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Executive Orders

EXECUTIVE ORDER BJ 14-13

Travel to Areas Impacted by Ebola Virus Disease

WHEREAS, Article IV, Section 5 the Louisiana Constitution establishes the governor as the chief executive officer of the State and, during times of emergency or the threat of emergency, the governor has emergency powers to protect the citizens and property of the State of Louisiana;

WHEREAS, the Louisiana Health Emergency Powers Act, La. R.S. 29:760, et seq., confers upon the Governor of the State of Louisiana emergency powers to deal with public health emergencies, including an occurrence or imminent threat of an illness or health condition that is believed to be caused by the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin, in order to ensure that preparations of this state will be adequate to deal with such emergencies or disasters and to preserve the health and lives of the people of the State of Louisiana;

WHEREAS, when the threat of an emergency is foreseeable, it is prudent to implement common sense, precautionary measures to prevent the occurrence of the emergency and eliminate the need to trigger emergency legal authorities;

WHEREAS, the World Health Organization has declared the Ebola Virus Disease outbreak an international public health emergency, with at least 8,997 worldwide cases of Ebola Virus Disease, including 4,493 deaths currently reported by the Centers for Disease Control, making the 2014 outbreak the largest in history;

WHEREAS, the Centers for Disease Control and Prevention (CDC) has issued Level 3 Travel Warnings for the West African nations of Liberia, Guinea, and Sierra Leone, advising against non-essential travel, and has also issued a Level 2 Travel Alert for Nigeria, advising travelers to practice enhanced precautions against the threat of contracting the Ebola Virus Disease;

WHEREAS, the federal government, to date, has failed to implement protections at the national level to prevent the entry of the Ebola Virus Disease into the United States of America;

WHEREAS, the State of Louisiana recognizes the potential threat of the Ebola Virus Disease to incapacitate large numbers of people who would require precautionary health monitoring during the incubation period after coming into direct contact with even a single person exhibiting symptoms;

WHEREAS, it is foreseeable that a public health emergency could result from the occurrence of an outbreak of Ebola Virus Disease in this state, and that such a threat can be reduced with the implementation of precautionary, common-sense measures for public employees and students, faculty, and staff of institutions of higher learning who travel to these countries;

WHEREAS, it is prudent to implement such precautionary, common-sense measures steps to reduce this foreseeable threat to the citizens and property of the State,

including the reporting of travel to these countries and the development of policies governing their return to normal duties or classroom attendance following such travel.

NOW THEREFORE, I, BOBBY JINDAL, Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: All departments, budget units, agencies, offices, entities, and officers of the executive branch of the State of Louisiana are authorized and directed to develop policies and reporting mechanisms for public employees and students, faculty, and staff of institutions of higher learning to report travel to the countries identified by the Centers for Disease Control as having a threat of contracting the Ebola Virus Disease, as those countries are periodically updated at: <http://wwwnc.cdc.gov/travel/notices>.

SECTION 2: All departments, budget units, agencies, offices, entities, and officers of the executive branch of the State of Louisiana, in consultation with Department of Health and Hospitals, Infectious Disease Epidemiology Section (EPI) are authorized and directed to develop policies for public employees and students, faculty, and staff of institutions of higher learning governing their return to normal duties or classroom attendance following such travel, to include:

A. Reporting of such travel to the Department of Health and Hospitals, Infectious Disease Epidemiology section (EPI), within forty-eight (48) hours of receiving the information if prior to travel and within twenty-four (24) hours of receiving the information if subsequent to travel.

B. Restrictions or advisories regarding use of commercial transportation (including airplane, ship, bus, train, taxi, or other public conveyance) for twenty-one (21) days after departing an impacted area.

C. Restrictions or advisories regarding going to places where the public congregates, including but not limited to, restaurants, grocery stores, gymnasiums, theaters, etc. for twenty-one (21) days after departing an impacted area.

D. Procedures for daily communication and monitoring, if determined necessary, by public health officials for twenty-one (21) days after departing an impacted area.

SECTION 3: Due to the urgency of this foreseeable threat and importance of having procedures in place to minimize the threatened harm, the policies required herein shall be developed at the earliest possible date, and no later than within five (5) business days from the effective date of this Order.

SECTION 4: All departments, budget units, agencies, offices, entities, and officers of the executive branch of the State of Louisiana are authorized and directed to cooperate in the implementation of the provisions of this Order.

SECTION 5: Nothing in this Order shall be applied in a manner which violates, or is contrary to, the Fair Labor Standards Act (FLSA), the Family and Medical Leave Act (FMLA), the Health Insurance Portability and

Accountability Act (HIPAA), or any other applicable federal or state law, rule, or regulation.

SECTION 6: The Order is effective October 20, 2014 and shall remain in effect modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the City of Baton Rouge, on this 20th day of October, 2014.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1411#096

EXECUTIVE ORDER BJ 14-14

Uniformity of Policies Related to the Crime of Sexual Assault

WHEREAS, Article I, Section 1 of the Louisiana Constitution is titled "Origin and Purpose of Government", and provides

"All government, of right, originates with the people, is founded on their will alone, and is instituted to protect the rights of the individual and for the good of the whole. Its only legitimate ends are to secure justice for all, preserve peace, protect the rights, and promote the happiness and general welfare of the people. The rights enumerated in this Article are inalienable by the state and shall be preserved inviolate by the state.";

WHEREAS, Article IV, Section 5 establishes the governor as the chief executive officer of the State and charged with the duty to faithfully support the constitution and laws of the State and see that the laws are faithfully executed;

WHEREAS, sexual assault is a horrendous crime that creates physical and emotional damage to victims, for which special measures must be taken by every public officer and agency in this state in order to bring the perpetrators to justice and assist the victims in their recovery;

WHEREAS, within the executive branch, Article VIII, Section 5 creates the Board of Regents with responsibilities to plan, coordinate, and have budgetary responsibilities for all public postsecondary education institutions;

WHEREAS, public postsecondary education institutions under the Board of Regents in this state have separately implemented measures to address the reporting of sexual assault on their campuses, and the prevention of such crimes;

WHEREAS, these separate measures implemented by the individual public postsecondary education institutions, while well-intentioned, are in some cases outdated and create a fractured approach to this critical issue that would benefit from a statewide uniformity of best practices that can be provided by the Board of Regents

exercising its constitutional authority to coordinate among these institutions;

WHEREAS, the Crime Victims Reparations Board, created in statute under the jurisdiction of the Louisiana Commission on Law Enforcement and Administration of Criminal Justice, is responsible for assisting victims of crime with the financial losses caused by the crime, and is charged with administering this vital program in accordance with law and the administrative rules which it has promulgated;

WHEREAS, reports indicate the existence of discrepancies between the enabling statutes of the Crime Victims Reparations Board and the rules it has promulgated, and that such discrepancies should be identified and eliminated immediately;

WHEREAS, reports indicate that, in some parts of this state, victims of sexual assault are requested or required to submit to polygraph examination as part of the law enforcement investigation of the crime;

WHEREAS, La. R.S. 15:241 plainly prohibits such a request or requirement, and states "No law enforcement officer, prosecutor, or other governmental official shall request or require any victim, regardless of age, of an alleged sex offense as defined in R.S. 15:541 to submit to a polygraph examination or other device used to measure the truthfulness of the victim as a condition of proceeding with the investigation of the offense.";

WHEREAS, it is the goal of this administration that a victim of sexual assault not be billed for the financial cost of forensic or other testing incident to the crime whether the victim reports the crime to law enforcement or not, that such bills be sent for payment directly to the Crime Victims Reparations Board, and that this outcome will require a change in statutory law;

WHEREAS, it is incumbent upon the public officers and agencies, with a role to play in bringing the perpetrators to justice and assisting the victims in their recovery, to coordinate their efforts to ensure that this vital issue is addressed immediately.

NOW THEREFORE, I, BOBBY JINDAL, Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: The Board of Regents shall coordinate uniform policies and best practices among the public postsecondary education institutions to implement measures to address the reporting of sexual assault on their campuses, the prevention of such crimes, and the medical and mental health care needed for these victims;

SECTION 2:

A. The Crime Victims Reparations Board is directed to immediately revise such administrative rules, policies and practices under R.S. 46:1809 as they pertain to victims of sexual assault that take into account prior behavior of the victim at the time of the crime giving rise to the claim was such that the victim bears some measure of responsibility for the crime that caused the physical injury, death, or catastrophic property loss or for the physical injury, death, or catastrophic property loss to eliminate any such that contain determinations made based on any of the following:

1. The manner in which the victim was dressed at the time of the assault;

EXECUTIVE ORDER BJ 14-15

**Bond Allocation—Louisiana Community
Development Authority**

- 2. Where the victim was prior to the sexual assault;
- 3. The time of the sexual assault;
- 4. Whether the victim was or may have been under the influence of alcohol or drugs;
- 5. Whether the victim had a previous sexual relationship with the offender;
- 6. Whether the victim was married to the offender;
- 7. Whether the victim was dating the offender;
- 8. Whether the victim consented to prior sexual activity with the offender;
- 9. The occupation of the victim;
- 10. Whether the victim has a history of prior sexual assaults;
- 11. Whether the victim has a criminal record;
- 12. Whether the victim consented to the sexual act if the victim is below the age of consent mentally defective, mentally incapacitated or physically helpless;
- 13. Whether the victim continued to live with the offender after the assault; and
- 14. Whether the victim has a familial relationship to the offender.

B. The Crime Victims Reparations Board is further directed to review and evaluate the eligibility of non-governmental organizations to serve as a partner or as a sub-grantee of the federal STOP grant program or other federal grant programs within its purview, in order to reimburse hospitals for victim services and offset programmatic costs.

C. The Crime Victims Reparations Board is further directed to immediately revise such administrative rules, policies and practices under R.S. 46:1809 as they pertain to victims of sexual assault that take into account the extent that the pecuniary loss is recouped from collateral or other sources to clarify that the victim has the discretion to choose whether or not to file for private insurance or Medicaid coverage of associated charges.

SECTION 3: All departments, budget units, agencies, offices, entities, and officers of the executive branch of the State of Louisiana are authorized and directed to cooperate in the implementation of the provisions of this Order.

SECTION 4: Nothing in this Order shall be applied in a manner which violates, or is contrary to, the Fair Labor Standards Act (FLSA), the Family and Medical Leave Act (FMLA), the Health Insurance Portability and Accountability Act (HIPAA), or any other applicable federal or state law, rule, or regulation.

SECTION 5: The Order is effective October 20, 2014 and shall remain in effect modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the City of Baton Rouge, on this 20th day of October, 2014.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1411#097

WHEREAS, pursuant to the Tax Reform Act of 1986 and Act 51 of the 1986 Regular Session of the Louisiana Legislature, Executive Order No. BJ 2008-47 was issued to establish:

- (1) a method for allocating bonds subject to private activity bond volume limits, including the method of allocating bonds subject to the private activity bond volume limits (hereafter “Ceiling”);
- (2) the procedure for obtaining an allocation of bonds under the Ceiling; and
- (3) a system of central record keeping for such allocations; and

WHEREAS, The Louisiana Community Development Authority has applied for an allocation of the 2014 Ceiling to be used in connection with the financing by Mirus Lake Charles, LLC for the acquisition, rehabilitation, and equipping of a 275 unit multifamily housing complex referred to as Fairview Crossing Apartments Project to be located at 4249 5th Avenue in the Parish of Calcasieu, City of Lake Charles, State of Louisiana, within the boundaries of the Issuer; and

NOW THEREFORE, I, BOBBY JINDAL, Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and the laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: The bond issue, as described in this Section, shall be and is hereby granted an allocation from the 2014 Ceiling in the amount shown:

Amount of Allocation	Name of Issuer	Name of Project
\$11,000,000	Louisiana Community Development Authority	Fairview Crossing Apartments Project

SECTION 2: The allocation granted herein shall be used only for the bond issue described in Section 1 and for the general purpose set forth in the “Application for Allocation of a Portion of the State of Louisiana’s Private Activity Bond Ceiling” submitted in connection with the bond issue described in Section 1.

SECTION 3: The allocation granted herein shall be valid and in full force and effect through December 31, 2014, provided that such bonds are delivered to the initial purchasers thereof on or before December 31, 2014.

SECTION 4: All references in this Order to the singular shall include the plural, and all plural references shall include the singular.

SECTION 5: This Order is effective upon signature and shall remain in effect until amended, modified, terminated, or rescinded by the Governor, or terminated by operation of law.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the city of Baton Rouge, on this 24th day of October, 2014.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1411#098

EXECUTIVE ORDER BJ 14-16

Executive Branch—Expenditure Freeze

WHEREAS, pursuant to the provisions of Article IV, Section 5 of the Louisiana Constitution of 1974, as amended, and Act 15 of the 2014 Regular Session of the Louisiana Legislature, the Governor may issue executive orders which limit the expenditure of funds by the various agencies in the executive branch of state government (hereafter "expenditure freeze"); and

WHEREAS, underlying assumptions and needs in the development of the current year's state budget would be altered by a decline in the State's revenues and the interests of the citizens of our State are best served by implementing fiscal management practices to ensure that appropriations will not exceed actual revenues; and

WHEREAS, in preparation of the budget challenges in the ensuing year, Executive Order BJ 2014-1 Limited Hiring Freeze issued on January 15, 2014, is updated periodically, is related to the Expenditure Category of Personal Services, therefore Personal Services Expenditures will not be addressed in this Executive Order; and

WHEREAS, to ensure that the State of Louisiana will not suffer a budget deficit due to fiscal year 2014-2015 appropriations exceeding actual revenues and that the budget challenges in the ensuing fiscal year are met, prudent money management practices dictate that the best interests of the citizens of the State of Louisiana will be served by implementing an expenditure freeze throughout the executive branch of state government.

