(b) the written criteria for selection, retention and removal of network providers; and

(c) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) a list and description, by specialty, of the network providers.

(6) copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) any other information requested by the commissioner.

F.(1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the commissioner at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) it is not reasonable to obtain such services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) other Medicare supplement policies or certificates offered by the issuer; and

(b) other Medicare Select policies or certificates.

(2) a description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized;

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer;

(7) a description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this Section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include mediation procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M.(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

(2) For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a *significant benefit* means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be re-authorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this Subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Paragraph, a *significant benefit* means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Section 11. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this Subsection without regard to age.

B. Except as provided in Section 22, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a pre-existing condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

Section 12. Standards for Claims Payment

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, P.L. 100-203) by:

(1) accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) paying the participating physician or supplier directly;

(4) furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) providing to the secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

Section 13. Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards

(1)(a) A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) at least 75 percent of the aggregate amount of premiums earned in the case of group policies; or

(ii) at least 65 percent of the aggregate amount of premiums earned in the case of individual policies;

(b) Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying Subsection A(1) of this Section and Subsection C(3) of Section 14 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

(4) For policies issued prior to January 20, 1991, expected claims in relation to premiums shall meet:

(a) the originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) the appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with January 1, 1998 to date; and

(c) the appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

B. Refund or Credit Calculation

(1) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this Section, policies or certificates issued prior to January 20, 1991, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1998. The first report shall be due by May 31, 2000 of this amendment.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of Health and Human Services, but

in no event shall it be less than the average rate of interest for 13-week Treasury Notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Filing of Rates and Rating Schedules. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(1) Each Medicare supplement policy or certificate form shall be accompanied, upon submission for approval, by an actuarial memorandum. The memorandum shall be prepared, signed and dated by a qualified actuary in accordance with generally accepted actuarial principles and practices, and shall contain at least the information listed in the following subparagraphs:

- (a) the form number that the actuarial memorandum addresses;
- (b) a brief description of benefits provided;
- (c) a schedule of rates to be used;
- (d) a complete explanation of the rating process, including assumptions, claims data, methodology, and formulae used in developing the gross premium rates;
- (e) a statement of what experience base will be used in future rate adjustments;
- (f) a certification that the anticipated aggregate loss ratio is at least 65 percent (for individual coverage) or at least 75 percent (for group coverage), which certification should include a statement of the period over which the aggregate loss ratio is expected to be realized;
- (g) a table of anticipated loss ratio experience for representative issue ages for each year from issue over the period of time over which the aggregate loss ratio is to be realized; and
- (h) a certification that the premiums are reasonable in relation to the benefits provided;
- (i) the memorandum shall be filed in duplicate;
- (j) any additional information requested by the commissioner.

(2) Subsequent rate adjustments filings, except for those rates filed solely due to a change in the Part A calendar year deductible, shall also provide an actuarial memorandum, prepared, signed and dated by a qualified actuary, in accordance with generally accepted actuarial principles and practices, which memorandum shall contain at least the information in the following subparagraphs:

- (a) the form number addressed by the actuarial memorandum shall be included;
- (b) a brief description of benefits provided shall be included;
- (c) a schedule of rates before and after the rate change shall be included;
- (d) a statement of the reason and basis for the rate change shall be included;

(e) a demonstration and certification by the qualified actuary shall be included to show that the past plus future expected experience after the rate change will result in an aggregate loss ratio equal to, or greater than, the required minimum aggregate loss ratio;

(i) this rate change and demonstration shall be based on the experience of the named form in Louisiana only, if that experience is credible.

(ii) the rate change and demonstration shall be based on experience of the named form nationwide, if the named form is used nationwide and the Louisiana experience is not credible, but the nationwide experience is credible.

(f) for policies or certificates in force less than three years, a demonstration shall be included to show that the third-year loss ratio is expected to be equal to, or greater than, the applicable percentage;

(g) a certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided shall be included;

(h) the memorandum shall be filed in duplicate;

(i) any additional information requested by the commissioner.

(3) An issuer of Medicare supplement policies and certificates issued before or after the effective date of Regulation 33 (Revised 1992) in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for the upcoming calendar year for approval by the commissioner no later than December 31. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

The actuarial memorandum filed for purposes of this Subsection shall contain all Medicare supplement plans issued by the issuer and shall not include rate adjustments. The memorandum shall be prepared, signed and dated by a qualified actuary in accordance with generally accepted actuarial principles and practices, and shall contain at least the information listed in the following subparagraphs:

- (a) the form number of each plan that the actuarial memorandum addresses;
- (b) plan type designation (for example: Plan A, Plan B, Pre-standardized);
- (c) the methodology for each plan;
- (d) identify filing as "ANNUAL MEDICARE SUPPLEMENT FILING" on the face page of the memorandum;
- (e) the memorandum shall be filed in duplicate;
- (f) any additional information requested by the commissioner.

(4) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of

Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(a)(i) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(ii) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(iii) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Section.

(b) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of Regulation 33 as revised July 20, 1992 if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

Section 14. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

B. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

C.(1) Except as provided in Paragraph (2) of this Subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(a) the inclusion of new or innovative benefits;

(b) the addition of either direct response or agent marketing methods;

(c) the addition of either guaranteed issue or underwritten coverage;

(d) the offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this Section, a *Type* means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

D.(1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this Subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

E.(1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined

for purposes of the refund or credit calculation prescribed in Section 13 of this regulation.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Section 15. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this Section, *Compensation* includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Section 16. Required Disclosure Provisions

A. General Rules

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to pre-existing conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(6)(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons, eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12-point type. Delivery of the guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the guide shall be made to the applicant at the time of application and acknowledgment of receipt of the guide shall be obtained by the issuer. Direct response issuers shall deliver the guide to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this Section, *form* means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

(a) include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

(3) The notices shall not contain or be accompanied by any solicitation.

C. Outline of Coverage Requirements for Medicare Supplement Policies

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage provided to applicants pursuant to this Section consists of four parts: a cover page; premium information; disclosure pages; and charts displaying the features of all benefit plans available by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans A-J shall be shown on the cover page, and each Medicare supplement policy and certificate currently available by an issuer shall be prominently identified. Premium information for plans that are available shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are available to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]

Outline of Medicare Supplement Coverage--Cover Page:

Benefit Plan(s) _____ [insert letter(s) of plan(s) available by the issuer]

Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (Generally, 20 percent) of Medicare-approved expenses).

Blood: First three pints of blood each year.

A	B	C	D	E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care

F	G	H	I	J
Basic Benefits				
Skilled Nursing Co-Insurance				
Part A Deductible				
Part B Deductible				Part B Deductible
Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency				
	At-Home Recovery		At-Home Recovery	At-Home Recovery
		Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (3,000 Limit)
				Preventive Care

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage.

Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this Paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9D of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A
MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD
 *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$0	\$[760](Part A Deductible)
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	\$0	Up to \$[95] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN A
MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR
 *Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B
MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD
 *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$[760](Part A Deductible)	\$0
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			

First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	\$0	Up to \$[95] a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

PLAN B
MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR
*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$[760](Part A Deductible)	\$0
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses \$0	\$0
--Beyond the Additional 365 days	\$0		All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	Up to \$[95] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN C

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN D

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$[760](Part A Deductible)	\$0
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after: --While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used: --Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	Up to \$[95] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respice care	\$0	Balance

PLAN D

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN D (continued)
PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN E

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$[760](Part A Deductible)	\$0
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	Up to \$[95] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN E

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare approved Amounts	80%	20%	\$0

(continued)

PLAN E (continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE			
Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

PLAN F

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$[760] (Part A Deductible)	\$0
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	Up to \$[95] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN F

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	All Costs	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$[760](Part A Deductible)	\$0
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All Approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	Up to \$[95] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN G

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G (continued)
PARTS A and B

(continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
--Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN H

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$[760](Part A Deductible)	\$0
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	Up to \$[95] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN H

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			\$100(Part B Deductible)
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN H (continued)

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50--\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN I

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$[760](Part A Deductible)	\$0
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0
--Beyond the Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	Up to \$[95] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN I

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	All Costs	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$0	\$100(Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN I (continued)
PARTS A and B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			\$100(Part B Deductible)
First \$100 of Medicare Approved Amounts*	\$0	\$0	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600	
--Calendar year maximum	\$0		

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS--NOT COVERED BY MEDICARE			
First \$250 each calendar year	\$0	\$0	\$250
Next \$2,500 each calendar year	\$0	50%--\$1,250 calendar year maximum benefit	50%
Over \$2,500 each calendar year	\$0	\$0	All Costs

PLAN J

MEDICARE (PART A) --HOSPITAL SERVICES--PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[760]	\$[760](Part A Deductible)	\$0
61st thru 90th day	All but \$[190] a day	\$[190] a day	\$0
91st day and after:			
--While using 60 lifetime reserve days	All but \$[380] a day	\$[380] a day	\$0
--Once lifetime reserve days are used:			
--Additional 365 days	\$0	100% of Medicare Eligible Expenses \$0	\$0
--Beyond the Additional 365 days	\$0		All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$[95] a day	Up to \$[95] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services			
	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN J

MEDICARE (PART B) --MEDICAL SERVICES--PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES* IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally, 80%	Generally, 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	All Costs	\$0
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES--BLOOD TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

PARTS A and B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
--Medically necessary skilled care services and medical supplies	100%	\$0	\$0
--Durable medical equipment			
First \$100 of Medicare Approved Amounts*	\$0	\$100(Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

(continued)

PLAN J (continued)
PARTS A and B (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE(cont'd.) AT-HOME RECOVERY SERVICES--NOT COVERED BY MEDICARE Home care certified by our doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
--Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
--Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600	
--Calendar year maximum	\$0		

OTHER BENEFITS--NOT COVERED BY MEDICARE

FOREIGN TRAVEL--NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
First \$250 each calendar year	\$0	\$0	\$250
Next \$6,000 each calendar year	\$0	50%--\$3,000 calendar year maximum benefit	50%
Over \$6,000 each calendar year	\$0	\$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT--NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All Costs

D. Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; or other policy identified in Section 3.B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

Section 17. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

An application for a medicare supplement policy shall not be combined with an application for any other type of insurance coverage. The application may not make reference to or include questions regarding other types of insurance coverage except for those questions specifically required under this Section.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) The benefits and premiums under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

(5) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

To the best of your knowledge,

(1) Do you have another Medicare supplement policy or certificate in force?

(a) If so, with which company?

(b) If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

(2) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(a) If so, with which company?

(b) What kind of policy?

(3) Are you covered for medical assistance through the state Medicaid program:

(a) as a Specified Low-Income Medicare Beneficiary (SLMB)?

(b) as a Qualified Medicare Beneficiary (QMB)?

(c) for other Medicaid medical benefits?

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five years which are no longer in force.

C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefit, but lower premiums.
- Fewer benefits and lower premiums.
- Other. (please specify)

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has

been properly recorded. [If the policy or certificate is guaranteed issue, this Paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

F. Paragraphs 1 and 2 of the replacement notice (applicable to pre-existing conditions) may be deleted by an issuer if the replacement does not involve application of a new pre-existing condition limitation.

Section 18. Filing Requirements for Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the commissioner of Insurance of this state for review and approval by the commissioner to the extent permitted under the *Insurance Code*, particularly under R.S. 22:1215.

Section 19. Standards for Marketing

A. An issuer, directly or through its producers, shall:

(1) establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

(2) establish marketing procedures to assure excessive insurance is not sold or issued;

(3) display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance;

(5) establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in R.S. 22:1211 et seq. the following acts and practices are prohibited:

(1) **Twisting.** Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(2) **High Pressure Tactics.** Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) **Cold Lead Advertising.** Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

D. No insurer providing Medicare supplement insurance in this state shall allow its agent to accept premiums except by check, money order, or bank draft made payable to the insurer. If payment in cash is made, the agent must leave the insurer's official receipt with the insured or the person paying the premium on behalf of the insured. This receipt shall bind the insurer for the monies received by the agent.

Under this Section, the agent is prohibited from accepting checks, money orders and/or bank drafts payable to the agent or his agency. The agent is not to leave any receipt other than the insurer's for premium paid in cash.

Section 20. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

Section 21. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

- (1) policy and certificate number, and
- (2) date of issuance.

B. The items set forth above must be grouped by individual policyholder.

Section 22. Prohibition Against Pre-existing Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to pre-existing conditions, waiting periods, elimination periods and probationary periods.

Section 23. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 24. Effective Date

The revisions to this regulation shall become effective on January 20, 1998.

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR _____

Type¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

	(a)	(b)
	Earned	Incurred
line ----	Premium ³	Claims ⁴

1. Current Year's Experience
 - a. Total (all policy years) _____
 - b. Current year's issues⁵ _____
 - c. Net (for reporting purposes = 1a - 1b) _____
2. Past Years' Experience (All Policy Years) _____
3. Total Experience (Net Current Year + Past Year's (Experience) _____
4. Refunds Last Year (Excluding Interest) _____
5. Previous Since Inception (Excluding Interest) _____
6. Refunds Since Inception (Excluding Interest) _____
7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1) _____
8. Experienced Ratio Since Inception _____

Total Actual Incurred Claims (line 3, col. b) = Ratio 2

Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)
9. Life Years Exposed Since Inception _____
 If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.
10. Tolerance Permitted (obtained from credibility table) _____

Medicare Supplement Credibility Table

Life Years Exposed <u>Since Inception</u>	<u>Tolerance</u>
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%

If less than 500, no credibility.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR _____

Type¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

11. Adjustment to Incurred Claims for Credibility _____

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims _____

[Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)] X Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6) -

Adjusted Incurred Claims (line 12)

 Benchmark Ratio (Ratio 1) _____

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

¹Individual, group, individual Medicare Select, or group Medicare Select only

²"SMSBP" = Standardized Medicare Supplement Benefit Plan

³Includes Modal Loadings and Fees Charged

⁴Excludes Active Life Reserves

⁵This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

 Signature

 Name - Please Type

 Title

 Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR **GROUP** POLICIES
FOR CALENDAR YEAR _____

Type¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(l + n)/(k + m)$: _____

¹Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

²"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

³Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

⁴For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR **INDIVIDUAL** POLICIES
FOR CALENDAR YEAR _____

Type¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

(a) ³	(b) ⁴	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o) ⁵
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(l + n)/(k + m)$: _____

¹Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

²"SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

³Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2

is 1989, etc.)⁴For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.⁵These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

Appendix B
FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare Supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____ Signature

_____ Name and Title (please type)

_____ Date

Appendix C
DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for
Health Insurance Policies Sold to Medicare Beneficiaries
that Duplicate Medicare

1. Federal law, P.L. 103-432, prohibits the sale of a health insurance policy (the term policy or policies includes certificates) that duplicate Medicare benefits unless it will pay benefits without regard to other health coverage and it includes the prescribed disclosure statement on or together with the application.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare Supplement policy to a person that already has a Medicare Supplement policy except as a replacement.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. The federal law does not pre-empt state laws that are more stringent than the federal requirements.

7. The federal law does not pre-empt existing state from filing requirements.

**THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

C hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

C hospitalization

C physician services

C other approved items and services

Before You Buy This Insurance

T Check the coverage in **all** health insurance policies you already have.

T For more information about Medicare and Medicare Supplement insurance, view the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits for specified limited services]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

C any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- C hospitalization
- C physician services
- C other approved items and services

Before You Buy This Insurance

- T Check the coverage in **all** health insurance policies you already have.
- T For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- C hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- C hospitalization
- C physician services
- C hospice
- C other approved items and services

Before You Buy This Insurance

- T Check the coverage in **all** health insurance policies you already have.
- T For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- C hospitalization
- C physician services
- C hospice
- C other approved items and services

Before You Buy This Insurance

- T Check the coverage in **all** health insurance policies you already have.
- T For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits for both expenses incurred and fixed indemnity basis]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- C any expenses or services covered by the policy are also covered by Medicare; or
- C it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- C hospitalization
- C physician services
- C hospice
- C other approved items and services

Before You Buy This Insurance

- T Check the coverage in **all** health insurance policies you already have.
- T For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies that provide benefits for both expenses incurred and fixed indemnity basis]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- C any expenses or services covered by the policy are also covered by Medicare; or
- C it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- C hospitalization
- C physician services
- C hospice care
- C other approved items and services

Before You Buy This Insurance

- T Check the coverage in **all** health insurance policies you already have.
- T For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For long-term care policies providing both nursing home and noninstitutional coverage]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

This is long-term care insurance that provides benefits for covered nursing home and home care services.

C In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.

C This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long-term care expenses.

Before You Buy This Insurance

T Check the coverage in **all** health insurance policies you already have.

T For more information about long-term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.

T For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies providing nursing home benefits only]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

C This insurance provides benefits primarily for covered nursing home services.

C In some situations Medicare pays for short periods of skilled nursing home care and hospice care.

C This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

T Check the coverage in **all** health insurance policies you already have.

T For more information about long-term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.

T For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For policies providing home care benefits only]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

C This insurance provides benefits primarily for covered home care services.

C In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.

C This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance

T Check the coverage in **all** health insurance policies you already have.

T For more information about long-term care insurance, review the *Shopper's Guide to Long Term Care Insurance*, available from the insurance company.

T For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[For other health insurance policies not specifically identified in the previous statements]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE
BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

C the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- C hospitalization
- C physician services
- C hospice care
- C other approved items and services

Before You Buy This Insurance

- T Check the coverage in **all** health insurance policies you already have.
- T For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- T For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

James H. "Jim" Brown
Commissioner

9801#011

RULE

**Department of Natural Resources
Office of Conservation**

Austin Chalk Formation (LAC 43:XIX.Chapter 43)

In accordance with the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Natural Resources, Office of Conservation adopts Statewide Order No. 29-S (LAC 43:XIX.Subpart 18.Chapter 43).

Title 43

NATURAL RESOURCES

**Part XIX. Office of Conservation: General Operations
Subpart 18. Statewide Order No. 29-S**

Chapter 43. Austin Chalk Formation

§4301. Scope

This Statewide Order provides rules and regulations governing the drilling of horizontal wells in the Austin Chalk Formation in the state of Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Conservation, LR 24:102 (January 1998).

§4303. Definitions

Unless the context otherwise requires, the words defined in §4303 shall have the following meaning when found in this Statewide Order.

Austin Chalk Formation Horizontal Well—well with the wellbore drilled laterally at an angle of at least 80E to the vertical and with a horizontal displacement of at least 50 feet in the Austin Chalk Formation measured from the initial point of penetration into the Austin Chalk.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Conservation, LR 24:102 (January 1998).

§4305. Order

From and after the effective date hereof, permission to develop the Austin Chalk Formation in the state of Louisiana by the use of horizontal wells may be obtained as hereinafter provided and upon strict compliance with the procedures set forth herein.

1. The restriction on tubing size as set forth in LAC 43:XIX.109.E.1 of Statewide Order No. 29-B shall not apply to Austin Chalk Formation horizontal wells.

2. Statewide Order No. 29-E well spacing rules shall not apply to Austin Chalk Formation horizontal wells. The following well spacing rules shall apply to Austin Chalk Formation horizontal wells in areas in which no spacing rules for Austin Chalk Formation horizontal wells have been established by special orders, provided that exceptions may be approved after a public hearing based on 10 days legal notice:

a. a subsequent Austin Chalk Formation horizontal well shall not be located so as to encroach into a rectangle formed by drawing north-south lines 3,000 feet east of the most easterly point and 3,000 feet west of the most westerly point and east-west lines 100 feet north of the most northerly point and 100 feet south of the most southerly point of any horizontal well completed in, drilling to, or for which a permit shall have been granted to drill to the Austin Chalk Formation. In the case of a single horizontal well, the point of entry into the Austin Chalk Formation (if available) is to be used in lieu of the surface location in determining the northern or southern boundary of the rectangle;

b. survey plats submitted with the application for permit to drill shall contain certification of the surveyor specifying compliance with this requirement;

c. multiple Austin Chalk Formation horizontal well laterals drilled into the same stratigraphic interval from a single wellbore will be treated as a single completion, even if the laterals are isolated by separate producing strings to the surface.

3. The gas allowable provisions of Statewide Order No. 29-F shall not apply to Austin Chalk Formation horizontal wells. Instead, Austin Chalk Formation horizontal wells shall be given an allowable based on the Maximum Efficient Rate (MER) of the well, being the maximum sustainable daily withdrawal rate from the reservoir which will permit economical development and depletion without causing waste. In the event an alternate unit well is authorized for any Austin Chalk Formation unit, such unit allowable shall be limited to the greater of the MER of the best well in said unit or the highest rate of withdrawal on a per acre basis of any unit in the same reservoir and field. If there is any complaint of waste or dispute relative to compliance with R.S. 30:11(B), the allowable assigned to an Austin Chalk Formation horizontal well shall be subject to adjustment after a public hearing based on 10 days legal notice.

a. Unless an exception is granted as provided herein, no allowable will be granted for a horizontal completion in the Austin Chalk Formation until a unit has been formed pursuant to an Office of Conservation Order for the well unless the operator agrees to escrow all monies received from pre-unitization production pending unitization and distribute such funds on the basis of the unit ultimately established.

b. The operator of a well may request an exception to this requirement for a well located on a large lease/voluntary unit or for other good cause shown.

c. The commissioner of Conservation will have the discretion to either approve or deny such application or require that the applicant request a public hearing to be held after 10 days legal notice to consider the matter.

4. The Office of Conservation's policy requiring a sand definition and production test in the field before units can be established shall not apply to Austin Chalk Formation horizontal wells.

5. The size and shape of units for Austin Chalk Formation horizontal wells should usually be based on the proposed design of the well because such units are expected to be developed by horizontal laterals which traverse the entire unit in a generally north-south direction. If the initial lateral in a drilling unit fails to provide full horizontal coverage in a north-south direction, additional horizontal laterals or wells drilled to acquire that coverage shall be considered and named unit wells rather than alternate unit wells. However, if any such additional unit well or lateral overlaps an existing unit well or lateral in an east-west direction, it shall be considered and named an alternate unit well. Overlaps shall be determined by use of a line parallel to the north and south unit boundaries. This provision shall only apply to Austin Chalk Formation horizontal wells and shall not be used as a precedent for any other formation.