NOW THEREFORE, I, BOBBY JINDAL, Governor of the State of Louisiana, by virtue of the authority vested by the Constitution and laws of the State of Louisiana, do hereby order and direct as follows:

SECTION 1: All departments, agencies, and/or budget units of the executive branch of the State of Louisiana as described in and/or funded by appropriations through Acts 15 and 45 of the 2014 Regular Session of the Louisiana Legislature (hereafter "Acts"), shall freeze expenditures as provided in this Executive Order.

SECTION 2: No department, agency, and/or budget unit of the executive branch of the State of Louisiana, unless specifically exempted by a provision of this Order or with the approval of the Commissioner of Administration, shall make any expenditure of funds related to the Expenditure Categories of Travel, Operating Services, Supplies, Professional Services, Other Charges, Interagency Transfers, Acquisitions, and Major Repairs.

SECTION 3:

A. The budget activities funded by the Acts which are exempt from the prohibitions set forth in Section 2 of the Order are as follows:

1. All budget activities directly related to declared emergencies;

2. All budget activities directly necessary for a statewide elected official to perform his or her constitutional functions;

3. All essential budget activities which are expressly and directly mandated by the constitution, existing court orders, existing cooperative endeavor agreements, or existing bona fide obligations;

4. All contracts associated with the transformation of state government that lead to future savings;

5. All essential budget activities of statewide control agencies;

6. All essential budget activities directly required for collection of state general fund revenues recognized by the Revenue Estimating Conference; and

7. All budget activities which are financed by Federal Funds directly.

B. Other budget activities funded by the Acts are exempt from the prohibitions set forth in Section 2 of this Order to the following degree:

1. Essential field travel, and supplies for incarceration, rehabilitation, diagnostic and health services, transportation of offenders, and probation and parole services related to adult corrections as well as positions and field travel for the Board of Pardons and Parole in the Department of Public Safety and Corrections, Corrections Services;

2. Essential field travel, and supplies for juvenile secure care facilities and the Field Services Program in the Department of Public Safety and Corrections, Youth Services;

3. Essential field travel and supplies related to direct patient care;

4. Essential State Police commissioned trooper expenses and cadet classes - not including personnel expenses - as well as data processing, communications, and crime lab positions in Public Safety Services, field travel for public safety and regulatory activities of the State Police, as well as automotive, aviation, and forensic supplies for the State Police;

5. Essential Wildlife and Fisheries commissioned agent expenses and cadet classes - not including personnel expenses - as well as data processing, and communications, field travel for public safety and regulatory activities of the Enforcement Division, as well as automotive, watercraft and aviation, supplies for the Enforcement Division;

6. Essential instructional and residential expenses - not including personnel expenses - field travel, and supplies deemed to be absolutely critical for the operations of Special Schools, Recovery School District, Special School District #1, and Youth Challenge;

7. Essential expenses for the State Military Department - not including personnel expenses - associated with the deployment for backfilling for active duty national guard personnel, and installation management and force protection;

8. Essential expenses related to the housing of state adult and juvenile offenders in local correctional or detention facilities or work release programs.

C. The budget activities funded by the Acts which are exempt from the portion of the provisions of Section 2 of this Order that prohibits the expenditure of funds for travel are as follows:

1. Essential travel associated with promoting or marketing the state of Louisiana and/or its products by:

a) the Office of Tourism within the Department of Culture, Recreation and Tourism; or

b) the Department of Economic Development;

2. Essential field travel for the Mental Health Advocacy Service and the Louisiana Public Defender Board;

3. Essential field travel required for the Office of Legal Affairs, district managers and roving motor vehicle workers in the Office of Motor Vehicles, and inspectors and arson investigators of the Office of the State Fire Marshal in the Department of Public Safety and Corrections, Public Safety Services;

4. Essential field travel for the Municipal Fire and Police Civil Service and the State Police Commission deemed to be essential;

5. Essential travel for the Board of Elementary and Secondary Education for board meetings;

6. Essential field travel associated with Minimum Foundation Program internal auditors and field travel associated with the accountability initiatives and monitoring local teacher assessments.

D. The budget activities funded by the Acts which are exempt from the portions of the provisions of Section 2 of this Order that prohibits the expenditure of funds for supplies are as follows:

1. Essential expenditures of all departments, agencies, offices, boards, and commissions for supplies that total no more than seventy-five (75) percent of the initial

appropriation for supplies for the department, agency, office, board or commission from State General Fund (direct) or State General Fund Equivalent for supplies expenditures;

2. Essential supplies for the Office of State Parks within the Department of Culture, Recreation and Tourism for maintenance and household needs to maintain state parks and commemorative areas;

3. Essential instructional supplies for post-secondary education;

4. Essential automotive supplies for travel exempted in Section 3.

SECTION 4: The Commissioner of Administration is authorized to develop additional guidelines as necessary to facilitate the administration of this Order.

SECTION 5: All departments, commissions, boards, offices, entities, agencies, and officers of the State of Louisiana, or any political subdivision thereof, are authorized and directed to cooperate in the implementation of the provisions of this Order.

SECTION 6: This Order is effective upon signature and shall remain in effect through June 30, 2015, unless amended, modified, terminated, or rescinded prior to that date.

IN WITNESS WHEREOF, I have set my hand officially and caused to be affixed the Great Seal of Louisiana, at the Capitol, in the city of Baton Rouge, on this 7th day of November, 2014.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1411#099

Emergency Rules

DECLARATION OF EMERGENCY

Board of Elementary and Secondary Education

Bulletin 741—Louisiana Handbook for School Administrators—Emergency Planning and Attendance (LAC 28: CXV.339 and 1103)

The Board of Elementary and Secondary Education (BESE) has exercised the emergency provision in accordance with R.S. 49:953(B), the Administrative Procedures Act, and R.S. 17:6, to adopt LAC 28: CXV, *Bulletin 741—Louisiana Handbook for School Administrators*: §339, Emergency Planning and Procedures; and §1103, Compulsory Attendance. This Declaration of Emergency, effective October 15, 2014, will remain in effect for a period of 120 days.

R.S. 17:154.1(B) addresses school closures by local superintendents due to emergency situations as defined in rules promulgated by BESE. Bulletin 741 addresses school emergency planning and response, student absences, and the continued education of students who are ill.

Pursuant to R.S. 17:154.1(B), the proposed revisions to Bulletin 741, §339, Emergency Planning and Procedures, broadly define emergency situations, inclusive of public health emergencies. Proposed revisions to §1103, Compulsory Attendance, address the continued education of students who have been quarantined following prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, as ordered by state or local health officials.

A delay in promulgating these rules could result in local school districts and other public schools not having critical policies in place in the event of a public health emergency.

Title 28

EDUCATION

Part CXV. Bulletin 741—Louisiana Handbook for School Administrators

Chapter 3. Operation and Administration

§339. Emergency Planning and Procedures

A. Each public school principal or school leader shall have written policies and procedures developed jointly with local law enforcement, fire, public safety, and emergency preparedness officials, that address the immediate response to emergency situations that may develop in the schools and comply with the requirements in R.S. 17:416.16. The principal or school leader shall:

1. submit the crisis management and response plan to the local superintendent for approval;
2. annually review and possibly revise the crisis management and response plan; and
3. within 30 days of each school year, conduct a safety drill to rehearse the plan.

B. The school shall maintain and use contingency plans for immediate responses to emergency situations.

C. The school shall establish and use procedures for reporting accidents to parents and/or the central office.

D. In the absence of a principal or school leader, another individual(s) at the school shall be delegated the necessary authority to use emergency procedures.

E. Procedures for the cancellation of school shall be established, communicated to students, teachers, and parents, and followed when necessary.

F. The school shall establish procedures for special calls to police, fire departments, and hospitals, and practice drills shall be used to ensure the effectiveness of the procedure.

G. The school shall establish procedures for the evacuation of the building in the event of fire, severe weather conditions, or bomb threats. Practice drills shall be used to ensure the effectiveness of the procedure.

H. The local superintendent or chief charter school officer may dismiss any or all schools due to emergency situations, including any actual or imminent threat to public health or safety which may result in loss of life, disease, or injury; an actual or imminent threat of natural disaster, force majeure, or catastrophe which may result in loss of life, injury or damage to property; and, when an emergency situation has been declared by the governor, the state health officer, or the governing authority of the school.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:416.16 and R.S. 17:154.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1262 (June 2005), amended LR 39:3258 (December 2013), LR 41:

Chapter 11. Student Services

§1103. Compulsory Attendance

A. Students who have attained the age of 7 years shall attend a public or private day school or participate in an approved home study program until they reach the age of 18 years. Any child below the age of 7 who legally enrolls in school shall also be subject to compulsory attendance. Refer to Chapter 33 for information on home study programs.

B. A parent, tutor, or legal guardian who has a student who is under the age of 18 and meets one of the requirements below shall be in compliance with the compulsory attendance law.

1. A student, under 18 years of age, who withdraws from school prior to graduating from high school and who has been ruled to be a truant, pursuant to the provisions of chapter 15 of title VII of the *Louisiana Children's Code*, by a court of competent jurisdiction can be ordered by the court to exercise one of the following options within 120 days of leaving school:

a. reenroll in school and make continual progress toward completing the requirements for high school graduation;

b. enroll in a high school equivalency diploma program and make continual progress toward completing the requirements for earning such diploma;

c. enlist in the Louisiana National Guard or a branch of the United States Armed Forces, with a commitment for at least two years of service, and earn a high school equivalency diploma during such service period.

2. If a student is under the age of 18, the parent or guardian may withdraw the student from high school if that

student is accepted into a National Guard Youth Challenge Program in this state.

3. For a student who is under the age of 18 and enrolled in school beyond his/her sixteenth birthday, the parent or guardian may request a waiver from the local superintendent for that student to exit school to enroll in an adult education program approved by the Louisiana Community and Technical College System (LCTCS).

a. In the case of a student with no parent or guardian, the local school superintendent may act on behalf of the student in requesting a waiver if appropriate documentation is on file at the local school board office and one or more of the following hardships exist:

- i. pregnant or actively parenting;
- ii. incarcerated or adjudicated;
- iii. institutionalized or living in a residential facility;
- iv. chronic physical or mental illness;
- v. family and/or economic hardships.

(a). Family and/or economic hardship is defined as a student who acts as a caregiver or must work to support the family due to a parent's death or illness, or needs to be removed from an existing home environment.

b. The local school superintendent or his/her designee may approve the request for exiting public or home school without requesting action from BESE. If the request to exit school to enroll in a LCTCS approved adult education program is denied at the local level, a student may request the waiver from the DOE for approval by BESE with documentation of reason for denial at the local level. Students seeking to exit school to enroll in adult education, who are enrolled in a formal education setting other than a public K-12 institution, may request a waiver from the institutional agency head or his/her designee. Mandatory attendance components shall be met in all of the above circumstances.

4. A student who is at least seventeen years of age may exit high school without violating compulsory attendance statute (R.S. 17:221), if that student has met the following criteria:

- a. completed a program established by BESE;
- b. achieved a passing score on the GED test; and
- c. received a Louisiana high school equivalency diploma issued by the Board of Supervisors of Louisiana Community and Technical College System.

C. Students shall be expected to be in attendance every student-activity day scheduled by the LEA.

D. A student is considered to be in attendance when he or she is physically present at a school site or is participating in an authorized school activity and is under the supervision of authorized personnel.

1. This definition for attendance would extend to students who are homebound, assigned to and participating in drug rehabilitation programs that contain a state-approved education component, participating in school-authorized field trips, or taking a state-approved virtual course.

a. Half-Day Attendance. Students are considered to be in attendance for one-half day when they:

- i. are physically present at a school site or participating in authorized school activity; and

- ii. are under the supervision of authorized personnel for more than 25 percent but not more than half (26-50 percent) of the students' instructional day.

b. Whole-Day Attendance. Students are considered to be in attendance for a whole day when they:

- i. are physically present at a school site or are participating in an authorized school activity; and

- ii. are under the supervision of authorized personnel for more than 50 percent (51-100 percent) of the students' instructional day.

E. A student who is enrolled in regular or special education and who, as a result of healthcare treatment, physical illness, accident, or the treatment thereof is temporarily unable to attend school, shall be provided instructional services in the home, or hospital environment.