6. The party who owns or controls the majority working interest in a drilling unit established for an Austin Chalk Formation horizontal well shall have the right to be designated the operator of such unit. Such ownership or control shall be

based on sworn testimony at the public hearing which creates the drilling unit. If the working interest ownership or control in a unit is not known or cannot be established with reasonable certainty when the unit is created, then the operator designation shall occur when a drilling permit is issued for the drilling of a well on the unit. The party requesting such drilling permit shall complete and file an affidavit corroborating such majority ownership or control on the affidavit form provided by the file in the Office of Conservation. It is provided, however, that any party designated as a unit operator can be removed or a working interest owner who does not own or control the majority in working interest can be designated as unit operator after a public hearing based on 10 days legal notice if it is demonstrated that the designated operator and/or majority working interest owner has not timely developed the unit, has not acted prudently, or that other good cause exists therefor.

7. Statewide Order No. 29-B requires that a directional survey be run on all wells which are directionally controlled and thereby intentionally deviated from the vertical. The requirement that a directional survey be run the entire length of the lateral in an Austin Chalk Formation horizontal well may be waived by the Office of Conservation if evidence is presented at the time such waiver is requested that the directional survey cannot reasonably reach the end of the lateral and that measuring from the point where the directional survey ends, the lateral of the well will still be:

a. within the spacing provisions for the unit upon which it has been drilled or, if a unit has not been established, under a tract for which authority to drill has been obtained, and

b. at least the distance from all offsetting wells required by applicable spacing rules or in the absence thereof, the provisions of §4305.A.2.

8. An application for permit to drill in an area affected by a pending application requesting the formation of one or more units will be issued without regard to the pending unitization proceedings. However, the permit so issued shall not be used at the hearing (only drilled wells may be considered), and the permit will be subject to the order issued as a result of such hearing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:1 et seq.

HISTORICAL NOTE: Promulgated by Department of Natural Resources, Office of Conservation, LR 24:102 (January 1998).

Warren A. Fleet
Commissioner

9801#063

RULE

Department of Public Safety and Corrections Corrections Services

Juvenile Transfer to Adult
Facility (LAC 22:I.335)

In accordance with the Administrative Procedure Act, R.S. 49:950 and in order to implement R.S. 15:9021, the Department of Public Safety and Corrections, Corrections

Services, hereby adopts regulations for transfer of juveniles to adult facilities.

Title 22

CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

Part I. Corrections

Chapter 3. Adult and Juvenile Services

Subchapter A. General

§335. Juvenile Transfer to Adult Facility

A. Purpose. To establish the secretary's policy regarding the limited transfer of juvenile offenders 17 years of age or older to adult facilities.

B. To Whom This Regulation Applies. LAC 22:I.335 is applicable to the deputy secretary, assistant secretaries, wardens, and director of the Division of Youth Services of the Department of Public Safety and Corrections.

C. Definitions

Adult—an individual convicted by a criminal court and sentenced to the custody of the Department of Public Safety and Corrections (DPS&C).

Disposition—the written order of the juvenile court, following adjudication, which specifies the court's sentence.

Juvenile—an individual who is adjudicated delinquent by a judge exercising juvenile jurisdiction and sentenced to the custody of the DPS&C.

D. Policy

1. It is the secretary's policy, in accordance with R.S. 15:902.1, to authorize the limited transfer of juveniles adjudicated delinquent to adult facilities when the juveniles have attained the age of 17 years and are otherwise eligible as defined by this regulation.

2. Juvenile offenders who are adjudicated delinquent for an offense that, if committed by an adult, could not result in a sentence at hard labor, are not eligible for transfer.

3. Generally, juvenile offenders will be transferred to one of the following adult facilities:

- a. Adult Reception and Diagnostic Center (ARDC);
- b. Elayn Hunt Correctional Center (EHCC);
- c. Wade Reception and Diagnostic Center (WRDC);
- d. David Wade Correctional Center (DWCC);
- e. Louisiana Correctional Institute for Women (LCIW).

4. Juvenile offenders in adult facilities will not have a parole or diminution of sentence release date.

a. They will only have a "full term date." This date will be either:

- i. their twenty-first birthday;
- ii. their eighteenth birthday if the crime was committed before their thirteenth birthday and it is not a crime enumerated under *Louisiana Children's Code*, Article 897.1;
- iii. the date upon which the juvenile has completed the period of commitment as specified in the judgment of the juvenile court; or
- iv. the date which reflects the maximum term that an adult could receive if sentenced for the same offense, whichever is earlier.

b. If the period of commitment specified by the juvenile court exceeds the twenty-first birthday, the eighteenth birthday under circumstances outlined, or the maximum term

for which an adult could be sentenced for the same crime, then the Office of Youth Development and the Headquarters Legal Section should be notified immediately.

5. Absent special statutory or regulatory restrictions to the contrary, juveniles in adult facilities will participate in all work, education, and other rehabilitative programs on the same basis as adults and will be subject to the same classification and disciplinary processes as adults, including custody status determination. Security supervision and security practices will also be the same for juvenile offenders in adult facilities as for adult inmates.

6. Records of juveniles housed in adult facilities shall be confidential and information may not be disclosed to anyone except in accordance with department Regulation No. B-03-003, "Access to and Release of Juvenile Offender and Ex-Offender Records," as set forth in R.S. 15:574.12 and *Louisiana Children's Code*, Article 412.

E. Procedures

1. A classification committee will be formed at all juvenile facilities to review offenders for eligibility and suitability for transfer and to make appropriate recommendations to the warden. It will be the responsibility of this committee to review all relevant information.

a. The offender shall be given 24-hour notice of the proposed transfer and shall be allowed to appear before the classification committee to provide input into the decision making process. He may select a staff representative to assist him in accordance with the process outlined in the "Disciplinary Rules and Procedures for Juvenile Offenders."

b. The following variables should be considered by the classification committee when evaluating a juvenile offender for possible transfer to an adult facility:

- i. chronological age of 17 years or older;
- ii. emotional and physical maturity;
- iii. disciplinary history and potential to disrupt juvenile institutional operations;
- iv. potential to benefit from educational programs;
- v. potential to benefit from other programs;
- vi. offenders diagnosed with mental health and/or medical special needs who can be better served in an adult facility;
- vii. offenders who pose a threat to security, i.e., who are considered escape risks, who have exhibited violent behavior, who are committed for serious offense(s), or who have an extensive criminal history;
- viii. to accomplish one of the following objectives:
 - (a). minimize risk to the public;
 - (b). minimize risk to institutional staff; and
 - (c). minimize risk to other offenders.

c. Disciplinary history may impact the recommendation, but the transfer itself is not a disciplinary sanction or disciplinary activity. The disciplinary committee can refer offenders to the classification committee for review.

2. The warden of each juvenile facility will review the recommendation made by the classification committee and will make the final determination relative to transfer. The secretary and assistant secretaries will be notified of any transfer. In addition, the warden will provide notification to the appropriate juvenile judge, Division of Youth Services office,

the legal guardian, and the classification administrator at ARDC, and WRDC. The notification must be given at least 72 hours prior to the proposed transfer, unless waived by the secretary or his designee.

3. Notification to the classification administrator at ARDC should include pertinent information, e.g., the Juvenile Information Reporting Management System (JIRMS) master record, judicial commitment documents, classification committee report and recommendation, and warden's decision. ARDC PreClass Section will then assign a unique six digit Department of Corrections (DOC) number to each juvenile-in-adult custody (such number will begin with the numeral seven followed by the juvenile's original JIRMS number), update the CAJUN II information, and establish the adult institutional record prior to transfer (except in emergency cases). The classification administrator will schedule the date of transfer and will notify the appropriate juvenile institution.

4. The sending facility will be responsible for the transportation of the offender to the appropriate receiving institution and will provide all institutional and medical records at the time of transfer in accordance with department Regulation No. B-06-001, "Health Care." The offender's personal funds should be transmitted by check at the time of transfer or as soon as possible thereafter. In addition, the JIRMS transfer screen will be updated to reflect the transfer and will be subsequently utilized for inquiry purposes.

5. Initial evaluation to determine appropriate housing while in the reception process should include evaluation of emotional and physical maturity.

6. ARDC, WRDC, or LCIW will conduct a full evaluation in accordance with department regulations and ACA Standards to determine subsequent placement at EHCC or DWCC (or suitable housing assignment at LCIW). The evaluation will include, but is not limited to, the following:

- a. emotional and physical maturity to evaluate the need for assignment to Level 1 or Level 2 protective custody;
- b. review of information previously generated by JRDC, as available;
- c. history of gang affiliation and prior juvenile institutional assignment and security history;
- d. special educational needs or other programming needs and the appropriateness of assignment to academic and/or vocational programs;
- e. medical needs, including substance abuse assessment, and assignment of an appropriate medical level of care;
- f. mental health needs with particular emphasis on suicide potential and assignment of an appropriate mental health level of care; and
- g. consideration of geographical location.

7. Upon completion of evaluation, the Transfer Section at ARDC will schedule transfer to the appropriate permanent facility.

8. The receiving institution will assign housing and provide services as set forth in department regulations and American Correctional Association (ACA) Standards. The records office of the receiving institution will maintain the juvenile institutional record and the adult inmate record and

will update the CAJUN database. Upon discharge, all institutional records will be returned to the Juvenile Reception and Diagnostic Center at Jetson Correctional Center for Youth.

9. The adult facility must report the location and condition of the juvenile to the juvenile court every six months (or more frequently if requested). This format may be utilized to make early release recommendations as appropriate.

10. Sex offender notifications are generally not applicable to juvenile offenders housed in adult facilities. Other crime victim notice requirements for juveniles as indicated in department Regulation No. C-01-007, "Crime Victims Services Bureau," are applicable.

11. Visiting lists will be established pursuant to the provisions of department Regulation No. C-03-006, "Inmate Visitation." These transfers are to be considered as new admissions for the purposes of §335.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:902.1.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services, LR 24:104 (January 1998).

Richard L. Stalder
Secretary

9801#037

RULE

Department of Public Safety and Corrections Office of State Police Transportation and Environmental Safety Section

Explosive Code
(LAC 55:I.1511-1543)

The Department of Public Safety and Corrections, Office of State Police, Transportation and Environmental Safety Section, Explosive Control Unit has amended rules pertaining to magazine construction requirements, general requirements of persons holding an explosives license, training, and drug testing requirements in the Explosive Code, LAC 55:I.Chapter 5, as authorized by R.S. 40:1472.1 et seq., and in accordance with R.S. 49:950 et seq.

The amendments consist primarily of technical changes to the above-mentioned sections.

Title 55

PUBLIC SAFETY

Part I. State Police

Chapter 15. Explosive Code

§1511. Magazine Construction Requirements

K. A Type 3 magazine is a "day box" or other portable magazine. It must be theft-resistant, fire-resistant, and weather-resistant (does not have to be bullet-resistant).

1. Minimum specifications require that a "day box" be constructed of not less than 12-gauge (.1046 inch) (2.66 mm) steel or aluminum, lined with ½ inch (12.7 mm) hardboard or plywood. The door or lid must overlap the door opening by at

least 1 inch (25 mm). Hinges, hasps, and panels shall be welded, riveted, or bolted (with nuts on inside) so they cannot be removed or disassembled from the outside.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1472.1 et seq.

HISTORICAL NOTE: Adopted by the Department of Public Safety, Office of State Police, 1974, amended and promulgated LR 10:803 (October 1984), amended by the Department of Public Safety and Corrections, Office of State Police, Transportation and Environmental Safety Section, Explosive Control Unit, LR 22:1230 (December 1996), LR 24:105 (January 1998).

§1531. General Requirements

* * *

B. It is the primary licensee's responsibility to control his explosives and the use thereof. The primary licensee must control his storage and keep an accurate and continuing inventory of all supplies as set forth in §1517. The primary licensee must employ only people of good judgment, who are careful and know how to handle explosives, to do the blasting for him. The primary licensee must be sure that his employees have a valid and subsisting blaster's license. The primary licensee must be certain that the license is issued under the name of himself or his company. The primary licensee should take all practical and necessary steps to ensure that his explosives are not finding their way into the hands of unauthorized persons. Licensed geophysical contractors may contract with licensed drilling contractors to possess and use explosives for the sole purpose of executing the contract between the two parties. All explosives shall be returned to the licensed geophysical contractor at the end of each day. For purposes of §1531, the transfer of the temporary possession of explosives between the contracting parties shall not constitute a sale. The safety and security of the explosives and the compliance with these regulations shall be the responsibility of the party to the contract who is in possession of the explosives. There shall be no requirement that the drilling contractor be licensed by each geophysical contractor with whom he contracts.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1472.1 et seq.

HISTORICAL NOTE: Adopted by the Department of Public Safety, Office of State Police, 1974, amended and promulgated LR 10:803 (October 1984), amended by the Department of Public Safety and Corrections, Office of State Police, Transportation and Environmental Safety Section, Explosive Control Unit, LR 22:1230 (December 1996), LR 24:106 (January 1998).

§1541. Training

* * *

B. Training records required in §1541.B.1 below must be maintained at the licensee's local office.

1. Training shall be documented on a form or certificate to include location, subject, date of instruction, and to include the instructor's signature.

2. In addition to §1541.B.1 above, the training provider shall also document training by a written examination. These training records shall be retained by the training provider.

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AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1472.1 et seq.

HISTORICAL NOTE: Adopted by the Department of Public Safety, Office of State Police, 1974, amended and promulgated LR 10:803 (October 1984), amended by the Department of Public Safety and Corrections, Office of State Police, Transportation and Environmental Safety Section, Explosive Control Unit, LR 22:1230 (December 1996), LR 24:106 (January 1998).

§1543. Drug Testing Requirements

* * *

C. Any company whose licensee employee refuses or fails any drug test shall notify the deputy secretary of the Department of Public Safety and Corrections, Explosives Control Unit of this fact.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1472.1 et seq.

HISTORICAL NOTE: Adopted by the Department of Public Safety, Office of State Police, at the Office of State Police, 1974, amended and promulgated LR 10:803 (October 1984), amended by the Department of Public Safety and Corrections, Office of State Police, Transportation and Environmental Safety Section, Explosive Control Unit, LR 22:1230 (December 1996), LR 24:106 (January 1998).

Thomas Normile
Undersecretary

9801#025

RULE

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

Electronic Benefits Transfer—Retailers
and Cash Access (LAC 67:III.403 and 405)

The Department of Social Services, Office of Family Support has amended the *Louisiana Administrative Code*, Title 67:Part III.Subpart 1, General Administrative Procedures.

The 1997 Louisiana Legislative Session provided that recipients of Family Independence Temporary Assistance Program (FITAP) cash assistance may be charged usual and customary fees for accessing cash benefits at retail establishments. This rule establishes guidelines and other provisions regarding retail establishments and fees.

Title 67

SOCIAL SERVICES

Part III. Office of Family Support

Subpart 1. General Administrative Procedures

Chapter 4. Electronics Benefits Issuance System

§403. Participation of Retailers Effective

October 1, 1997

A. Retail establishments which are U.S. Department of Agriculture, Food and Consumer Service authorized food stamp benefit redemption points must be allowed the opportunity to participate in the state EBT system. All other retail establishments must be approved by the agency in order to participate in the cash access component of the system. Retailers approved by the agency to participate in cash access may be charged connection fees and/or monthly lease fees for electronic and telephone equipment lines necessary to establish connection to the EBT System.

B. Retail establishments found guilty of abuse, misuse or fraud of the system by using the EBT "Louisiana Purchase" card in a manner or intent contrary to the purpose of the card, in providing benefits to eligible recipients, shall be permanently disqualified from participating as a cash redemption point and shall have all equipment provided by the vendor disconnected and removed from the establishment after due process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 24:106 (January 1998).

§405. Service Fees Effective October 1, 1997

A. Recipients of cash assistance may be charged fees for accessing cash only benefits. Retailers may charge their usual and customary check cashing fee for providing cash only benefits to FITAP recipients under the following circumstances:

1. the recipient presents a valid EBT system card (known as the "Louisiana Purchase Automated Benefit Card"); and

2. the recipient is not using the card to obtain cash in conjunction with the purchase of goods or services through the EBT system.

B. Retailers may process cash transactions through the EBT system only while the system is available. Retailers shall not dispense cash to recipients using vouchers or other means of implied payment to the retailer.

C. Retailers are prohibited from recovering losses through the EBT system due to their errors that are discovered after the transaction is completed and the recipient has left the place of business.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:450.1(C)(3), R.S. 46:231.13, R.S. 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support in LR 24:107 (January 1998).

Madlyn B. Bagneris
Secretary

9801#040

RULE

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

Family Independence Temporary Assistance
Program (FITAP)—Individual Development
Account (LAC 67:III.1115)

The Department of Social Services, Office of Family Support (OFS) has amended the LAC 67:III.Subpart 2, the Family Independence Temporary Assistance Program (FITAP), which has replaced the Aid to Families with Dependent Children (AFDC) Program.

Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, empowered the state to establish a cash assistance program for the expenditure of

federal funds for the *Temporary Assistance to Needy Families Block Grant*. The 1997 Regular Session of the Louisiana Legislature passed legislation directing the Office of Family Support to allow FITAP recipients to maintain a special Individual Development Account. This rule defines the Individual Development Account which will be exempted as a resource.

Title 67

SOCIAL SERVICES

Part III. Office of Family Support

Subpart 2. Family Independence Temporary Assistance Program (FITAP)

Chapter 11. Application, Eligibility and Furnishing Assistance

Subchapter B. Conditions of Eligibility

§1115. Resource Limit

A. - B.3. ...

4. an Individual Development Account (IDA) which is a special account established in a financial institution for the purposes of work-related education or training. Only one IDA per assistance unit is allowed. The amount of the deposits cannot exceed \$6,000, excluding interest, and the balance of the account cannot exceed \$6,000, including interest, at any time. Deposits to the account may be made by the recipient, by a nonprofit organization, or by an individual contributor. OFS is not responsible for enforcing stipulations placed on the use of the money by a nonprofit organization or by an individual contributor. IDA funds may be used only for the following purposes:

a. educational expenses incurred at an accredited institution of higher education;

b. training costs incurred for a training program approved by the agency; or

c. payments for work-related expenses, such as clothing, tools or equipment approved by the agency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:443 and R.S. 46:460.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 8:8 (January 1982), amended by the Department of Social Services, Office of Family Support, LR 19:1340 (October 1993), LR 24:107 (January 1998).

Madlyn B. Bagneris
Secretary

9801#041

RULE

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

Food Stamps—Deductions and Case
Actions (LAC 67:III.1701 and Chapter 19)

The Department of Social Services, Office of Family Support has amended the *Louisiana Administrative Code*, Title 67, Part III, Subpart 3, Food Stamps.

Under authority granted by the United States Department of Agriculture (USDA), Food and Consumer Service, the Food

Stamp Program has established a mandatory standard utility allowance and basic utility allowance in the eligibility determination process. The option to establish mandatory standards was offered to state agencies under Section 809 of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

The agency also revised the sequence of certain actions in the process of reducing or terminating a recipient's benefits. USDA approved a waiver which allows the agency to send a notice of adverse action, in lieu of a notice of expiration, when the agency becomes aware of a change in a household's circumstances but does not have all the information needed to process the change.

Program authority in §1701 has been amended to include appropriate state legislation.

Title 67
SOCIAL SERVICES
Part III. Office of Family Support
Subpart 3. Food Stamps

Chapter 17. Administration

Subchapter A. General Provisions

§1701. Authority

The Food Stamp Program is administered under the authority of applicable federal and state laws.

AUTHORITY NOTE: Promulgated in accordance with applicable sections of 7 CFR and R.S. 36:474.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 17:1226 (December 1991), amended LR 24:108 (January 1998).

Chapter 19. Certification of Eligible Households

Subchapter I. Income and Deductions

§1965. Standard Utility Allowance (SUA)

A. Households which incur heating or cooling costs separate and apart from their rent or mortgage use a mandatory single Standard Utility Allowance (SUA) in the determination of shelter costs and deductions. To be qualified, the household must be billed on a regular basis for heating or cooling costs. However, during the heating season a household that is billed less often than monthly, but is eligible to use the standard allowance, may continue to use the standard allowance between billing months. The SUA is available to those households receiving energy assistance payments or reimbursements but who continue to incur heating or cooling costs that exceed the payment during any month covered by the certification period.

B. Any household living in a housing unit which has central utility meters and which charges the household for excess utility costs only, shall not be permitted to use the SUA.

C. Where the household shares a residence and utility costs with other individuals, the SUA shall be divided equally among the parties which contribute to meeting the utility costs. In such cases, the household shall only be permitted to use its prorated share of the standard allowance.

AUTHORITY NOTE: Promulgated in accordance with F.R. 47:51551 et seq., 7 CFR 272 and 273.9, P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 9:64 (February 1983), amended by the Department of Social Services, Office of

Family Support, LR 20:860 (August 1994), LR 20:991 (September 1994), LR 20:1363 (December 1994), LR 21:188 (February 1995), LR 23:82 (January 1997), LR 24:108 (January 1998).

§1966. Basic Utility Allowance (BUA)

Households which do not incur heating or cooling costs separate and apart from their rent or mortgage use a mandatory single Basic Utility Allowance (BUA). To be eligible, a household must be billed on a regular basis for utility costs. Any household living in a housing unit which has central utility meters and which charges the household for excess utility costs only shall use the BUA. When the household shares a residence and utility costs with other individuals, the BUA shall be divided equally among the parties which contribute to meeting the utility costs. In such cases, the household should only be permitted to use its prorated share of the BUA.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 24:108 (January 1998).