1. Homebound instruction shall be provided by a properly certified teacher on the eleventh school day following an absence of more than 10 consecutive school days for a qualifying illness.

a. After a student has been absent for 10 days for one of the above identified reasons, the student shall be referred for review by the SBLC, to determine need for referral for section 504 services if the student has not previously been identified as a student with a disability.

2. Homebound instruction, at a minimum, shall be provided in the core academic subjects:

- a. English;
- b. mathematics;
- c. science; and
- d. social studies.

3. A minimum of four hours of homebound instruction shall be provided per week, unless the student's health as determined by a physician requires less.

a. Consideration shall be given to the individual need for services beyond the core academic subjects for students with disabilities.

4. Homebound services may be provided via a consultative model (properly certified regular or special education teacher when appropriate, consults with the homebound teacher delivering instruction) for students needing such services less than 20 days during a school year.

F. A student who has been quarantined by order of state or local health officers following prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, and is temporarily unable to attend school, shall be provided any missed assignments, homework, or other instructional services in core academic subjects in the home, hospital environment, or temporary shelter to which he has been assigned. The principal, with assistance from the local superintendent or chief charter school officer and the LDE, shall collaborate with state and local health officers and emergency response personnel to ensure the timely delivery or transmission of such materials to the student.

G. Elementary students shall be in attendance a minimum of 60,120 minutes (equivalent to 167 six-hour days) a school year. In order to be eligible to receive grades, high school students shall be in attendance a minimum of 30,060 minutes (equivalent to 83.5 six-hour school days), per semester or 60,120 minutes (equivalent to 167 six-hour school days) a school year for schools not operating on a semester basis.

1. Students in danger of failing due to excessive absences may be allowed to make up missed time in class sessions held outside the regular class time. The make-up sessions must be completed before the end of the current semester and all other policies must be met.

H. Each LEA shall develop and implement a system whereby the principal of a school, or his designee, shall notify the parent or legal guardian in writing upon or before a student's third unexcused absence or unexcused occurrence of being tardy, and shall hold a conference with such student's parent or legal guardian. This notification shall include information relative to the parent or legal guardian's legal responsibility to enforce the student's attendance at school and the civil penalties that may be incurred if the student is determined to be habitually absent or habitually tardy. The student's parent or legal guardian shall sign a receipt for such notification.

I. Tardy shall include but not be limited to leaving or checking out of school unexcused prior to the regularly scheduled dismissal time at the end of the school day but shall not include reporting late to class when transferring from one class to another during the school day.

J. Exceptions to the attendance regulation shall be the enumerated extenuating circumstances below that are verified by the supervisor of child welfare and attendance or the school principal/designee where indicated. These exempted absences do not apply in determining whether a student meets the minimum minutes of instruction required to receive credit:

1. extended personal physical or emotional illness as verified by a physician or nurse practitioner licensed in the state;

2. extended hospital stay in which a student is absent as verified by a physician or dentist;

3. extended recuperation from an accident in which a student is absent as verified by a physician, dentist, or nurse practitioner licensed in the state;

4. extended contagious disease within a family in which a student is absent as verified by a physician or dentist licensed in the state; or

5. quarantine due to prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, as ordered by state or local health officials; or

6. observance of special and recognized holidays of the student's own faith;

7. visitation with a parent who is a member of the United States Armed Forces or the National Guard of a state and such parent has been called to duty for or is on leave from overseas deployment to a combat zone or combat support posting. Excused absences in this situation shall not exceed five school days per school year;

8. absences verified and approved by the school principal or designee as stated below:

a. prior school system-approved travel for education;

b. death in the immediate family (not to exceed one week); or

c. natural catastrophe and/or disaster.

K. For any other extenuating circumstances, the student's parents or legal guardian must make a formal appeal in accordance with the due process procedures established by the LEA.

L. Students who are verified as meeting extenuating circumstances, and therefore eligible to receive grades, shall not receive those grades if they are unable to complete makeup work or pass the course.

M. Students participating in school-approved field trips or other instructional activities that necessitate their being away from school shall be considered to be present and shall be given the opportunity to make up work.

N. If a student is absent from school for 2 or more days within a 30-day period under a contract or employment arrangement to render artistic or creative services for compensation as set forth in the Child Performer Trust Act (R.S. 51:2131 et seq.) the employer shall employ a certified teacher, beginning on the second day of employment, to provide a minimum of three education instruction hours per day to the student pursuant to the lesson plans for the particular student as provided by the principal and teachers at the student's school. There must be a teacher to student ratio of 1 teacher for every 10 students.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:112, R.S. 17:221.3-4, R.S. 17:226.1, and R.S. 17:233.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1273 (June 2005), amended LR 32:546 (April 2006), LR 32:1030 (June 2006), LR 33:2351 (November 2007), LR 35:641 (April 2009), LR 35:1097 (June 2009), LR 35:1475 (August 2009), LR 36:482 (March 2010), LR 36:1224 (June 2010), LR 37:1126 (April 2011), LR 37:2132 (July 2011), LR 38:1000 (April 2012), LR 38:1225 (May 2012), LR 38:1399 (June, 2012), LR 39:2205 (August 2013), LR 41:

Charles E. "Chas" Roemer, IV
President

1411#002

DECLARATION OF EMERGENCY

Board of Elementary and Secondary Education

Bulletin 135—Health and Safety
Communicable Disease Control
(LAC 28:CLVII.309)

The Board of Elementary and Secondary Education (BESE) has exercised the emergency provision in accordance with R.S. 49:953(B), the Administrative Procedures Act, and R.S. 17:6, to adopt LAC 28:CLVII, *Bulletin 135—Health and Safety: §309, Communicable Disease and Control*. This Declaration of Emergency, effective October 15, 2014, will remain in effect for a period of 120 days.

Bulletin 135 addresses health and safety issues in Louisiana public schools, including the prevention and control of communicable diseases.

Proposed revisions to §309, Communicable Disease Control address the dissemination of public health information by LDE to school governing authorities, as well as the local superintendent or charter school leader's exclusion of students or employees having been diagnosed with or exposed to communicable diseases.

A delay in promulgating these rules could result in local school districts and other public schools not having critical policies in place in the event of a public health emergency.

Title 28
EDUCATION

Part CLVII. Bulletin 135—Health and Safety

Chapter 3. Health

§309. Communicable Disease Control

A. The LDE will work cooperatively with the Louisiana Department of Health and Hospitals for the prevention, control and containment of communicable diseases in schools and shall assist in the dissemination of information relative to communicable diseases to all school governing authorities, including but not limited to information relative to imminent threats to public health or safety which may result in loss of life or disease.

B. Students are expected to be in compliance with the required immunization schedule.

1. The principal is required under R.S. 17:170 to exclude children from school attendance who are out of compliance with the immunizations required by this statute.

2. School personnel will cooperate with public health personnel in completing and coordinating all immunization data, waivers and exclusions, including the necessary Vaccine Preventable Disease Section's school immunization report forms (EPI-11, 11/84) to provide for preventable communicable disease control.

C. The local superintendent or chief charter school officer may exclude a student or staff member for not more than five days, or the amount of time required by state or local public health officials, from school or employment when reliable evidence or information from a public health officer or physician confirms him/her of having a communicable disease or infestation that is known to be spread by any form of casual contact and is considered a health threat to the school population. Such a student or staff member may be excluded unless state or local public health officers determine the condition is no longer considered contagious.

D. Mandatory screening for communicable diseases that are known not to be spread by casual contact shall not be required as a condition for school entry or for employment or continued employment.

E. Irrespective of the disease presence, routine procedures shall be used and adequate sanitation facilities shall be available for handling blood or bodily fluids within the school setting or on school buses. School personnel shall be trained in the proper procedures for handling blood and bodily fluids and these procedures shall be strictly adhered to by all school personnel.

F. Any medical information that pertains to students or staff members, proceedings, discussions and documents shall be confidential information. Before any medical information is shared with anyone in the school setting, a "need-to-know" review shall be made which includes the parent/guardian, student if age 18, employee or his/her representative unless the information is required to meet the mandates of federal or state law or regulation, or BESE policy.

G. Age-appropriate instruction on the principal modes by which communicable diseases are spread and the best methods for the restriction and prevention of these diseases shall be taught to students and in-service education provided to all staff members.

H. A local superintendent may only exclude a student or employee from a school or employment setting when reliable evidence or information from a public health officer or physician confirms that a student/staff member is known to have a communicable disease or infection that is known not to be spread by casual contact if a review panel is held to ensure due process.

I. Due Process Procedures

1. The Review Panel

a. Communicable diseases that are known not to be spread by casual contact (e.g., AIDS, Hepatitis B and other like diseases) will be addressed on a case-by-case basis by a review panel.

b. Panel membership:

i. the physician treating the individual;

ii. a health official from the local parish health department;

iii. a child/employee advocate (e.g., nurse, counselor, child advocate, social worker, employee representative, etc., from in or outside the school setting) approved by the infected person or parent/guardian;

iv. a school representative familiar with the student's behavior in the school setting or the employee's work situation (in most cases the building principal or in the case of a special education student, a representative may be more appropriate);

v. either the parent/guardian of a child, a student if 18, employee, or their representative; and

vi. the school system superintendent.

c. The superintendent will assign a stenographer to record the proceedings.

d. The superintendent will designate the chair of the panel.

e. The chair of the review panel will designate the panel member who will write the proposal for decision.

2. Case Review Process

a. Upon learning of a student/staff member with the LEA who has been identified as having a communicable disease that is known not to be spread by casual contact, the superintendent shall:

i. immediately consult with the physician of the student/staff member or public health officer who has evidence of a present or temporary condition that could be transmitted by casual contact in the school setting:

(a) if the public health officer indicates the student/staff member is well enough to remain in the school setting and poses no immediate health threat through casual contact to the school population because of their illness, the student/staff member shall be allowed to remain in the school setting while the review panel meets;

(b) if the public health officer indicates the student/staff member is currently not well enough to remain in the school setting and/or the affected individual currently has evidence of an illness or infection that poses a potential health threat through casual contact to the school population because of the illness, the student/staff member shall be excluded from the school setting while the review panel meets;

(c) if the public health officer recommends exclusion because a public health threat exists, the review panel will discuss the conditions under which the individual may return to school;

ii. immediately contact the review panel members to convene a meeting to explore aspects of the individual's case;

iii. submit to the parent/guardian or infected person if 18 or older, a copy of the communicable disease control policy;

iv. observe all federal and state statutes, federal and state regulations, and all BESE policies pertaining to provision of special educational services.

3. The Review Panel Process

a. The review panel shall meet within 24-48 hours to review the case. The following aspects should be considered in that review:

i. the circumstances in which the disease is contagious to others;

ii. any infections or illnesses the student/staff member could have as a result of the disease that would be contagious through casual contact in the school situation;

iii. the age, behavior, and neurologic development of the student;

iv. the expected type of interaction with others in the school setting and the implications to the health and safety of others involved;

v. the psychological aspects for both the infected individual remaining in the school setting;

vi. consideration of the existence of contagious disease occurring within the school population while the infected person is in attendance;

vii. consideration of a potential request by the person with the disease to be excused from attendance in school or on the job;

viii. the method of protecting the student/staff member's right to privacy, including maintaining confidential records;

ix. recommendations as to whether the student/staff member should continue in the school setting or if currently not attending school, under what circumstances he/she may return;

x. recommendations as to whether a restrictive setting or alternative delivery of school programs is advisable;

xi. determination of whether an employee would be at risk of infection through casual contact when delivering an alternative educational program;

xii. determination of when the case should be reviewed again by the panel; and

xiii. any other relevant information.

b. Proposal for Decision

i. Within three operational days (i.e., a day when the school board central office is open for business) after the panel convenes, the superintendent shall provide a written decision to the affected party based on the information brought out in the review panel process and will include the rationale for the decision concerning school attendance for the student or continuation of employment for staff member.

ii. If the decision is to exclude the affected person from the school setting because of the existence of a temporary or present condition that is known to be spread by casual contact and is considered a health threat, the written decision shall include the conditions under which the exclusion will be reconsidered.

iii. If the affected person is a special education student, an individualized education program conference must be convened to determine the appropriateness of the program and services for the student.

4. Appeal Process

a. Rehearing Request

i. The parent, guardian or affected person who considers the proposal for decision unjust may request a rehearing, in writing, directed to the superintendent within three days of the date of the decision. Grounds for requesting a rehearing are limited to:

(a) new evidence or information that is important to the decision; or

(b) substantial error of fact.

ii. The superintendent, within 48 hours from the date of receipt of the request for rehearing, shall either grant or deny the request for rehearing. If the request for rehearing is granted, the chair shall reconvene the same panel that originally heard the matter within five business days of the date the hearing is granted.

iii. Within three operational days (a day when the school system's central office is open for business) after the rehearing, the superintendent shall submit the decision to the parent/guardian or affected person.

b. Request for a Local Board Decision

i. The parent/guardian, affected person or their representative, may make a final written appeal to the president of the local board of education within five operational days after the superintendent's decision. The board shall meet within three operational days and hear the student/staff member's appeal along with the proposal for decision and superintendent's decision. Within two business days of the hearing, the board shall render its decision in writing with copies sent to the superintendent, health department official, and parent/guardian or affected person.

ii. Should the superintendent deny the request for rehearing, the appellant may appeal to the local board of education by exercising the process in Subparagraph b.

iii. Review Panel Request for Appeal. If the proposal for decision or the superintendent's decision is contrary to the majority opinion of the review panel, a majority of the panel has the right to appeal either decision in the same manner stated in the appeal process.