§1967. Setting the Standard Utility Allowance and Basic Utility Allowance

[Editor's Note: section heading changed.]

* * *

AUTHORITY NOTE: Promulgated in accordance with 7 CFR 273.9(d)(6), P.L. 104-193.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 11:864 (September 1985), repromulgated by the Department of Social Services, Office of Family Support, LR 24:108 (January 1998).

Subchapter M. Notice of Adverse Action (NOAA)

§1999. Reduction or Termination of Benefits

* * *

B. A Notice of Adverse Action (NOAA) will be sent instead of a Notice of Expiration of the certification period when the agency becomes aware of a change in the household's circumstances and the household has not furnished verification of the change, requested more time to obtain the information, or requested the agency's assistance in obtaining the required verification. The NOAA will advise the household of the specific information which must be provided by the last day of the month following the month the notice is sent so that the agency can determine the effect of the change in the household's eligibility and benefit level. If the household provides the information before the adverse action period expires and continues to be eligible, its participation will continue without reapplication. If the verification is not provided in this period of time, benefits will be terminated and the household will be required to reapply. The time frames involved will be the same as if the certification period is shortened.

AUTHORITY NOTE: Promulgated in accordance with F.R. 47:55903 et seq., 7 CFR 273.13, 7 CFR 273.12(f)(3).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 9:324 (May 1983), amended by the Department of Social Services, Office of Family Support, LR 24:108 (January 1998).

Madlyn B. Bagneris
Secretary

9801#057

RULE

Department of Social Services Office of the Secretary Bureau of Licensing

Adult Day Care Center
(LAC 48:I.Chapter 43)

The Department of Social Services, Office of the Secretary, Bureau of Licensing is amending the *Louisiana Administrative Code*, Title 48, Part 1, Subpart 3, Licensing and Certification.

This rule is mandated by R.S. 46:1971-1980.

These standards are being revised to supersede any previous regulations heretofore published.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensing and Certification

Chapter 43. Adult Day Care Center

§4301. Purpose

The overall purpose of these regulations is the well-being of persons involved in adult day care programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:109 (January 1998).

§4303. Authority

A. Legal Authority. The legal authority of these regulations and of the licensing authority of the Department of Social Services (DSS) is found in the following statutes:

R.S. 46:51;

R.S. Title 28 Sections 1 through 2;

R.S. Title 28 Sections 421 through 427;

R.S. Title 46 Sections 1971 through 1980;

R.S. Title 46 Section 2102; and

29 U.S.C. 795K (34 CFR Part 363) (P.L. 99-506).

B. Effective Date. These regulations (LAC 48:I.Chapter 43) are effective upon publication as a final rule in the *Louisiana Register*, in accordance with the Administrative Procedure Act.

C. Penalties

1. All adult day care facilities, including facilities owned or operated by any governmental, profit, nonprofit, private, or church agency shall be licensed.

2. Any person operating an adult day care facility, as defined in R.S. 46:1972, in violation of Chapter 43, shall be guilty of a misdemeanor and shall be fined not less than \$100 nor more than \$500 for each such offense. Each day of operation in violation of Chapter 43 shall constitute a separate offense.

D. Inspections

1. According to law, it shall be the duty of the Department of Social Services "through its duly authorized agents, to inspect at regular intervals not to exceed one year,

or as deemed necessary by the department, and without previous notice all adult day care facilities subject to the provisions of the Chapter" (R.S. 46:1971-1980).

2. Whenever the department is advised, or has reason to believe, that any person, agency, or organization is operating an adult day care facility without a license or provisional license, the department shall make an investigation to ascertain the facts.

3. Whenever the department is advised, or has reason to believe, that any person, agency, or organization is operating in violation of the Adult Day Care Minimum Standards, the department shall complete a complaint investigation. All reports of mistreatment of clients coming to the attention of the Department of Social Services will be investigated.

E. Waivers

1. The secretary of the Department of Social Services, in specific instances, may waive compliance with a minimum standard if it is determined that the economic impact is sufficiently great to make compliance impractical, as long as the health and well-being of the clients/staff are not imperiled. If it is determined that the facility or agency is meeting or exceeding the intent of a standard or regulation, the standard or regulation may be deemed to be met.

2. All waivers must be reviewed at least annually for continuance. However, a waiver may be withdrawn when it is determined that it was issued in error; situations have changed as to why the waiver was first issued; or when the provider has not complied with agreed-upon stipulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:109 (January 1998).

§4305. Types of Programs (Modules) Licensed

A. Sheltered Workshop

1. This is a facility-based program providing prevocational and vocational training to functionally-impaired adults that is comprehensive in nature, and offers opportunity for structured work among a variety of other services.

2. This module shall meet standards listed in §§4301-4329.

B. Enclave Module

1. *Enclave Module*—a work group of functionally-impaired individuals performing real work in a business or industrial setting among typical co-workers with supervision, training, and support provided both by the host company and the provider. Payment for work performed is made in compliance with Department of Labor regulations. Opportunities for integration with typical co-workers are facilitated through use of common dining facilities, break areas, and other settings/events that may be appropriate.

2. A provider with the enclave module must meet the applicable requirements/standards (except for the physical plant standards).

3. This module must meet standards listed in §§4301-4323.

C. Mobile Work Crew Module

1. Mobile work crew module is:
 - a. designed to provide employment through contracts in the community;
 - b. typically comprised of eight or fewer individuals with a staff person;
 - c. operated at a customer's site, rather than at the provider's building, performing service jobs in the community;
 - d. typically contracted to provide grounds-keeping and janitorial services; and
 - e. useful in providing meaningful wages and constant opportunities for crew members to interact with nonhandicapped people in the community.

2. A provider with the mobile work crew module must meet the applicable requirements (except for the physical plant standards).

3. This module must meet standards listed in §§4301-4323.

D. Psychosocial Module

1. This module is concerned with individuals who need emphasis on social and enhancement skills. Staff is involved in a highly interactive manner with clients in the day program in an effort to build friendship and other skills in the clients.

2. This module must meet standards listed in §§4301-4323. If services are provided within the facility, all standards shall be met.

E. Supported Competitive Jobs Module

1. Supported competitive jobs module requires staff to locate jobs in the community, match individuals to those jobs and provide ongoing support. Wages are commensurate to the work performed, and workers are highly integrated with nonhandicapped workers.

2. A provider with the supported competitive jobs module must meet the applicable requirements (except for the physical plant standards).

3. This module must meet standards listed in §§4301-4323.

F. Community Rehabilitation Program Module

1. *Community Rehabilitation Program (CRP)*—a program that provides vocational rehabilitation services to individuals with disabilities to enable those individuals to maximize their opportunities for employment, including career advancement.

2. A Community Rehabilitation Program may also provide services compatible with any or all of the modules listed under §4305.

3. A CRP must meet standards listed in §§4301-4323. If the services are provided within the facility, all standards shall be met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:109 (January 1998).

§4307. Definitions

Administrator—the owner or the manager designated by the governing body as responsible for the management, administration, and supervision of the program.

Adult Day Care—a group program designed to meet the individual needs of functionally-impaired adults that is structured and comprehensive and provides a variety of health, social, vocational, or related services in a protective setting for a portion of a 24-hour day.

Adult Day Care Center—any place owned or operated for profit, or not for profit, by a person, society, agency, corporation, institution, or any other group wherein are received, for a portion of a 24-hour day, 10 or more functionally-impaired adults who are not related to the owner or operator of the facility for the purpose of supervision or participation in a training program. If the facility receives state or federal funding, directly or indirectly, it must be licensed regardless of the number of adults in its care.

Change of Ownership—transfer of ownership to someone other than the owner listed on the initial application. Ownership of the business, not the building, determines the owner.

Department (DSS)—the Department of Social Services.

Director—the full-time staff responsible for the day-to-day operation of the facility or program as recorded with the Bureau of Licensing. For the purpose of these regulations, the term *director* also refers to director designee, if applicable.

Director Designee—the on-site staff appointed by the director when the director is not a full-time employee of the licensed location. This staff shall meet director qualifications.

Documentation—written evidence or proof, signed and dated.

Facility—adult day care center(s).

Functionally-Impaired Adult—a person 17 years of age or older who is physically, mentally, or socially impaired to a degree requiring supervision.

Human Services Field—means psychology, sociology, special education, rehabilitation counseling, juvenile justice, corrections, nursing, etc.

Owner or Operator—the actual owner of a facility, i.e., the person who owns or controls a facility either directly or indirectly.

Physically, Mentally or Socially Impaired—any impairment, physical or mental, that limits one or more of the following major life activities:

1. self-care;
2. receptive or expressive language;
3. learning;
4. mobility;
5. self-direction;
6. capacity for independence;
7. economic self-sufficiency.

Provider—the owner of an adult day care facility and the representatives, agents, and employees of the facility. If the owner is a closely held corporation or a nonprofit organization, provider includes the natural persons with actual

ownership or control over the corporation and the corporation's officers, directors, and shareholders.

Universal Precautions—the infectious disease control precautions recommended by the Centers for Disease Control to be used in all situations to prevent transmission of blood-borne pathogens (e.g., human immunodeficiency virus, hepatitis B virus).

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:110 (January 1998).

§4309. Procedures

A. Initial Application. Facilities applying for a license after the effective date of these standards shall meet all of the requirements herein. Before beginning operation, it is mandatory to obtain a license from the Department of Social Services.

1. Prior to purchasing, leasing, etc., carefully check all local zoning and building ordinances in the area of the planned facility location. Guidelines from the Office of Public Health, Sanitarian Services; Office of the State Fire Marshal and Office of the City Fire Department (if applicable) should be obtained.

2. After securing property, obtain an application form issued by the Department of Social Services, Bureau of Licensing, Box 3078, Baton Rouge, LA 70821-3078; Telephone: (504) 922-0015 and by FAX (504) 922-0014.

3. The completed application shall indicate the type of adult day care module(s) that will be provided. An initial application fee shall accompany all applications.

4. Nonprofit providers shall submit documentation of nonprofit status with the completed application and initial fee.

5. After the facility's location has been established, complete and return the application form. The applicant must contact the following offices prior to building or renovating a facility:

- a. Office of Public Health, Sanitarian Services (if applicable);
- b. Office of the State Fire Marshal (if applicable);
- c. Office of the City Fire Department (if applicable);
- d. Zoning Department (if applicable);
- e. City or Parish Building Permit Office.

6. After the application has been received by the department, a request will be made to the Office of the State Fire Marshal, Office of the City Fire Department, Office of Public Health, and any known required local agencies, as applicable, to make an inspection of the location, as per their standards. It is the applicant's responsibility to obtain these inspections and approvals. A licensing specialist will visit the facility to conduct a licensing inspection.

7. A license will be issued on an initial application when the following items have been met and verification is received by the Bureau of Licensing:

- a. fire approval (state and/or city) (if applicable);
- b. health approval (if applicable);
- c. zoning (if applicable);
- d. full licensure fee where applicable;

- e. licensure survey verifying substantial compliance;
- f. director meets qualifications.