5. General

a. If the affected student cannot attend school, the LEA will provide an alternative education setting.

i. If the public health officer determines there is a risk of infection to an employee through casual contact while delivering this program, the employee will not be required to provide educational services.

ii. If the public health officer determines there is no risk of infection to an employee, the employee will be expected to participate in the delivery of educational services.

b. The review panel member who is serving as the advocate for the infected individual (or another person designated by the panel and approved by the parent/guardian, or the infected person) will serve as the liaison between the student/staff member, family and attending physician as it relates to the school setting.

c. These procedures in no way limit or supersede the procedural due process requirements established in 29

USC 706(7), R.S. 17:1941, 7946, and 20 USC 1400-1485 et seq.

6. Confidentiality

a. All persons involved in these procedures shall be required to treat all proceedings, deliberations, and documents as confidential information. Records of the proceedings and the decisions will be kept by the superintendent in a sealed envelope with access limited to only those persons receiving the consent of the parent/guardian or infected person as provided in 20 USC 1232(g).

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(10)(15), R.S. 17:170, R.S. 17:437, R.S. 17:1941, and 20 USCS 1232.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 39:1035 (April 2013), amended LR 41:

Charles E. "Chas" Roemer, IV
President

1411#003

DECLARATION OF EMERGENCY

**Office of the Governor
Board of Examiners of Certified Shorthand Reporters**

**Employment Relationship with Court Reporting Firms
(LAC 46:XXI.1303)**

In accordance with the emergency provisions of the Administrative Procedures Act, R.S.49:953(B), and under the authority of R.S. 37:2557(B), R.S. 37:2555(G), and R.S. 37:2556(D), the Louisiana Board of Examiners of Certified Shorthand Reporters ("CSR board") declares an emergency and adopts by emergency process the attached rules and accompanying forms as LAC 46:I.1303, establishing the procedures governing court reporters in their relationships with court reporting firms in accordance with Act 839 enacted by the 2014 Legislature of Louisiana.

Act 839 charges the board with responsibility for promulgating by Rule procedures and forms to comply with the new statutory language.

This Emergency Rule is effective on November 10, 2014, 2014 and shall remain in effect for 120 days or until re-enacted by Emergency Rule or through the normal promulgation process, whichever comes first.

Title 46

**PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part XXI. Certified Shorthand Reporters

Chapter 13. Code of Ethics

**§1303. Employment Relationship with
Court Reporting Firm**

A. Application and Scope. This rule protects the integrity, independence, and impartiality of court reporters in their relationships with court reporting firms, as defined in R.S. 37:2555(G) that are doing business in Louisiana.

B. Safe Harbor. A licensed Louisiana court reporter may accept employment from a court reporting firm and shall not be considered an "employee" for purposes of *Code of Civil Procedure* article 1434 upon furnishing to the board a certification, on a form approved by the board, from an

authorized and knowledgeable officer of the court reporting firm that the firm has no prohibited employment or contractual relationship, direct or indirect, under *Code of Civil Procedure* article 1434 with a party litigant in the matter for which the reporter was retained to provide services. The reporter must file with the board a copy of the certification within 30 days after the date of the deposition. The reporter shall obtain and maintain, for a minimum of three years, the schedule of all charges and other disclosures, which shall be obtained by the reporter concurrently with the original certification from the court reporting firm. Upon request, the reporter shall provide to the board a copy of the schedule of all charges and other disclosures. The Louisiana court reporter shall immediately notify the board, in writing, if a safe harbor request was made upon a court reporting firm and the firm refused or failed to provide the requested certification or the schedule of all charges and other disclosures. The reporter shall include the name of the court reporting firm and the date the request was made.

C. Certification by Court Reporting Firm. Upon request by a licensed Louisiana court reporter, a court reporting firm doing business in Louisiana shall provide a certification on forms adopted by the board and executed by affidavit from an authorized and knowledgeable officer of the firm, attesting that the firm has no prohibited employment or contractual relationship, direct or indirect, under *Code of Civil Procedure* article 1434 with a party litigant in the matter for which the reporter was retained to provide services.

D. The court reporting firm and the court reporter shall immediately inform the board of any changes in relationships or actual knowledge of any relationships, direct or indirect, that are at variance with representations made in the certification by the court reporting firm.

E. Certification Affidavit of Court Reporting Firm

CERTIFICATION AFFIDAVIT OF COURT REPORTING FIRM

STATE OF _____
PARISH OR COUNTY OF _____

BEFORE ME, the undersigned authority, duly qualified to take acknowledgments and administer oaths within the state and locality inscribed above, personally appeared _____ ("Affiant"), who is representing _____ a

_____ [state] corporation [or limited liability company or other form of business organization] that is doing business in Louisiana as a court reporting firm as defined by Acts 2014, No. 839 (hereinafter, "Court Reporting Firm"). The physical address of the entity's principal place of business is _____ [street and suite number, if any] in _____ [city], State of _____, Zip _____,

Telephone: (_____) _____, Email _____.

After being duly sworn, Affiant did attest as follows:

1. Affiant is a knowledgeable representative who is authorized to act on behalf of the Court Reporting Firm in executing this Certification Affidavit.
2. The Court Reporting Firm has engaged a Louisiana licensed court reporter to perform court reporting services in connection with the deposition(s) of _____ [identify by name each deponent covered by this certification] to be taken in the following proceeding: _____ vs. _____, pending in the _____ Court under number _____.
3. Affiant certifies, after performing due diligence, that the Court Reporting Firm has no prohibited employment or contractual relationship, direct or indirect, under Louisiana Code of Civil Procedure

Article 1434 with a party litigant in the matter for which the court reporter's services have been engaged. Affiant further acknowledges affiant's duty to provide information and will provide information promptly to the Louisiana Board of Examiners of Certified Shorthand Reporters (hereinafter, "CSR Board") regarding any change in these relationships or in Affiant's knowledge of these relationships.

4. Affiant attaches hereto the schedule of all charges and other disclosures that the court reporter must have available at the time of taking the deposition.
5. Affiant further states that Affiant is familiar with the nature of an oath and with penalties as provided by applicable state laws for falsely swearing to statements made in an instrument of this nature. Affiant further certifies that Affiant has read and understands the full facts and content of this Affidavit.

SIGNATURE OF AFFIANT: _____

Sworn before me this me this _____ day of _____, 201__

 Notary Public
 Print name: _____
 My commission expires: _____

Each Firm Certification Affidavit must be filed with the CSR Board by the court reporter within 30 days of the date of the deposition. The filing does not need to include the schedule of charges.

<p>I, a Louisiana Licensed Court Reporter, hereby submit this certification affidavit via _____ [facsimile/e-mail] within 30 days of the date of the depositions to which this certification applies and acknowledge my obligation to maintain the schedule for a minimum of three years. I further certify that I have received the required schedule of all charges and other disclosures from the Court Reporting Firm in connection with this certification.</p>	
<p>_____ Signature</p>	<p>_____ Date</p>
<p>_____ Printed Name</p>	<p>_____ LA CCR NO.</p>

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2557(B), R.S. 37:2555(G), and R.S. 37:2556(D).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Examiners of Certified Shorthand Reporters, LR 40:

Judge Paul A. Bonin
Chair

1411#052

DECLARATION OF EMERGENCY

**Office of the Governor
Crime Victims Reparations Board**

Eligibility Requirements for Sexual Assault Victims
(LAC 22:XIII.301)

The following amendment is published in accordance with R.S. 46:1807(C)(1), the Crime Victims Reparations Act, which allows the Crime Victims Reparations Board to promulgate rules necessary to carry out its business or provisions of the Chapter. This Rule will clarify the eligibility requirements for crime victims.

This Emergency Rule, effective October 28, 2014, is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Title 22

**CORRECTIONS, CRIMINAL JUSTICE AND LAW
ENFORCEMENT**

Part XIII. Crime Victims Reparations Board

Chapter 3. Eligibility and Application Process

§301. Eligibility

A. - A.1.b.ii. ...

c. The following factors shall not be considered a reason for denying or reducing an award to a claimant who is a victim of sexual assault, or who submits a claim on behalf of a victim of sexual assault:

i. the manner in which the victim was dressed at the time of the sexual assault;

ii. where the victim was located prior to the sexual assault;

iii. the time of the sexual assault;

iv. the occupation of the victim;

v. whether the victim:

(a). was or may have been under the influence of alcohol or drugs;

(b). had a previous sexual relationship with the alleged offender;

(c). was married to the alleged offender;

(d). was dating the alleged offender;

(e). consented to prior sexual activity with the alleged offender;

(f). has a history of being a victim of prior sexual assaults;

(g). has a criminal record;

(h). consented to the sexual act if the victim is below the age of consent, mentally incapacitated or physically helpless;

(i). continued to live with an alleged offender after the assault;

(j). has a familial relationship to the alleged offender.

2. Collateral Sources

a. - a.ii. ...

b. Insurance

i. The victim/claimant must process any potential insurance before applying for reimbursement of mental health claims, except for victims of sexual assault.

ii. For claims that pertain to victims of sexual assault, the victim has the discretion to choose whether or not to file for private insurance or Medicaid coverage.

3. - 3.g. ...

AUTHORITY NOTE: Promulgated in accordance with R. S. 46:1801 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Crime Victims Reparations Board, LR 20:538 (May 1994), amended LR 22:709 (August 1996), LR 31:2009 (August 2005), LR 35:65 (January 2009), LR 36:2278 (October 2010), LR 37:1605 (June 2011), LR 41:

Public Comments

Interested persons may submit written comments on this Emergency Rule no later than December 20, 2014 at 5 p.m. to Bob Wertz, Louisiana Commission on Law Enforcement, P.O. Box 3133, Baton Rouge, LA 70821.

Lamarr Davis
Chairman

1411#010

DECLARATION OF EMERGENCY

Department of Health and Hospitals Board of Examiners of Psychologists

Licensed Specialists in School Psychology

Editor's Note: The following Emergency Rule was not submitted in accordance with the prescribed uniform system of *Louisiana Administrative Code* codification guidelines. It is being published as an informative measure for public review without regard to validity, as provided in R.S. 49:954.1.

The Louisiana Department of Health and Hospitals, Louisiana State Board of Examiners of Psychologists has exercised the emergency provisions of the Administrative Procedures Act, specifically R.S. 49:953(B)(1), to create rules relative to the licensure of specialists in school psychology pursuant to Act 136 of the 2014 Legislative Session effective August 1, 2014. This Emergency Rule, effective October 15, 2014, will remain in effect for a period of 120 days.

TITLE OMITTED PART OMITTED

Subpart 2. Licensed Specialists in School Psychology

Chapter 1. Definitions

§. SECTION NAME AND NUMBER OMITTED

Board—the Louisiana State Board of Examiners of Psychologists.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 2. Licensed Specialist in School Psychology Advisory Committee

§201. Scope

A. The rules of this Chapter identify the constitution, functions and responsibilities of the licensed specialist in School Psychology Advisory Committee to the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§202. Constitution, Function and Responsibilities of Advisory Committee

A. The board shall constitute and appoint a licensed specialist in School Psychology Advisory Committee, which shall be organized, and function in accordance with the law and rules of the board.

B. Composition. The committee shall be comprised of four members, consisting of:

1. two members that are licensed school psychologists licensed under the LSBEP who meets all requirements as determined by the board, selected from a list of self-nominations to the board;

2. one member that is either a licensed school psychologist licensed under the LSBEP or a licensed specialist in school psychology licensed under LSBEP who meets all requirements as determined by the board selected from a list of self-nominations to the board; and

3. the board's executive director as the ex-officio, non-voting member.

C. Appointment. Each member, to be eligible for and prior to appointment to the committee, shall have maintained residency and a current and unrestricted license to practice in the state of Louisiana under the authority of LSBEP for not less than two years.

D. Vacancy. In the event of a vacancy on the committee, the board shall appoint a replacement for the remainder of the member's term. The replacement shall meet the same requirements as determined by the board and be drawn from a list of self-nominations to the board.

E. Term of Service. Each member of the initial committee shall serve staggered terms. For the first appointment to the committee, one member will serve three years, one member will serve two years and one member will serve one year. The ex-officio member will serve continuously. Initial committee members shall be eligible for one reappointment for a full term of three years.

1. For future committee appointments, members will serve for a term of three years, or until a successor is appointed and shall be eligible for one reappointment. Committee members serve at the pleasure of the board.

F. Functions of the Committee. The committee will provide the board with recommendations relating to the following matters:

1. applications for licensure (initial and renewal);
2. educational requirements for licensure (initial and renewal);
3. changes in related statutes and rules; and
4. other activities as might be requested by the board.

G. Committee Meetings, Officers. The committee shall meet at least quarterly, or more frequently as deemed necessary by a quorum of the committee or the board. Two members of the committee constitute a quorum. The committee shall elect from among its members a chair. The chair shall designate the date, time and place of, and preside at all meetings of the committee.

H. Confidentiality. In discharging the functions authorized under this Section, the committee and the individual members thereof shall, when acting within the scope of such authority, be deemed agents of the board. Committee members are prohibited from disclosing, or in any way releasing to anyone other than the board, any confidential information or documents obtained when acting as agent of the board without first obtaining written authorization from the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 3. Definition of Applicant for Licensure as a Specialist in School Psychology

§ SECTION NAME AND NUMBER OMITTED

A. An *applicant* is a person who submits to the board the required application fee and the complete prescribed application which includes evidence that the person:

1. is at least 21 years of age; and
2. is of good moral character; and
3. is a citizen of the United States or has declared his

intention to become a citizen. A statement by the person under oath that he is a citizen or that he intends to apply for citizenship when he becomes eligible to make such application shall be sufficient proof of compliance with the requirement of this Subsection;

4. has completed a school specialist degree from a National Association of School Psychologists-approved program or equivalent;

5. has completed a 1,200 hour, at least a 9-month internship under the supervision of a certified school psychologist in a school setting or by a licensed psychologist in a community setting. Of the 1,200 hours, 600 hours shall be completed in a school setting;

6. has completed three years of supervised experience as a certified school psychologist within the public school system;

7. has passed the nationally certified school psychologist examination;

8. has demonstrated professional knowledge of the laws and rules regarding the practice of psychology in Louisiana; and

9. is not in violation of any of the provisions of this Chapter and the rules and regulations adopted by the board.

B. Applicant status shall not be used for professional representation.

C. An applicant who is denied licensure by the board based on the evidence submitted as required under §301.A, may reapply to the board after two years have elapsed, and having completed additional training meeting the requirements of the law and as defined in the rules and regulations adopted by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 4. Specialist Programs in School Psychology

§401. Program Requirements General

A. A graduate of a specialist in school psychology program that is a National Association of School Psychologists (NASP) -approved program is recognized as holding a specialist degree, or an equivalent certificate, from a university offering a full-time graduate course of study in school psychology. The NASP criteria for program approval serves as a model for specialist-level training in school psychology.

B. Graduate education in specialist in school psychology is delivered within the context of a comprehensive program framework based on clear goals and objectives and a sequential, integrated course of study in which human diversity is emphasized. Graduate education develops candidates' strong affiliation with school psychology, is delivered by qualified faculty, and includes substantial coursework and supervised field experiences necessary for the preparation of competent specialist-level school

psychologists whose services positively impact children, families, schools, and other consumers.

C. Degrees from online programs will only be accepted if NASP-approved and meet the requirements in §401.D.

D. A graduate of a specialist program that is not approved by the NASP must meet the criteria listed below.

1. Training in school psychology is at the specialist level offered in a regionally accredited institution of higher education.

2. The program, wherever it may be administratively housed, must be clearly identified and labeled as a specialist in school psychology, or certificate, program. Such a program must specify in pertinent institutional catalogs and brochures its intent to educate and train specialist-level school psychologists.

3. The specialist program must stand as a recognizable, coherent organizational entity within the institution.

4. There must be a clear authority and primary responsibility for all specialist program components consistent with NASP standards for training programs.

5. The program must be an integrated, organized sequence of study.

6. There must be an identifiable school psychology faculty and a school psychologist responsible for the program. A minimum of two program faculty must have earned doctorates in school psychology.

7. The specialist program must have an identifiable body of students who have matriculated in that program for a degree.

8. The specialist program must include supervised practicum and internship completed in field-based settings consistent with NASP standards for training.

9. The specialist program shall involve at least one continuous academic year of full-time residency on the campus of the institution at which the degree is granted.

10. The curriculum shall encompass a minimum of two academic years of full-time graduate study and an approved one-year internship consistent with published NASP standards for training. Additionally, the program shall require each student to demonstrate competence in each of the NASP practice domains:

- a. data-based decision making and accountability;
- b. consultation and collaboration;
- c. interventions and instructional support to develop academic skills;
- d. interventions and mental health services to develop social and life skills;
- e. school-wide practices to promote learning;
- f. preventive and responsive services;
- g. family-school collaboration services;
- h. diversity in development and learning;
- i. research and program evaluation;
- j. legal, ethical, and professional practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§402. Program Requirements—Supervised Practica Prior to Internship

A. The school psychology program should include supervised practica prior to internship that includes the following:

1. completion of practica, for academic credit that are distinct from, precede, and prepare students for the school psychology internship;

2. specific, required activities and systematic evaluation of skills that are consistent with goals of the program;

3. emphasize human diversity, and are completed in settings relevant to program objectives for development of practice competencies;

4. direct oversight by the program to ensure appropriateness of the placement, activities, supervision, and collaboration with the placement sites and practicum supervisors; and

5. close supervision of students by program faculty and qualified practicum supervisors, including appropriate performance-based evaluation, to insure that students are developing professional work characteristics and designated competencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§403. Program Requirements—Internship

A. The school psychology program should include a comprehensive, supervised, and carefully evaluated internship in school psychology that includes the following:

1. a culminating experience in the program's course of study that is completed for academic credit or otherwise documented by the institution;

2. a primary emphasis on providing breadth and quality of experiences, attainment of comprehensive school psychology competencies, and integration and application of the full range of domains of school psychology;

3. completion of activities and attainment of school psychology competencies that are consistent with the goals and objectives of the program and emphasize human diversity, and provision of school psychology services that result in direct, measurable, and children, families, schools, and/or other consumers;

4. inclusion of both formative and summative performance-based evaluations of interns that are completed by both program faculty and field-based supervisors, are systematic and comprehensive, and insure that interns demonstrate professional work characteristics and attain competencies needed for effective practice as school psychologists;

5. a minimum of 1200 clock hours, including a minimum of 600 hours of the internship completed in a school-based setting;

6. at least nine-month internship under the supervision of a certified school psychologist in a school setting or by a licensed psychologist in a community setting;

7. completion in settings relevant to program objectives for intern competencies and direct oversight by the program to ensure appropriateness of the placement, activities, supervision, and collaboration with the placement sites and intern supervisors;

8. provision of field-based supervision from a school psychologist holding the appropriate state school psychologist credential for practice in a school setting or, if

in an a program approved alternative setting, field-based supervision from a psychologist holding the appropriate state psychology credential for practice in the internship setting;

9. an average of at least two hours of field-based supervision per full-time week or the equivalent for part-time placements; and

10. a written plan specifying collaborative responsibilities of the school psychology program and internship site in providing supervision and support ensuring that internship objectives are achieved.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§404. Program Requirements—Foreign Programs

A. Graduates of foreign programs will be evaluated according to the following:

1. graduates of foreign programs must meet the substantial criteria in §401.D above;

2. applicants for specialist licensure whose applications are based on graduation from foreign universities shall provide the board with such documents and evidence to establish that their formal education is equivalent to specialist-level training in an NASP-approved program granted by a United States university that is regionally accredited. The applicant must provide the following:

a. an original diploma or other certificate of graduation, which will be returned, and a photostatic copy such a document, which will be retained;

b. a transcript or comparable document of all course work completed;

c. a certified translation of all documents submitted in a language other than English;

d. satisfactory evidence of supervised experiences; and

e. a statement prepared by the applicant based on the documents referred to in the Section, indicating the chronological sequence of studies. The format of this statement shall be comparable as possible to a transcript issued by United States universities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 5. Limits in Practice

§ SECTION NAME AND NUMBER OMITTED

A. Licensed specialists in school psychology shall apply their knowledge of both psychology and education to render services that are germane to the current state educational bulletins, including but not limited to Louisiana Bulletins 1508 and 1706.

B. A licensed specialist in school psychology cannot diagnose mental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders or disease as defined by the International Classification of Diseases.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 6. Supervision

§601. Supervisor/Supervisee Relationship

A. A licensed specialist in school psychology may contract with and work outside of the school system under the clinical supervision of a licensed psychologist or medical psychologist licensed in accordance with R.S. 37:1360.51 et seq.

B. The supervising psychologist shall be administratively, clinically and legally responsible for all professional activities of the licensed specialist in school psychology. This means that the supervisor must be available to the supervisee at the point of decision-making. The supervisor shall also be available for emergency consultation and intervention.

C. The supervising psychologist shall have demonstrated competency and continue maintenance of competency in the specific area of practice in which supervision is being given.

D. The supervising psychologist shall be required to sign any final reports prepared by the licensed specialist in school psychology.

E. The supervising psychologist is responsible for the representation to the public of services, and the supervisor/supervisee relationship.

F. All clients shall be informed of the supervisory relationship, to whatever extent is necessary to ensure the client to understand, the supervisory status and other specific information as to the supervisee's qualifications and functions.

G. The supervising psychologist is responsible for the maintenance of information and files relevant to the client. The client shall be fully informed, to whatever extent is necessary that ensures the client understands that the supervising psychologist is to be the source of access to this information.

H. An ongoing record of supervision shall be created and maintained which adequately documents activities occurring under the supervision of the supervising psychologist.

I. Failure and/or neglect in maintaining the above standards of practice may result in disciplinary action of the licensed specialist in school psychology and/or the licensed psychologist/medical psychologist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§602. Qualifications of Supervisors

A. A supervising psychologist must at least be licensed for one full year prior to entering into a supervision relationship with a licensed specialist in school psychology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§603. Amount of Supervisory Contact

A. The purpose of this Section is to set the minimum standard of one hour per week for general professional supervision.

B. Supervision is to be conducted on a one-on-one, face-to-face basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§604. Supervision of Graduate Students and Graduates in Specialist-Level School Psychology

A. A licensed specialist in school psychology may supervise graduate students and graduates if they have been licensed for a minimum of one year and supervise no more than a total of two individuals at the same time.

B. Graduate students and graduates providing services must be under the direct and continuing professional supervision of a licensed specialist in school psychology.

C. In order to maintain ultimate legal and professional responsibility for the welfare of every client, a licensed specialist in school psychology must be vested with functional authority over the services provided by graduate students or graduates.

D. Supervisors shall have sufficient contact with clients, and must be empowered to contact any client in order to plan effective and appropriate services and to define procedures. They shall be available for emergency consultation and intervention.

E. Work assignments shall be commensurate with the skills of the graduate student or graduates. All work and procedures shall be planned in consultation with the supervisor.

F. In the case of prolonged illness or absence, the supervisor should designate another licensed specialist in school psychology to perform as full supervisor with all of the responsibilities of the original supervisor. All legal and professional liability shall transfer to the temporary supervisor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 7. Examinations

§701. NAME OF SECTION OMITTED

A. A licensed specialist in school psychology must have successfully taken and passed the Praxis Series school psychologist exam as constructed by the National Association of School Psychology. The acceptable passing rate for state licensure is the passing rate established by the National Association of School Psychology.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§702. NAME OF SECTION OMITTED

A. A licensed specialist in school psychology must demonstrate professional knowledge of laws and rules regarding the practice of psychology in Louisiana prior to the issuance of a license by successfully taking and passing a Jurisprudence examination developed by and issued by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 8. Fees

§801. Licensing and Administrative Fees

A. Licensing Fees

Licensing Fees:	
Application for Licensure	\$200
Jurisprudence Examination	\$75
Annual License Renewal	\$100
Reinstatement of Lapsed License	\$300
Criminal Background Check	\$50

B. Administrative Fees

Administrative Fees:	
Address List	\$100
Licensure Verification	\$15
Replacement License/Certificate	\$15
Disciplinary Action Documents	\$25

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:
Chapter 9. Renewal Requirements for Licensed Specialists in School Psychology

§901. Renewal Process

A. A licensed specialist in school psychology shall renew their current license every year by July 31 beginning in July 2015. The renewal period shall open in May and will close July 31 annually. The licensed specialist in school psychology must submit the required renewal forms, renewal fee and proof of fulfillment of all continuing education requirements as approved by the board.

B. A license may be valid for one year beginning August 1 through July 31 for each renewal period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§902. Noncompliance—Renewal Process

A. Noncompliance shall include, in part, incomplete forms, unsigned forms, failure to file all of the required renewal forms by July 31, failure to postmark the renewal package by July 31 and failure to report a sufficient number of acceptable continuing education credits as determined by the board.

B. If the license is not renewed by the end of July, due notice having been given, the license shall be regarded as lapsed effective August 1. An individual shall not practice as licensed specialist in school psychology in Louisiana while the license is lapsed.

C. A lapsed license may be reinstated, at the approval of the board, if all applicable requirements have been met, along with payment of the reinstatement fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§903. Extensions/Exemptions—Renewal Process

A. The board may grant requests for renewal extensions or exemptions on a case-by-case basis. All requests must be made in writing, submitted via U.S. mail, to the board office and shall be reviewed at the next regularly scheduled board meeting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 10. Continuing Education Requirements of Licensed Specialist in School Psychology

§1001. General Requirements

A. Pursuant to R.S. 37:2357 each licensed specialist in school psychology is required to complete continuing education hours within biennial reporting periods. Continuing education is an ongoing process consisting of learning activities that increase professional development.