8. When a provider changes location, it is considered a new operation, and a new application and fee for licensure shall be submitted. All applicable items in §4309.A.7 shall be resubmitted, except director qualifications if director remains the same.

9. When a provider changes ownership, a new application and fee for licensure shall be submitted. All applicable items in §4309.A.7 shall be current. Documentation is required from the previous owner assuring change of ownership, e.g., letter from previous owner, copy of bill of sale, or a lease agreement.

10. All new construction or renovation of a facility requires approval from agencies listed in §4309.A.5, if applicable.

11. The department is authorized to determine the period during which the license shall be effective. A license is valid for the period for which it is issued.

12. A license is not transferable to another person or location.

13. Separate licenses shall be required for facilities maintained on separate premises even though operated under the same management or owner. Separate licenses will not be required for separate buildings on the same grounds.

14. If an owner/director or member of his immediate family has had a previous license revoked, refused, or denied, upon re-application, applicant shall provide written evidence that the reason for such revocation, refusal, or denial no longer exists. A licensing survey will then be conducted to verify that the reasons for revocation, refusal, or denial have been corrected, and the facility is in substantial compliance with all minimum standards.

B. Fees

1. Initial application fee of \$25 shall be submitted with all initial applications. This fee will be applied toward the total licensure fee, where applicable, when the provider is licensed. This fee shall be paid by all initial providers. All fees shall be paid by certified check or money order only and are nonrefundable.

2. Annual licensure fee of \$150 shall be submitted prior to issuance or renewal of the license, where applicable.

3. Licensure fee shall be waived for nonprofit providers.

4. Other licensure fees:

a. \$25 replacement fee for any provider replacing a license when changes are requested by the provider, e.g., change in capacity, name change, age range change. (No processing charge when request coincides with regular renewal of license.)

b. \$5 processing fee for issuing a duplicate provider license with no changes.

C. Relicensing

1. An application form shall be resubmitted annually to the Department of Social Services, Bureau of Licensing, Box 3078, Baton Rouge, LA, 70821-3078.

2. A provider changing ownership, or making any substantial changes in the services offered or in the buildings, shall reapply for a license. In the event of a change of ownership, the old license shall be immediately returned to the

Department of Social Services, Bureau of Licensing, Box 3078, Baton Rouge, LA 70821-3078.

3. The Department of Social Services shall be notified prior to making changes which might have an effect upon the license (e.g., changes in program, services, physical plant of the facility, director, hours/months/days of operation, ownership, location).

4. A license is issued for a period of up to one year, based upon provider's compliance with minimum standards. Before expiration of the license, applicable re-inspections by the Office of Public Health, Sanitarian Services; Office of State Fire Marshal; Office of the City Fire Department (if applicable) and Department of Social Services shall be required.

5. Licensing inspections are conducted at least annually and more often if deemed necessary by the department. No advance notice is given. Licensing specialists shall be given access to all of the areas in the facility, staff members, clients, and all relevant files and records. Licensing specialists will explain the licensing process in an initial interview and will report orally, and in writing, (the exit interview) to the director or designee on any deficiencies found during the inspection.

6. If the licensing inspection reveals that the provider is not substantially meeting minimum requirements, a recommendation will be made that a new license not be issued.

D. Denial, Revocation, or Nonrenewal of License. An application for a license may be denied, or a license may be revoked, or renewal thereof denied, for any of the following reasons:

1. violation of any provision of R.S. 46:1971 through R.S. 46:1980, or failure to meet any of the minimum standards, rules, regulations, or orders of the Department of Social Services promulgated thereunder;

2. cruelty or indifference to the welfare of the clients;

3. conviction of a felony, as shown by a certified copy of the record of the court of conviction, of the applicant or the members or the officers of the firm or corporation or the person designated to manage or supervise the facility;

4. the director is not reputable;

5. history of noncompliance;

6. failure of the provider to hire a qualified director;

7. disapproval from any agency whose approval is required for licensure;

8. nonpayment of licensure fee/failure to submit application for renewal prior to the expiration of the current license;

9. any validated instance of corporal punishment, physical punishment, cruel, severe, or unusual punishment, physical or sexual abuse/neglect if the owner is responsible or if the employee who is responsible remains in the employment of the provider;

10. closure of the provider with no plans for reopening and no means of verifying compliance;

11. any act of fraud such as falsifying or altering documents required for licensure.

E. Appeal Procedure. If the license is refused, revoked, or denied because the provider does not meet minimum requirements for licensure, the procedure is as follows:

1. the Department of Social Services, by certified letter, shall advise the provider of the reasons for refusal, revocation, or denial and its right of appeal;

2. the director/owner may appeal this decision by submitting a written request, with the reasons, to the secretary of the Department of Social Services. Write to Department of Social Services, Appeals Section, Box 2944, Baton Rouge, LA 70821-9118. This written request must be post marked within 30 days of the director/owner's receipt of the above notification in §4309.E.1;

3. the Appeals Bureau of the Department of Social Services shall set a hearing to be held within 30 days after receipt of such a request;

4. an appeal hearing officer of the Department of Social Services shall conduct the hearing. Within 90 days after the date the appeal is filed, the Department of Social Services shall advise the appellant, by certified letter, of the decision, either affirming or reversing the original decision. If the license is refused or revoked, the provider shall terminate operation immediately;

5. if the provider continues to operate without a license, the Department of Social Services may seek injunctive relief.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971 through 1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:111 (January 1998).

§4311. General Requirements

A. Licensing Authority. The provider shall allow representatives of the licensing agency and the appropriate program office(s), in the performance of their mandated duties, to inspect all aspects of a program's functioning which impact on clients and to interview staff members and clients.

1. The provider shall make any information required in these standards and any information reasonably related to assessment of compliance with these requirements available to the licensing agency and the appropriate program office(s).

i. The client's rights shall not be considered abridged by this requirement.

ii. A provider shall promptly provide all necessary and needed information for review.

iii. A provider shall provide adequate space and privacy for the licensing specialist to review records uninterrupted.

2. The administrator, or a person authorized to act on behalf of the administrator, shall be accessible to agency staff and designated representatives of the licensing agency at all times.

B. Jurisdictional Approvals. The provider shall comply and show proof of compliance with all relevant standards, regulations, and requirements established by federal, state, local, and municipal regulatory bodies, including but not limited to:

1. the Office of Public Health;
2. the Office of the State Fire Marshal and Office of the City Fire Department (if applicable);
3. the Department of Labor (if applicable);
4. fiscal and program review agencies (if applicable);
5. zoning approval (if applicable).

C. Documentation of Authority to Operate. A private provider shall be incorporated in the state of Louisiana.

1. A privately-owned provider shall have documents identifying the names and addresses of owners.

2. A corporation, partnership, or association shall identify the names and addresses of its members and officers and shall, where applicable, have a charter, partnership agreement, constitution, articles of association/incorporation, or bylaws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:112 (January 1998).

§4313. Administration and Organization

A. Governing Body. The provider shall have an identifiable governing body with responsibility for and authority over the policies and activities of the provider.

1. The provider shall have documents identifying all members and officers of the governing body, their addresses, and their terms of membership, if applicable.

2. When the governing body of the provider is composed of more than one person, the governing body shall hold formal meetings at least twice a year.

3. When the governing body is composed of more than one person, the provider shall have written minutes of all formal meetings of the governing body and bylaws specifying frequency of meetings and quorum requirements.

4. The bylaws or other written policy shall describe the circumstances under which a business relationship may exist between a member of the governing body and the provider, so as not to create a conflict of interest.

B. Responsibilities of a Governing Body. The governing body shall:

1. ensure the provider's compliance and conformity with the governing body's charter;

2. ensure the provider's continual compliance and conformity with all relevant federal and state laws and regulations;

3. review and approve the provider's annual budget;

4. ensure that the provider is housed, maintained, staffed, and equipped appropriately, considering the nature of the provider's program;

5. designate a person to act as administrator and delegate sufficient authority to this person to manage the provider;

6. formulate and annually review, in consultation with the administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, and fiscal management;

7. annually evaluate the administrator's performance;

8. have the authority to dismiss the administrator;

9. meet with designated representatives of the licensing agency and the program office(s) whenever required to do so;

10. inform the licensing agency and the program office(s), in writing, prior to initiating any substantial changes in the program, services, or physical plant of the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:113 (January 1998).

§4315. Management Responsibilities

A. Administrative File. A provider shall have an administrative file including:

1. documents identifying the governing body;

2. list of members and officers of the governing body and their addresses and terms of membership, if applicable;

3. bylaws of the governing body and minutes of formal meetings, if applicable;

4. documentation of the provider's incorporation in the state;

5. organizational chart of the provider;

6. all leases, contracts, and purchase-of-service agreements to which the provider is a party;

7. insurance policies (The provider shall maintain in force at all times a comprehensive general liability insurance policy. The policy shall be in addition to any professional liability policies maintained by the provider. The provider shall extend coverage to any staff member who provides transportation for any client in the course and scope of his/her employment);

8. annual budgets;

9. incident reports and required documentation.

B. Program Description

1. The provider shall have a written program plan describing the services and programs offered by the provider.

2. The provider shall have a written policy regarding participation of clients in activities related to fundraising, publicity, photographing and audio, or audio-visual recordings of clients.

a. The written, informed consent of the client and, where appropriate, the legally responsible person, shall be obtained prior to participation in such activities.

b. Client involvement in these activities shall be in a manner which respects the dignity and confidentiality of the client.

3. The provider shall have written policies regarding the participation of clients in research projects. No client shall participate in any research project without the written, informed consent of the client and the client's legally responsible person, if applicable.

a. The provider shall have a detailed written description of any research projects approved.

b. The provider may conduct research for educational purposes as long as client names are not used or identified in any manner.

C. Client Rights. The provider shall have a written policy on client rights. This policy shall give assurances that:

1. a client's civil rights are not abridged or abrogated solely as a result of placement in the provider's program;
2. a client's civil rights are protected through accessibility or referral to legal counsel;
3. a client is not denied admission, segregated into programs, or otherwise subjected to discrimination on the basis of race, color, religion, sex, age, national origin, handicap, political beliefs, or any nonmerit factor, in accordance with all state and federal regulations.

D. Confidentiality and Security of Files

1. The provider shall have written procedures for the maintenance and security of records specifying who shall supervise the maintenance of records, who shall have custody of records, and to whom records may be released. The provider, as custodian, shall secure records against loss, tampering, or unauthorized use.

2. The provider shall maintain the confidentiality of all clients' case records. Employees, volunteers, and interns of the provider shall not disclose, or knowingly permit the disclosure of, any information concerning the client or his/her family, directly or indirectly, to any unauthorized person.

3. The provider shall implement and have written policies and procedures regarding the release of information. The client's file shall contain documentation concerning any information released with the individual's written consent. The policies and procedures shall require that the release form shall:

- a. specify the name of the person or agency to whom the information is released;
- b. describe the information to be released;
- c. specify the purpose for the release of information;
- d. specify the length of time for which the release is valid, not to exceed one year; and
- e. include the date and signature of the client or his/her legally responsible person, if applicable. The signature of two witnesses must be obtained when client signs with a mark.

4. The provider shall have a written policy which defines who has access to client records.

5. The provider's written policies shall ensure that information from the case record is made available to the client, the legally responsible person, or legal counsel of the client upon request. If, in the professional judgment of the provider, it is felt that the information contained in the record would be damaging to a client, that information *only* may be withheld from the client, except under court order.

E. Record Keeping

1. All records shall be maintained in an accessible, standardized order and format and shall be retained and disposed of according to state laws.

2. The provider shall ensure that all entries in records are legible, signed by the person making the entry, and accompanied by the date on which the entry was made.

3. The provider shall have sufficient space, facilities, and supplies for providing effective record keeping services.

F. Client's Case Record. A provider shall have a written record for each client which shall include:

1. the name, sex, race, birth date, and current address of the client;

2. date of admission to the program;
3. court status or legal status, and who is authorized to give consent;
4. client's history, including family data, employment record, and prior medical history;
5. current medication and any known allergies;
6. a copy of the client's individual service plan, any subsequent modifications, and any objectives to guide and assist direct service workers in implementing the client's program;
7. quarterly reviews and progress notes;
8. a copy of the discharge summary, when applicable;
9. critical incident reports;
10. reports of any client grievances and the conclusions or dispositions of these reports;
11. the name, address, and telephone number of the next of kin and/or legally responsible person;
12. a signed consent giving the provider authorization to obtain emergency medical care;
13. the name, address, and phone number of the client's physician and dentist;
14. client's evaluations as required in §4319.B.2.

G. Personnel File

1. The provider shall have a record for each staff member which shall contain:

- a. the application for employment or résumé;
- b. documentation of three reference checks;
- c. evidence of applicable professional credentials;
- d. in-service training records or summary;
- e. annual performance evaluations;
- f. personnel actions, reports, and notes relating to the individual's employment with the facility;
- g. employee's starting and termination dates;
- h. a satisfactory criminal history check, in accordance with state law;
- i. TB test result; and
- j. documentation of current driver's license for all staff who transport clients.

2. The provider shall have written policies ensuring that staff members have reasonable access to their file and are allowed to add any written statement they wish to the file.

3. The provider shall retain the personnel file of an employee for at least three years after the employee's termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:113 (January 1998).

§4317. Human Resources

A. Staff Plan/Personnel Practices. The provider shall have written personnel policies that include:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision, and performance evaluation of staff members;
 - a. the provider shall have a nondiscrimination policy prohibiting discrimination against any person on the basis of

race, color, religion, sex, age, national origin, disability, veteran status, or any nonmerit factor;

b. the provider's screening procedures shall address the prospective staff member's qualifications, ability, and experience, as related to the appropriate job description;

c. prior to employing any person, the provider shall obtain written references or document phone contacts on oral references from three persons;

d. a satisfactory criminal history check shall be obtained by the provider, prior to an offer of employment, in accordance with state law;

e. all persons, prior to or at time of employment, shall be free of tuberculosis in a communicable state, as evidenced by:

i. a negative Mantoux skin test for tuberculosis;

ii. a normal chest x-ray if the aforementioned skin test is positive; or

iii. a statement from a physician certifying that the individual is noninfectious if the chest x-ray is other than normal;

(a). any employee who has a negative Mantoux skin test for tuberculosis, in order to remain employed, shall be retested annually;

(b). any employee who has a positive Mantoux skin test for tuberculosis, in order to remain employed, shall complete an adequate course of therapy, as prescribed by a licensed physician, or shall present a signed statement from a licensed physician stating that therapy is not indicated;

f. where certification or licensing standards exist for professional staff, these individuals shall possess current certifications/licenses. Documentation of such shall be on file and available for review;

g. the provider shall not knowingly hire, or continue to employ, any person whose history or current behavior impairs his/her ability to properly protect the health and safety of the clients or is such that it would endanger the physical or psychological well-being of the clients. This requirement is not to be interpreted to exclude continued employment in other than direct service capacities of persons undergoing temporary medical or emotional problems;

h. the provider shall complete an annual performance evaluation of all staff members. For any person who interacts with clients, a provider's performance evaluation procedures shall address the quality and nature of a staff member's relationships with clients;

2. written job descriptions for each staff position;

3. written employee grievance procedure.

B. Orientation

1. A provider's orientation program shall include training in the following topics for *all* employees:

a. philosophy, organization, program, practices, and goals of the provider;

b. instruction in the specific responsibilities of the employee's job;

c. the provider's emergency and safety procedures, including medical emergencies;

d. detecting and reporting suspected abuse and neglect;

e. reporting critical incidents;

f. client rights; and

g. universal precautions.

2. Orientation for direct-care staff shall include additional training in the following topics:

a. implementation of service plans;

b. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

c. basic skills required to meet the health needs and problems of the clients;

d. passive physical restraint;

e. crisis de-escalation and the management of aggressive behavior, including acceptable and prohibited responses; and

f. safe administration and handling of all medications.

3. All direct care employees shall receive certification in adult CPR and first aid within the first 30 days of employment.

4. A new direct care employee shall not be given sole responsibility for the implementation of a client's program plan until all required training is completed.

5. The employee shall sign a statement of understanding certifying that such training has occurred.

C. Annual Training

1. A provider shall document that *all* employees receive training on an annual basis in the following topics:

a. provider's policies and procedures;

b. emergency and safety procedures;

c. medical emergencies;

d. client's rights;

e. detecting and reporting suspected abuse and neglect;

f. reporting critical incidents;

g. universal precautions.

2. Direct care staff shall receive additional annual training in the following topics:

a. training in implementation of service plans;

b. confidentiality;

c. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

d. basic skills required to meet the health needs and problems of the client;

e. passive physical restraint;

f. crisis de-escalation; and

g. the management of aggressive behavior, including acceptable and prohibited responses.

3. All direct care staff shall have documentation of current certification in first aid and CPR.

4. Staff in supervisory positions shall have annual training in supervisory and management techniques.

D. Number and Qualifications of Staff

1. The provider shall delegate sufficient authority to qualified staff to ensure that the responsibilities the provider undertakes are carried out.

2. The provider shall not be dependent upon clients or volunteers for performing necessary services such as maintenance or client supervision.

3. Qualified direct care staff shall be employed and present with the clients as necessary to ensure the health,

safety and well-being of clients. Staff coverage shall be maintained in consideration of the time of day, the size and nature of the agency, and the ages and needs of the clients.

4. The client/staff ratio shall be one staff per eight clients unless client(s)' functional impairment require(s) additional staff coverage to meet the client(s)' needs.

5. The following staff positions are required; however, one person may occupy more than one position:

a. Director/Director Designee. The director (or director designee, if applicable) shall have a bachelor's degree plus one year's experience relative to the population being served.

b. Qualified Professional. A person with a bachelor's degree in the human services field and one year's experience in human services with the relevant type of client population.

c. Food Service Supervisor. The facility shall designate one staff member who shall be responsible for meal preparation/serving if meals are prepared in the facility.

d. Any staff hired after the effective date of publication shall meet requirements of that position.

E. Volunteers/Student Interns

1. A provider utilizing volunteers or student interns on a regular basis shall have a written plan for using such resources. This plan shall be given to all volunteers and interns. The plan shall indicate that all volunteers and interns shall:

- a. be directly supervised by a paid staff member;
- b. be oriented and trained in the philosophy and policy and procedures of the provider, confidentiality, the needs of clients, and methods of meeting those needs; and
- c. have documentation of three reference checks.

2. Volunteers/student interns shall be a supplement to the required staffing component.

F. External Professional Services

1. When a client's plan indicates the need for professional services that are not available from the provider, the provider shall facilitate access to such services and shall document such.

2. The provider shall have a written agreement with appropriately qualified professionals.

3. Current documentation of the professional's certification/licensure shall be kept on file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:114 (January 1998).

§4319. Direct Service Management

A. Admissions

1. The provider shall have a written description of the admission process and the criteria for admission.

2. The provider shall not refuse admission to any client on the grounds of race, color, religion, sex, age, national origin, handicap, political beliefs, or any other nonmerit factor. The provider shall not refuse admission on the grounds of age, except where funded by state or federal monies and the appropriate program office's eligibility criteria indicate age restrictions.

3. The provider shall not admit more clients into care than the number specified on the license.

4. The provider shall not admit any client into care whose presence would pose a documented health and safety risk to the client or to other clients and for whom the provider cannot provide the necessary care.

5. The provider shall determine the legal status of applicants, as well as any changes in such status of applicants or current clients (e.g., full interdiction, partial interdiction, continuing tutorship, competent major).

In the event that a restrictive legal action has been filed on behalf of an applicant or current client, the responsible individual shall be informed of the need to provide a copy of the legal document, or affidavit to that effect, to the provider.

6. There shall be a written orientation program for clients admitted to the program which shall include the following:

- a. the responsibilities of the organization;
- b. wage payment practices;
- c. work program rules;
- d. nondiscrimination provisions;
- e. client rights and responsibilities;
- f. grievance and appeal procedures for clients; and
- g. the availability of community-based job training and placement services;

h. The client and staff shall sign and date a statement verifying the client received an explanation of information covered in §4319.A.6.a-g.

B. Individual Service Plans

1. Within 30 days of admission, an individualized plan shall be developed by a team composed of the following:

- a. the client, and when appropriate, legally responsible person(s);
- b. any representative the client may select, if the representative agrees;
- c. a qualified professional;
- d. the staff person(s) involved in the client's program;
- e. other professionals deemed appropriate by the team.

2. Prior to the development of the initial individualized plan, the following evaluations shall be on file and shall be current (not over a year old):

- a. social history;
- b. vocational profile;
- c. psychological or psychiatric;
- d. medical; and
- e. any other evaluations that may be recommended by the team.

NOTE: Omission of a specific evaluation may be made in certain instances, provided the state referring agency documents that the information is not necessary to develop a valid service plan.

3. Individualized plans shall be reviewed and updated at least annually and more often, if needed, by the team as defined in §4319.B.1.a-e.

4. Individualized plans shall include, at a minimum, the following:

- a. a list of the client's interests, preferences, and goals;
- b. a list of the client's general and specific abilities, based on observations, interviews and other techniques;

- c. a statement of the client's strengths and needs; and
- d. measurable, functional outcomes based on the results of required evaluations and §4319.B.4.a-c.

5. For each measurable, functional outcome the plan shall include:

- a. methods for achieving the outcome;
- b. persons responsible for implementing the plan;
- c. projected time frames for completion; and
- d. procedures for evaluation of progress.

6. The individualized plan shall be made available to staff person(s) who work with the client.

7. A quarterly summary, approved by a qualified professional, shall include successes and failures of the client's program, and shall address each functional outcome and any recommendations for modification. This shall be located in the client's file.

C. Work

1. The provider shall meet all state and federal wage and hour regulations regarding employment of persons admitted to the agency.

a. The provider must maintain full financial records of clients' earnings if the agency pays the client.

b. The provider shall have written assurance that the conditions and compensation of work are in compliance with applicable state and federal wage and hour laws.