1. Each licensed specialist in school psychology is required to complete 50 hours of credit of continuing education within the biennial reporting period beginning in July 2015.

2. Two of the above 50 hours of credit of continuing education must be in the areas of ethics or law.

3. Within each reporting period, LSSPs must earn credits in at least two of the nine categories listed under §1002.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§1002. Categories and Calculation of Credits Earned

A. Workshops, Conferences, In-Service Training. This category is defined by professional development activities that involve opportunities for direct instruction and interaction. It includes seminars, workshops, real-time webcasts, and distance learning programs with interactive capabilities. One hour of participation: 1 credit. Required documentation: Certificate of attendance.

B. College and University Coursework. This category includes all college or university credit, including both onsite and distance learning courses. One semester hour: 15 credits (e.g., 3 credit course = 45 credits) One quarter hour: 10 credits. Required documentation: Official college or university transcript.

C. Training and In-Service Activities. Credit may be claimed once for development and presentation of new workshops or in-service training activities. One hour of participation: 1 credit. Maximum credit: 30 credits. Required documentation: Program flyer or syllabus. The hours of credit, date of training, and sponsor must be included in the documentation.

D. Research and Publications—Research and Contribution to the Professional Knowledge. To claim credit in this category, it is necessary for the participant to reasonably estimate the amount of time spent and claim those actual hours up to the maximum specified. Maximum credit: 25 credits total; Empirical research: Up to 10 credits per project; Professional publication: Up to 5 credits per project Required documentation: Board-approved form.

E. Supervision of Graduate Students. Field supervisors of school psychology interns should consider the extent to which this activity leads to professional growth on the part of the supervisor. Supervision of one intern for one academic year: Up to 10 credits. Supervision of one practicum student per semester: Up to 5 credits. Maximum credit: 20 CPD credits Required documentation board-approved form.

F. Supervised Experience. Supervised experiences that occur as part of a planned and sequential program on the job or in settings outside the licensed specialist in school psychology's regular job setting. For credit, the supervised experience should lead to professional growth and new knowledge and skills. One hour per month: Up to 10 credits;

Two hours per month: Up to 20 credits; Maximum credits: 20 CPD credits. Required documentation: Board-approved form.

G. Program Planning/Evaluation. Credit for program planning and evaluation may be claimed when planning, implementing, and evaluating a new program, but not for maintenance and evaluation of an ongoing program. One hour of participation: 1 credit. Maximum credits: Maximum of 25 CPD credits. Required Documentation: Board-approved form.

H. Self-Study

1. Two types of self-study are valid for CPD credit.

a. Formal structured programs are self study programs developed and published to provide training in specific knowledge or skill areas, including, for example, NASP online modules. A test is typically given at the end of the program and often a certificate of completion is issued. This could also include a course taken on the internet.

b. Informal self-study involves systematically studying a topic of interest by reviewing the literature and becoming familiar with the available resources. Included in this category are the reading of books, journals, and manuals.

2. One hour of participation in either type: 1 credit. Maximum credits: 25 credits. Required documentation: Certificate of completion.

I. Professional Organization Leadership. A licensed specialist in school psychology may earn credit for holding a position in a local, state, or national professional school psychology organization. Officer, board position, committee chair: 5 CPD credits per position. Maximum credit: A maximum of 5 credits are allowed every two years. Required documentation: Verification form approved by the board.

AUTHORITY NOTE Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§1003. Acceptable Sponsors, Offerings and Activities

A. The board will recognize the following as fulfilling the continuing education requirements:

1. accredited institutions of higher education;
2. hospitals which have approved regional medical continuing education centers;
3. hospitals which have APA-approved doctoral training internship programs;
4. national, regional, or state professional associations or divisions of such associations, which specifically offer or approve graduate or post doctoral continuing education training;
5. National Association of School Psychologists (NASP)-approved sponsors and activities offered by NASP;
6. activities sponsored by the Board of Examiners of Psychologists; and
7. activities sponsored by the Louisiana Department of Health and Hospitals, its subordinate units, and approved by the chief psychologist of the sponsoring state office.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§1004. Reporting Requirements

A. Each licensed specialist in school psychology shall complete the continuing education report provided by the

board. By signing the report form, the licensee signifies that the report is true and accurate.

B. Licensees shall retain corroborative documentation of their continuing education for six years.

1. The board may, at its discretion, request such documentation. Any misrepresentation of continuing education will be cause for disciplinary action by the board.

2. Licensed specialists in school psychology holding even-numbered licenses must submit to the board, in even-numbered years, their continuing education report along with renewal form and fee. Licensed specialists in school psychology holding odd-numbered licenses must submit to the board, in odd-numbered years, their continuing education report along with renewal form and fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§1005. Extensions/Exemptions

A. Licensed specialists in school psychology on extended military leave outside of the state of Louisiana during the applicable reporting period and who do not engage in delivering psychological services within the state of Louisiana may be granted an extension or an exemption if the board receives timely notice.

B. Licensed specialists in school psychology who are unable to fulfill the requirement because of illness or other personal hardship may be granted an exemption if timely confirmation of such status is received by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§1006. Noncompliance

A. Noncompliance shall include, in part, incomplete forms, unsigned forms, failure to file a renewal form, failure to pay the appropriate renewal fee, failure to report a sufficient number of accepted continuing education credits as determined by the board.

B. Failure to fulfill the requirements of continuing education rule shall cause the license to lapse.

C. If the licensee fails to meet continuing education requirements by the appropriate date, the license shall be regarded as lapsed beginning August 1 of the year for which the licensee is seeking renewal.

D. The board shall serve written notice of noncompliance on a licensee determined to be in noncompliance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§1007. Reinstatement

A. For a period of two years from the date of lapse of the license, the license may be renewed upon proof of fulfilling all continuing education requirements applicable through the date of reinstatement and upon payment of a fee equivalent to the application fee and a renewal fee.

B. After a period of two years from the date of lapse of the license, passing a new jurisprudence examination and payment of a fee equivalent to the application fee and renewal fee may renew the license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 11. Contact Information

§ SECTION NAME AND NUMBER OMITTED

A. A licensed specialist in school psychology shall notify the board within 30 calendar days, with documentation, attesting to any change of mailing/home address, and email address. The documentation notice shall include the LSSP's full name, license number, and the old and new information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 12. Ethical Standards for Licensed Specialists in School Psychology

§1201. Ethical Principles and Code of Conduct

A. The board incorporates by reference and maintains that the licensed specialists in school psychology shall follow the current version of NASP's Principles for Professional Ethics.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 13. Public Information

§1301. Public Display of License

A. The license of the specialist shall be publicly displayed in the office where services are offered. The LSSP shall provide a copy of the license in any setting in which they work.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2357.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Kelly Parker
Executive Director

1411#004

DECLARATION OF EMERGENCY

**Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Behavioral Health**

Behavioral Health Services
Statewide Management Organization
LaCHIP Affordable Plan Benefits Administration
(LAC 50:XXXIII.103)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health amend LAC 50:XXXIII.103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions to implement a coordinated behavioral health services system under the

Louisiana Medicaid Program to provide services through the utilization of a statewide management organization that is responsible for the necessary administrative and operational functions to ensure adequate coordination and delivery of behavioral health services (*Louisiana Register*, Volume 38, Number 2).

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health promulgated an Emergency Rule which amended the February 2012 Rule in order to include the administration of behavioral health services covered under the LaCHIP Affordable Plan (phase 5) (*Louisiana Register*, Volume 38, Number 12). LaCHIP Affordable Plan benefits, including behavioral health services, were administered by the Office of Group Benefits. The administration of these services was transferred to the statewide management organization under the Louisiana Behavioral Health Partnership. The department promulgated an Emergency Rule which amended the provisions of the January 1, 2013 Emergency Rule in order to revise recipient coverage under the LaCHIP Affordable Plan (*Louisiana Register*, Volume 40, Number 7). This Emergency Rule is being promulgated in order to continue the provisions of the August 1, 2014 Emergency Rule. This action is being taken to avoid a budget deficit in the medical assistance programs, and to promote the health and welfare of LaCHIP Affordable Plan recipients.

Effective November 30, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing behavioral health services coordinated by the statewide management organization.

Title 50

**PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services**

Subpart 1. Statewide Management Organization

Chapter 1. General Provisions

§103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in the coordinated behavioral health system of care:

1. - 6. ...
7. title XXI SCHIP populations, including:
 - a. LaCHIP phases 1 - 4; and
 - b. LaCHIP Affordable Plan (phase 5);
8. recipients who receive both Medicare and Medicaid benefits; and
9. recipients enrolled in the LaMOMS program.

B. ...

C. Notwithstanding the provisions of §103.A above, the following Medicaid recipients are excluded from enrollment in the PIHP/SMO:

1. recipients enrolled in the Medicare beneficiary programs (QMB, SLMB, QDWI and QI-1);
2. adults who reside in an intermediate care facility for persons with developmental disabilities (ICF/DD);
3. recipients of refugee cash assistance;
4. recipients enrolled in the Regular Medically Needy Program;
5. recipients enrolled in the Tuberculosis Infected Individual Program;
6. recipients who receive emergency services only coverage;

7. recipients who receive services through the Program of All-Inclusive Care for the Elderly (PACE);

8. recipients enrolled in the Low Income Subsidy Program;

9. participants in the TAKE CHARGE family planning waiver; and

10. recipients enrolled in the LaMOMS Program.

11. - 12. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#066

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Coordinated Care Network
Physician Services
Reimbursement Methodology
(LAC 50:I.3307 and 3509)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:I.3307 and §3509 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions which implemented a coordinated system of care in the Medicaid Program designed to improve quality of care and health care outcomes through a healthcare delivery system called coordinated care networks, also known as the BAYOU HEALTH Program (*Louisiana Register*, Volume 37, Number 6).

The Patient Protection and Affordable Care Act (PPACA) requires states to reimburse certain physician services (if they were covered) at an increased rate. In compliance with PPACA and federal regulations, the department promulgated an Emergency Rule which amended the provisions

governing the reimbursement methodology for physician services rendered by health plans in the coordinated care networks to increase the reimbursement rates (*Louisiana Register*, Volume 39, Number 1).

The department promulgated an Emergency Rule which amended the provisions of the January 1, 2013 Emergency Rule to revise the formatting of these provisions in order to ensure that the provisions are appropriately incorporated into the *Louisiana Administrative Code* (*Louisiana Register*, Volume 40, Number 8).

The department has now determined that it is necessary to amend the provisions of the August 20, 2014 Emergency Rule to correct an error in the formatting of these provisions. This action is being taken to avoid federal sanctions and to secure enhanced federal funding.

Effective November 20, 2014 the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions of the August 20, 2014 Emergency Rule governing the reimbursement methodology for physician services rendered by health plans in the coordinated care networks.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE

Part I. Administration

Subpart 3. Medicaid Coordinated Care

Chapter 33. Coordinated Care Network Shared Savings Model

§3307. Reimbursement Methodology

A. - F.3.I. ...

m. durable medical equipment and supplies;

n. orthotics and prosthetics; and

o. payments made to providers for purposes of complying with section 1932(f) of the Social Security Act and 42 CFR 438.6(c)(5)(vi).

4. - 8. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1581 (June 2011), amended LR 40:

Chapter 35. Coordinated Care Network Managed Care Organization Model

§3509. Reimbursement Methodology

A. - A.5. ...

6. A CCN-P shall be reimbursed payments in order to comply with Section 1932(f) of the Social Security Act and 42 CFR 439.6(c)(5)(vi) on a quarterly basis or other period specified by DHH.

a. For calendar years 2013 and 2014 the CCN-P shall make payments to designated physicians consistent with 42 CFR Part 447, Subpart G, at least equal to the amounts set forth and required under Part 447, Subpart G, and the provisions of this Chapter, consistent with 42 CFR 438.5 and 438.804 as approved by CMS and as specified in the terms and conditions of the contract between DHH and the CCN-P.

B. - J.1. ...

2. For calendar years 2013 and 2014, the CCN-P shall make payments to designated physicians consistent with 42 CFR Part 447, Subpart G, at least equal to the amounts set forth and required under Part 447, Subpart G, and the provisions of this Chapter, as specified in the terms and conditions of the contract between DHH and the CCN-P. The

CCN-P shall also provide documentation to the state sufficient to enable the state and CMS to ensure that provider payments increase as required by paragraph 42 CFR 438.6(c)(5)(vi)(A) of this Section.

a. The term *member* shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served.

3. The CCN-P may enter into alternative payment arrangements with its network providers or potential providers with prior approval by the department.

a. The CCN-P shall not enter into alternative payment arrangements with federally qualified health centers or rural health clinics as the CCN-P is required to reimburse these providers according to the published FQHC/RHC Medicaid prospective payment schedule rate in effect on the date of service, whichever is applicable.