2. Clients shall not be required to perform any kind of work involving operation and maintenance of the facility without compensation.

3. Clients shall be directly supervised when operating any type of power driven equipment such as lawn mowers or electric saws, unless the team has determined that direct supervision is not necessary and the equipment has safety guards or devices and adequate training is given to the client and the training is documented.

4. Clients shall be provided with the necessary safety apparel and safety devices.

D. Abuse and Neglect. The provider shall have a comprehensive, written procedure concerning client abuse which includes, but is not limited to, the following:

1. current definitions of abuse and neglect, reporting requirements, and applicable laws;

2. provisions ensuring that regulations for reporting critical incidents involving abuse and neglect are followed;

3. provisions ensuring the administrator/director completes an investigation report within 10 working days;

4. provisions ensuring the client is protected from potential harassment during the investigation;

5. provisions for disciplining staff members who abuse or neglect clients.

E. Incident Reports

1. The provider shall have written procedures for the reporting and documentation of deaths of clients, injuries, fights or physical confrontations, situations requiring the use of passive physical restraints, suspected incidents of abuse or neglect, unusual incidents, and other situations or circumstances affecting the health, safety, or well-being of a client(s).

Such procedures shall ensure timely verbal reporting to the administrator/director and a preliminary written report within 24 hours of the incident.

There shall be documentation that the director or designee reviewed the written report within 24 hours.

2. When an incident occurs, a detailed report of the incident shall be completed. As a minimum, the incident report shall contain the following:

- a. circumstances under which the incident occurred;
- b. date and time the incident occurred;
- c. location where the incident occurred;
- d. immediate treatment and follow-up care;
- e. names and addresses of witnesses;
- f. date and time the legally responsible person was notified, if applicable;

g. symptoms of pain and injury discussed with the physician, if applicable;

h. signatures and dates of the staff completing the report and the administrator/director.

3. When an incident results in death of a client, involves abuse or neglect of a client, or entails any serious threat to the client's health, safety, or well-being the provider shall:

a. immediately report verbally to the administrator/director and submit a preliminary written report within 24 hours of the incident;

There shall be documentation that the director or designee reviewed the report within 24 hours.

b. immediately notify the Bureau of Licensing and other appropriate authorities, according to state law (e.g., DHH Adult Protection Services, Office of Elderly Affairs, and law enforcement authority). The provider must notify the above agencies, in writing, within 24 hours of the suspected incident;

c. immediately notify the next of kin or legally responsible person, with written notification to follow within 24 hours;

d. provide follow-up written reports to all the above persons and agencies;

e. take appropriate corrective action to prevent future incidents.

4. Copies of all critical incident reports shall be kept as part of the clients' record, and a separate copy shall be kept in the administrative file of the provider, along with documentation of compliance with procedures required in §4319.E.3.

F. Behavior Management

1. The provider shall have written policies and procedures for behavior management which:

a. prohibit corporal punishment; chemical restraints; psychological abuse; verbal abuse; seclusion; forced exercise; mechanical restraints; any procedure which denies food, drink, or use of rest room facilities; and any cruel, severe, unusual, or unnecessary punishment;

b. ensure that nonintrusive, positive approaches to address the meaning/origin of behaviors are used prior to the development of a restrictive plan;

c. define the use of behavior modification programs, define mechanisms which authorize their use, and provide for the monitoring and control of their use;

d. indicate that passive/physical restraint may be used only after other, less restrictive interventions/strategies have failed; shall be implemented only by trained staff; and shall be of short duration;

e. cover any behavioral emergency and provide documentation of the event in incident report format.

2. Any behavior management plan for an individual must be developed or approved by a licensed psychologist or psychiatrist.

G. Discharge

1. There shall be a written discharge policy and procedure. This policy shall ensure that emergency discharges initiated by the provider shall occur only when the health and safety of a client or other clients might be endangered by the client's further stay at the facility.

2. A summary shall be written at the time of discharge and shall include:

a. the name and address of the client and, where appropriate, the legally responsible person;

b. dates of admission and discharge;

c. reason for discharge and details of the circumstances leading to the discharge;

d. a summary of accomplishments while at the facility;

e. a summary of services provided during care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:116 (January 1998).

§4321. Food and Nutrition

A. If meals are prepared by the facility or contracted from an outside source:

1. menus shall be written in advance and shall provide for a variety of foods;

2. records of menus, as served, shall be filed and maintained for at least 30 days;

3. modified diets shall be prescribed by a physician;

4. if there are modified diets, a registered dietician shall review all the orders for special diets and plan the diets;

5. only food and drink of safe quality shall be purchased, and storage, preparation, and serving techniques shall be provided to ensure nutrients are retained and spoilage is prevented;

6. food preparation areas and utensils shall be kept clean.

B. When meals are not provided by the facility:

1. provisions must be made for obtaining food for clients who do not bring their lunch;

2. there shall be an adequate area for eating.

C. Drinking water shall be readily available. If a drinking fountain is not available, single-use disposable cups shall be used.

D. The dining areas shall be adequately equipped with tables, chairs, eating utensils, and dishes designed to meet the functional needs of all clients.

E. Adequate refrigeration for food shall be maintained, and refrigerators shall be kept at 45°F, or below.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:118 (January 1998).

§4323. Transportation

A. The provider shall have means of transporting clients in cases of emergency.

B. If transportation is provided, the provider shall ensure that the client is provided with the transportation necessary for implementing the client's service plan.

C. Any vehicle used in transporting clients in care of the provider, whether such vehicle is operated by a staff member or any other person acting on behalf of the provider, shall be properly licensed and inspected, in accordance with state law.

D. The provider shall have documentation of liability insurance coverage for all owned and nonowned vehicles used to transport clients. Employees' personal liability insurance shall not be substituted for required coverage.

E. Any staff member of the provider, or other person acting on behalf of the provider, operating a vehicle for the purpose of transporting clients, shall be properly licensed to operate that class of vehicle, according to state law.

F. The provider shall not allow the number of persons in any vehicle used to transport clients to exceed the number of available seats in the vehicle.

G. All vehicles used for the transportation of clients shall be maintained in a safe condition and be in conformity with all applicable motor vehicle laws. The provider shall document that all vehicles, whether provider or employee owned, have a current license and inspection.

H. The provider shall ascertain the nature of any need or problem of a client which might cause difficulties during transportation. The provider shall communicate such information to the operator of any vehicle transporting clients in care.

I. The following additional arrangements are required for providers serving handicapped, nonambulatory clients:

1. A ramp device to permit entry and exit of a client from the vehicle shall be provided for vehicles, except automobiles, normally used to transport persons with disabilities. A mechanical lift may be utilized, provided that a ramp is also available in case of emergency, unless the mechanical lift has a manual override.

2. In all vehicles, except automobiles, wheelchairs used in transit shall be securely fastened to the vehicle.

3. In all vehicles, except automobiles, the arrangement of the wheelchairs shall not impede access to the exit door of the vehicle.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:118 (January 1998).

§4325. General Safety Practices

A. A facility shall not maintain any firearms or chemical weapons at any time.

B. A facility shall ensure that all poisonous, toxic, and flammable materials are safely stored in appropriate containers labeled as to contents. Such materials shall be maintained only as necessary and shall be used in such a manner as to ensure the safety of clients, staff, and visitors.

C. Adequate supervision/training shall be provided where potentially harmful materials, such as cleaning solvents and detergents, are used.

D. A facility shall ensure that a first aid kit is available in the facility and in all vehicles used to transport clients.

E. If the provider holds medication for clients, it shall be locked.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:119 (January 1998).

§4327. Emergency and Safety

A. A provider shall have a written overall plan of emergency and safety procedures.

1. The plan shall provide for the evacuation of clients to safe or sheltered areas.

2. The plan shall include provisions for training staff and clients in preventing, reporting, and responding to fires and other emergencies.

3. The plan shall provide means for an ongoing safety program, including continuous inspection of the center for possible hazards, continuous monitoring of safety equipment, and investigation of all accidents or emergencies.

4. The plan shall include provisions for training personnel in their emergency duties and in the use of any fire fighting or other emergency equipment in their immediate work areas.

B. The facility shall conduct fire drills once every month, with documentation including:

1. date of drill;
2. time of drill;
3. lapse time of drill;
4. number of staff and clients participating;
5. any problems and corrective actions taken; and
6. signature of person responsible for conducting the drill.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of

Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:119 (January 1998).

§4329. Physical Environment

A. The building shall be constructed, equipped, and maintained to ensure the safety of all concerned.

The building shall be maintained in good repair and kept free of hazards, such as those created by any damaged or defective parts of the building.

B. The provider shall maintain all areas of the facility that are accessible to clients and ensure that all structures on the grounds of the facility are in good repair and free from any reasonably foreseeable hazard to health or safety.

C. The facility shall be accessible to and functional for those cared for, the staff, and the public. All necessary accommodations shall be made to meet the needs of persons with disabilities.

Training or supports are provided to help clients effectively negotiate their environment.

D. There shall be a minimum of 35 square feet of space per client. Kitchens, bathrooms, halls used as passageways, and other spaces not directly associated with program activities shall not be considered as floor space available for clients.

E. There shall be storage space, as needed by the program, for training and vocational materials, office supplies, etc.

F. Rooms used for client activities shall be well ventilated and lighted.

G. There shall be separate space for storage of clients' personal belongings.

H. Chairs and tables shall be adequate in number to serve the clients.

I. Bathrooms and lavatories shall be accessible, operable, and equipped with soap, paper towels or hand drying machines, and tissue.

J. Individuals shall be provided privacy when using bathroom facilities.

K. Every bathroom door shall be designed to permit opening of the locked door from the outside, in an emergency, and the opening device shall be readily accessible to the staff.

L. Stairways shall be kept free of obstruction, and fire exit doors shall be maintained in working order. All stairways shall be equipped with handrails.

M. There shall be a telephone available and accessible to all clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:1971-1980.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:119 (January 1998).

Madlyn B. Bagneris
Secretary

9801#056

RULE

**Department of the Treasury
Board of Trustees of the Louisiana
State Employees' Retirement System**

Definition of Terminate (LAC 58:I.101)

Pursuant to the authority granted by R.S. 11:515 vesting the Board of Trustees with the responsibility for administration of the Louisiana State Employees' Retirement System ("LASERS") and granting the power to adopt and promulgate rules with respect thereto, the Board of Trustees and the executive director hereby adopts the following rule which adds the definition of "terminate" to the definitions section.

The current definition is too ambiguous and could be interpreted to prevent rehired LASERS retirees from accessing funds from the Deferred Retirement Option Plan ("DROP").

Title 58

RETIREMENT

**Part I. Louisiana State Employees' Retirement
System (LASERS)**

Chapter 1. General Provisions

§101. Definitions

* * *

Terminate—to completely cease employment with the state of Louisiana for a period of not less than 30 consecutive days.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:515.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the State Employees' Retirement System, LR 22:373 (May 1996), amended LR 24:120 (January 1998).

James O. Wood
Executive Director

9801#035