K. - N.2.a. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1587 (June 2011), amended LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#061

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Facility Need Review
(LAC 48:I.12501 and 12525)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 48:I.12501 and §12525 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2116. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the facility need review (FNR) process to adopt provisions governing the inclusion of outpatient abortion facilities in the FNR Program (*Louisiana Register*, Volume 38, Number 8). The department now proposes to amend the provisions governing the FNR Program in order to revise the definition for home and community-based service providers to include monitored in-home caregiving (MIHC) services, and to revise the provisions governing the service area for adult day health care providers.

This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation in the FNR Program. It is estimated that implementation of this Emergency Rule will have no programmatic costs for state fiscal year 2014-2015.

Effective November 20, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the Facility Need Review Program.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 5. Health Planning

Chapter 125. Facility Need Review

Subchapter A. General Provisions

§12501. Definitions

A. ...

Home and Community Based Service (HCBS) Providers—those agencies, institutions, societies, corporations, facilities, person or persons, or any other group intending to provide or providing respite care services, personal care attendant (PCA) services, supervised independent living (SIL) services, monitored in-home caregiving (MIHC) services, or any combination of services thereof, including respite providers, SIL providers, MIHC providers, and PCA providers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004), LR 32:845 (May 2006), LR 34:2611 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2437 (November 2009), amended LR 36:323 (February 2010), LR 38:1961 (August 2012), LR 40:

Subchapter B. Determination of Bed, Unit, Facility, or Agency Need

§12525. Adult Day Health Care Providers

A. ...

B. For purposes of facility need review, the service area for a proposed ADHC provider shall be within a 30 mile radius of the proposed physical address where the provider will be licensed.

C. - E.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:323 (February 2010), amended LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency

Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#062

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Home and Community-Based Services Providers
Licensing Standards
(LAC 48:I.Chapters 50 and 51)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 48:I.Chapter 50 and adopts Chapter 51 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2120.2. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the licensing standards for Home and Community Based Services (HCBS) providers to revise the definitions and the staffing qualifications (*Louisiana Register*, Volume 40, Number 5).

The department now proposes to amend the provisions governing the licensing standards for HCBS providers to clarify these provisions and to include licensing provisions for monitored in-home caregiving services. This action is being taken to protect the health and welfare of Louisiana citizens who depend on services rendered by HCBS providers. It is anticipated that implementation of this Emergency Rule will have no fiscal impact to the Medicaid Program in state fiscal year 2014-2015.

Effective November 20, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the licensing standards for HCBS providers.

Title 48

PUBLIC HEALTH—GENERAL

Part 1. General Administration

Subpart 3. Licensing and Certification

Chapter 50. Home and Community-Based Services Providers Licensing Standards

Subchapter A. General Provisions

§5001. Introduction

A. - B. ...

C. Providers of the following services shall be licensed under the HCBS license:

1. - 5. ...

6. supervised independent living (SIL), including the shared living conversion services in a waiver home;

7. supported employment; and

8. monitored in-home caregiving (MIHC).

D. The following entities shall be exempt from the licensure requirements for HCBS providers:

1. - 4. ...

5. any person who is employed as part of a Department of Health and Hospitals' authorized self-direction program; and

a. For purposes of these provisions, a self-direction program shall be defined as a service delivery option based upon the principle of self-determination. The program enables clients and/or their authorized representative(s) to become the employer of the people they choose to hire to provide supports to them.

6. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:63 (January 2012), amended LR 38:1410 (June 2012), LR 40:1007 (May 2014), LR 40:

§5003. Definitions

Monitored In-Home Caregiving—services provided by a principal caregiver to a client who lives in a private unlicensed residence. The principal caregiver shall reside with the client, and shall be contracted by the licensed HCBS provider having a MIHC service module.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:64 (January 2012), amended LR 40:1007 (May 2014), LR 40:

§5005. Licensure Requirements

A. - B.8. ...

C. An HCBS provider shall provide only those home and community-based services or modules:

1. specified on its license; and

2. only to clients residing in the provider's designated service area, DHH Region, or at the provider's licensed location.

D. - J.1.Example ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:65 (January 2012), amended LR 40:

§5007. Initial Licensure Application Process

A. ...

B. The initial licensing application packet shall include:

1. - 9. ...

10. any other documentation or information required by the department for licensure including, but not limited to, a copy of the facility need review approval letter.

C. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:66 (January 2012), amended LR 40:

Subchapter D. Service Delivery

§5043. Contract Services

A. ...

B. When services are provided through contract, a written contract must be established. The contract shall include all of the following items:

1. - 4. ...

5. a statement that the person contracted shall meet the same qualifications and training requirements as the position being contracted;

B.5.a. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:77 (January 2012), amended LR 40:

Subchapter F. Provider Responsibilities

§5055. Core Staffing Requirements

A. - D.4. ...

E. Direct Care Staff

1. ...

2. The provider shall employ, either directly or through contract, direct care staff to ensure the provision of home and community-based services as required by the ISP.

E.3. - M.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:79 (January 2012), amended LR: 40:1001 (May 2014), LR 40:

Chapter 51. Home and Community-Based Services Providers

Subchapter N. Monitored In-Home Caregiving Module

§5101. General Provisions

A. Monitored in-home caregiving (MIHC) services are provided by a principal caregiver to a client who lives in a private unlicensed residence.

1. The principal caregiver shall:

a. be contracted by the licensed HCBS provider having a MIHC service module; and

b. reside with the client.

2. Professional staff employed by the HCBS provider shall provide oversight, support, and monitoring of the principal caregiver, service delivery, and client outcomes through on-site visits, training, and daily web-based electronic information exchange.

B. Providers applying for the Monitored In-Home Caregiving module under the HCBS license shall meet the core licensing requirements (except those set forth in §5005.B.4, §5005.C. and §5007.F.1.c) and the module specific requirements of this Section.

C. During any survey or investigation of the HCBS provider with the MIHC module conducted by the DHH-HSS, the survey process begins once the surveyor enters either the client's place of residence or the provider's licensed place of business. When the survey begins at the client's residence, the provider shall transmit any records requested by the HSS surveyor within two hours of such request to the location as designated by the HSS surveyor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§5103. Staffing Requirements, Qualifications, and Duties

A. The MIHC provider shall employ a registered nurse (RN) and a care manager who will monitor all clients served. The RN or the care manager may also serve as the administrator if he/she meets the requirements as set forth in §5055.A.1.

B. The HCBS provider with a MIHC module shall contract with at least one principal caregiver for each client served.

1. The principal caregiver shall:

a. serve only one client at any time; and

b. be able to provide sufficient time to the client as required to provide the care in accordance with the ISP.

2. Prior to MIHC services being provided to the client, the HCBS provider shall perform an assessment of the client's ability to be temporarily unattended by the principal caregiver and determine how the client will manage safely in the qualified setting without the continuous presence of a principal caregiver.

C. The MIHC registered nurse shall:

1. be licensed and in good standing with the Louisiana State Board of Nursing; and

2. have at least two years' experience in providing care to the elderly or to adults with disabilities.

D. The responsibilities of the registered nurse include:

1. participating in the determination of the qualified setting for MIHC services, based on on-site assessment of the premises;

2. ensuring that the client's applicable health care records are available and updated as deemed necessary;

3. developing, in collaboration with the care manager, client and principal caregiver, the client's Person-centered ISP, based upon assessment of the client and medical information gathered or provided;

4. periodically reviewing and updating, at least annually, each client's ISP;

5. certifying, training, and evaluating principal caregivers in conjunction with the care manager;

6. monitoring, through daily review of electronic client progress notes, observation of at-home visits, and by documented consultations with other involved professionals, the status of all clients to ensure that MIHC services are delivered in accordance with the ISP;

7. conducting on-site visits with each client at the qualified setting at least every other month or more often as deemed necessary by the client's health status;

8. completing a nursing progress note corresponding with each on-site visit or more often as deemed necessary by the client's health status; and

9. planning for, and implementing, discharges of clients from MIHC services relative to if the health care needs of the client can be met in the qualified setting.

E. MIHC Care Manager Qualifications

1. The MIHC care manager shall meet one of the following requirements:

a. possess a bachelor's or master's degree in social work from a program accredited by the Council on Social Work Education;

b. possess a bachelor's or master's degree in nursing (RN) currently licensed in Louisiana (one year of experience as a licensed RN will substitute for the degree);

c. possess a bachelor's or master's degree in a human service related field which includes:

i. psychology;

ii. education;

iii. counseling;

iv. social services;

- v. sociology;
- vi. philosophy;
- vii. family and participant sciences;
- viii. criminal justice;
- ix. rehabilitation services;
- x. substance abuse treatment;
- xi. gerontology; or
- xii. vocational rehabilitation; or

d. possess a bachelor's degree in liberal arts or general studies with a concentration of at least 16 hours in one of the fields in §5103.E.1.c.i-xii.

2. The MIHC care manager shall have at least two years' experience in providing care to the elderly or to adults with disabilities.

3. The MIHC care manager may serve as the administrator of the HCBS provider; however, any such individual that serves as both administrator and care manager shall meet both sets of minimum qualifications and have the ability to service both sets of specified functions.

F. Care Manager Responsibilities. The following responsibilities of the care manager for the MIHC module shall substitute for the requirements in §5055.I and §5055.J. The responsibilities of the MIHC care manager shall include:

1. conducting the initial and ongoing assessment and determination of the qualified setting;

2. certifying, training, and evaluating principal caregivers in conjunction with the registered nurse;

3. developing, in collaboration with the registered nurse, an ISP for delivery of MIHC services for each client, based upon assessment and medical information gathered or provided;

4. monitoring, in collaboration with the registered nurse, through daily review of electronic client progress notes, and observation of at-home visits, the status of all clients to ensure that all MIHC services are delivered;

5. conducting on-site visits with each client at the qualified setting every other month or more often as deemed necessary by the client's health status;

6. completing a care management client progress note corresponding with each on-site visit every other month or more often as the client's condition warrants;

7. assisting with obtaining information and accessing other health-care and community services in accordance with the ISP;

8. reviewing and documenting the fire and safety procedures for the qualified setting;

9. providing training related to MIHC services for each principal caregiver before the principal caregiver begins to provide care;

10. participating in discharge planning of clients from monitored in-home care services by determining if the needs of the client can be met safely in the qualified setting;

11. reviewing and documenting that the qualified setting continues to meet the needs of the client, in accordance with the ISP, at every on-site visit and as situations change; and

12. being readily accessible and available to the principal caregivers either by telephone or other means of prompt communication.

a. The care manager shall maintain a file on each principal caregiver which shall include documentation of

each principal caregiver's performance during the care manager's bimonthly on-site visit and more often as caregiver's performance warrants.

G. MIHC Principal caregiver Qualifications. The following principal caregiver qualifications under the MIHC module shall substitute for the requirements in §5055.F.

1. The principal caregiver shall be certified by the HCBS provider before serving a client.

2. In order to be certified, the principal caregiver applicant shall:

a. participate in all required orientations, trainings, monitoring, and corrective actions required by the HCBS provider;

b. have a criminal background check conducted by the HCBS provider in accordance with the applicable state laws;

c. comply with the provisions of R.S. 40:2179-2179.2 and the rules regarding the Direct Service Worker Registry;

d. be at least 21 years of age and have a high school diploma or equivalent;

e. have the ability to read, write, and carry out directions competently as assigned; and

f. be trained in recognizing and responding to medical emergencies of clients.

3. To maintain certification, the principal caregiver shall reside in the state of Louisiana and shall provide MIHC services in a qualified setting located in Louisiana.

H. MIHC Principal caregiver Responsibilities. The following principal caregiver responsibilities under the MIHC module shall substitute for the responsibilities in §5055.G. The responsibilities of the principal caregiver shall include:

1. supervision and assistance with personal care services for the client that is necessary for his/her health, safety and well-being in accordance with the ISP;

2. monitoring and reporting any non-urgent or nonemergency changes in the client's medical condition to the HCBS care manager;

3. promptly reporting and communicating a client's request for services or change in services to the care manager;

4. maintaining the qualified setting consistent with the criteria noted herein;

5. completing and submitting to the HCBS agency an electronic client progress note daily;

6. providing ongoing supervision of health-related activities, including, but not limited to:

a. reminding the client about prescribed medications;

b. ensuring that the client's prescriptions are refilled timely;

c. transporting or arranging for client transportation to medical and other appointments;

d. assisting the client to comply with health care instructions from health care providers, including but not limited to, dietary restrictions;

e. recognizing and promptly arranging for needed urgent medical care by activating the 911 call system;

f. notifying the care manager of the need for alternative care of the client;

g. immediately reporting any suspected abuse, neglect, or exploitation of a client to the HCBS care manager, as well as timely reporting any suspected abuse, neglect, or exploitation of a client to any other persons required by law to receive such notice;

h. immediately notifying the care manager when any of the following events occur:

- i. death of a client;
- ii. a medical emergency or any significant change in a client's health or functioning;
- iii. a fire, accident, and/or injury that requires medical treatment or the medical diagnosis of a reportable communicable disease of the client and/or principal caregiver;
- iv. any planned or unexpected departure from the residence by a client or principal caregiver; and
- v. all other client or principal caregiver major incidents or accidents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§5105. Operational Requirements for Monitored

In-Home Caregiving

A. Training. The following requirements for training and competency for the MIHC module shall substitute for the training and competency requirements in §5055.K, §5055.L, and §5055.M.

1. Prior to the principal caregiver providing MIHC services to a client, the HCBS provider shall ensure that the principal caregiver satisfactorily completes documented training in the following areas:

- a. the client's support needs in accordance with the ISP, including the following:
 - i. medical and behavioral diagnoses;
 - ii. medical and behavioral health history;
 - iii. required ADLs and IADLs;
 - iv. management of aggressive behaviors, including acceptable and prohibited responses; and
 - v. any other pertinent information.
- b. completion and transmission of the daily electronic client progress note;
- c. emergency and safety procedures, including the HCBS provider's fire, safety, and disaster plans;
 - i. this training shall include recognizing and responding to medical emergencies or other emergencies that require an immediate call to 911;
 - ii. detection and reporting suspected abuse, neglect and exploitation, including training on the written policies and procedures of the HCBS provider regarding these areas;
- d. written policies and procedures of the HCBS provider including, but not limited to:
 - i. documentation and provider's reporting requirements;
 - ii. infection control;
 - iii. safety and maintenance of the qualified setting;
 - iv. assistance with medication(s);
 - v. assistance with ADLs and IADLs;
 - vi. transportation of clients; and
 - vii. client rights and privacy;
- e. confidentiality;
- f. detecting signs of illness or dysfunction that warrant medical or nursing intervention; and

h. the roles and responsibilities of the HCBS staff and the principal caregiver.

2. The HCBS provider shall ensure that each principal caregiver satisfactorily completes a basic first aid course within 45 days of hire.

B. Transmission of Information

1. The HCBS provider shall use secure, web-based information collection from principal caregivers for the purposes of monitoring client health and principal caregiver performance.

2. All protected health information shall be transferred, stored, and utilized in compliance with applicable federal and state privacy laws.

3. HCBS providers shall sign, maintain on file, and comply with the most current DHH HIPAA Business Associate Addendum.

C. Monitoring. The HCBS provider shall provide ongoing monitoring of the client and the performance of the principal caregiver in accordance with the ISP. Ongoing monitoring shall consist of the following:

1. conducting on-site visits with each client at the qualified setting monthly by either the RN or the care manager in order to monitor the health and safety status of the client and to ensure that all MIHC services are delivered by the principal caregiver in accordance with the ISP;

2. reviewing and documenting at least every other month that the qualified setting meets the needs of the MIHC services to be provided to the client in accordance with the ISP;

3. receiving and reviewing the daily electronic client progress notes to monitor the client's health status and principal caregiver's performance to ensure appropriate and timely follow up;

4. ensuring the competency of the principal caregiver by written or oral exam before providing services and annually; and

5. ensuring that each principal caregiver receives annual training to address the needs of the client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§5107. Qualified Setting Provisions

A. The residence where MIHC services are provided to a client shall be a qualified setting as stipulated herein. The qualified setting determination shall be completed by the HCBS provider as part of the admission process and on an on-going basis as stipulated herein.

B. In order for a setting to be determined qualified for MIHC services, the setting shall meet the following criteria:

1. is a private residence located in Louisiana, occupied by the client and a principal caregiver and shall not be subject to state licensure or certification as a hospital, nursing facility, group home, intermediate care facility for individuals with intellectual disabilities or as an adult residential care provider;

2. is accessible to meet the specific functional, health and mobility needs of the client residing in the qualified setting;

3. is in compliance with local health, fire, safety, occupancy, and state building codes for dwelling units;

4. is equipped with appropriate safety equipment, including, at a minimum, an easily accessible Class ABC fire

extinguisher, smoke and carbon monoxide detectors (which shall be audible in the client's and principal caregiver's sleeping areas when activated);

5. is equipped with heating and refrigeration equipment for client's meals and/or food preparation, e.g. warming or cooling prepared foods;

6. has a bedroom for the client which shall contain a bed unit appropriate to his/her size and specific needs that includes a frame, a mattress, and pillow(s). The

bedroom shall have a closeable door and window coverings to ensure privacy of the client with adequate lighting to provide care in accordance with the ISP;

7. has a closet, permanent or portable, to store clothing or aids to physical functioning, if any, which is readily accessible to the client or the principal caregiver;

8. has a bathroom with functioning indoor plumbing for bathing and toileting with availability of a method to maintain safe water temperatures for bathing;

9. is equipped with functional air temperature controls which maintain an ambient seasonal temperature between 65 and 80 degrees Fahrenheit;

10. is maintained with pest control;

11. is equipped with a 24 hour accessible working telephone and/or other means of communication with health care providers;

12. is equipped with household first aid supplies to treat minor cuts or burns; and

13. as deemed necessary, has secured storage for potentially hazardous items, such as fire arms and ammunition, drugs or poisons.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§5109. Waiver of Module Provisions

A. In its application for a license, or upon renewal of its license, a provider may request a waiver of specific MIHC module licensing provisions.

1. The waiver request shall be submitted to HSS, and shall provide a detailed description as to why the provider is requesting that a certain licensing provision be waived.

2. HSS shall review such waiver request. Upon a good cause showing, HSS, at its discretion, may grant such waiver, provided that the health, safety, and welfare of the client is not deemed to be at risk by such waiver of the provision(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2120.2.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821, or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#063

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing Office of Aging and Adult Services

Home and Community-Based Services Waivers
Community Choices Waiver
(LAC 50:XXI.8329 and 8601)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend LAC 50:XXI.8329 and §8601 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the Community Choices Waiver to add two new waiver services, to incorporate a new service delivery method and to clarify the provisions governing personal assistance services (*Louisiana Register*, Volume 40, Number 4). The department now proposes to amend the provisions governing the Community Choices Waiver in order to clarify the provisions of the April 20, 2014 Rule.

This action is being taken to promote the health and welfare of waiver participants. It is anticipated that the implementation of this Emergency Rule will have no fiscal impact to the Medicaid Program for state fiscal year 2014-2015.

Effective November 20, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend the provisions governing the Community Choices Waiver.

Title 50

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

Subpart 7. Community Choices Waiver

Chapter 83. Covered Services

§8329. Monitored In-Home Caregiving Services

A. Monitored in-home caregiving (MIHC) services are services provided by a principal caregiver to a participant who lives in a private unlicensed residence. The principal caregiver shall be contracted by the licensed HCBS provider having a MIHC service module. The principal caregiver shall reside with the participant. Professional staff employed by the HCBS provider shall provide oversight, support and monitoring of the principal caregiver, service delivery, and participant outcomes through on-site visits, training, and daily, web-based electronic information exchange.

B. - B.6. ...

C. Unless the individual is also the spouse of the participant, the following individuals are prohibited from being paid as a monitored in-home caregiving principal caregiver:

1. - 5. ...

D. Participants electing monitored in-home caregiving services shall not receive the following community choices waiver services during the period of time that the participant is receiving monitored in-home caregiving services:

1. - 3. ...

E. Monitored in-home caregiving providers must be licensed home and community based service providers with a monitored in-home caregiving module who employ professional staff, including a registered nurse and a care manager, to support principal caregivers to perform the direct care activities performed in the home. The agency provider must assess and approve the home in which services will be provided, and shall enter into contractual agreements with caregivers who the agency has approved and trained. The agency provider will pay per diem stipends to caregivers.

F. The MIHC provider must use secure, web-based information collection from principal caregivers for the purposes of monitoring participant health and caregiver performance. All protected health information must be transferred, stored, and otherwise utilized in compliance with applicable federal and state privacy laws. Providers must sign, maintain on file, and comply with the most current DHH HIPAA business associate addendum.

1. - 3. Repealed.

G. ...

1. Monitored in-home caregiving services under tier 1 shall be available to the following resource utilization categories/scores as determined by the MDS-HC assessment:

- a. special rehabilitation 1.21;
- b. special rehabilitation 1.12;
- c. special rehabilitation 1.11;
- d. special care 3.11;
- e. clinically complex 4.31;
- f. clinically complex 4.21;
- g. impaired cognition 5.21;
- h. behavior problems 6.21;
- i. reduced physical function 7.41; and
- j. reduced physical function 7.31.

2. Monitored in-home caregiving services under tier 2 shall be available to the following resource utilization categories/scores as determined by the MDS-HC assessment:

- a. extensive services 2.13;
- b. extensive services 2.12;
- c. extensive services 2.11; and
- d. special care 3.12.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 40:

Chapter 86. Organized Health Care Delivery System

§8601. General Provisions

A. - C. ...

D. Prior to enrollment, an OHCDs must show the ability to provide all of the services available in the Community Choices Waiver on December 1, 2012, with the exceptions of support coordination, transition intensive support

coordination, transition services, environmental accessibility adaptations, and adult day health care if there is no licensed adult day health care provider in the service area.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 40:792 (April 2014), amended LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#064

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Intermediate Care Facilities for Persons
with Intellectual Disabilities
Provider Fee Increase
(LAC 50:VII.32903)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.32903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Due to a budgetary shortfall in state fiscal year 2013, the Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for non-state intermediate care facilities for persons with developmental disabilities (ICFs/DD), hereafter referred to as intermediate care facilities for persons with intellectual disabilities (ICFs/ID), to reduce the per diem rates (*Louisiana Register*, Volume 39, Number 10).

The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for ICFs/ID to increase the add-on amount to the per diem rate for the provider fee (*Louisiana Register*, Volume 40, Number 3). This Emergency Rule is being promulgated in order to continue the provisions of the April 1, 2014 Emergency Rule. This action is being taken to secure new and enhanced funding by increasing revenue collections to the state.

Effective November 29, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for intermediate care facilities for persons with intellectual disabilities to increase the provider fee.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part VII. Long Term Care

Subpart 3. Intermediate Care Facilities for Persons with Intellectual Disabilities

Chapter 329. Reimbursement Methodology

Subchapter A. Non-State Facilities

§32903. Rate Determination

A. - D.4.d. ...

i. Effective for dates of service on or after April 1, 2014, the add-on amount to each ICF/ID's per diem rate for the provider fee shall be increased to \$16.15 per day.

E. - M. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:2253 (September 2005), amended LR 33:462 (March 2007), LR 33:2202 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1555 (July 2010), LR 37:3028 (October 2011), LR 39:1780 (July 2013), LR 39:2766 (October 2013), LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#067

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Medicaid Eligibility
Modified Adjusted Gross Income
(LAC 50:III.2327, 2529, 10307, and 10705)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:III.10705 and adopts §2327, §2529 and §10307 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Section 1004(a)(2) of the Patient Protection and Affordable Care Act (ACA) of 2010 and Section 36B(d)(2)(B) of the *Internal Revenue Code* mandate that Medicaid eligibility use the modified adjusted gross income (MAGI) methodology for eligibility determinations

for certain eligibility groups. In compliance with the ACA and *Internal Revenue Code*, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule to amend the provisions governing Medicaid eligibility to adopt the MAGI eligibility methodology (*Louisiana Register*, Volume 40, Number 1). The department also adopted provisions which allow qualified hospitals to make determinations of presumptive eligibility for individuals who are not currently enrolled in Medicaid.

The department promulgated an Emergency Rule which amended the provisions of the December 31, 2013 Emergency Rule in order to make technical revisions to ensure that these provisions are appropriately promulgated in a clear and concise manner (*Louisiana Register*, Volume 40, Number 4). The provisions governing the MAGI eligibility changes for the State Children's Health Insurance Program were removed from this Emergency Rule and repromulgated independently. This Emergency Rule is being promulgated in order to continue the provisions of the April 20, 2014 Emergency Rule. This action is being taken to avoid federal sanctions.

Effective December 18, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing Medicaid eligibility.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part III. Eligibility

Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2327. Modified Adjusted Gross Income (MAGI) Groups

A. For eligibility determinations effective December 31, 2013 eligibility shall be determined by modified adjusted gross income (MAGI) methodology in accordance with section 1004(a)(2) of the Patient Protection and Affordable Care Act (ACA) of 2010 and section 36B(d)(2)(B) of the *Internal Revenue Code*, for the following groups:

1. parents and caretakers relatives group which includes adult individuals formerly considered for low income families with children as parents or caretaker relatives;
2. pregnant women;
3. child related groups; and
4. other adult related groups including breast and cervical cancer, tuberculosis (TB) and family planning.

B. A MAGI determination will be necessary for each individual in the home for whom coverage is being requested. The MAGI household resembles the tax household.

1. MAGI Household. The individual's relationship to the tax filer and every other household member must be established for budgeting purposes. The MAGI household is constructed based on whether an individual is a:

- a. tax filer;
- b. tax dependent; or
- c. non-filer (neither tax filer or tax dependent).

2. For the tax filer the MAGI household includes the tax filer and all claimed tax dependents.

a. Whether claimed or not, the tax filer's spouse, who lives in the home, must be included.

b. If a child files taxes and is counted as a tax dependent on his/her parent's tax return, the child is classified as a tax dependent not a tax filer.

3. When taxes are filed for the tax dependent the MAGI household consists of the tax filer and all other tax dependents unless one of the following exceptions is met:

a. being claimed as a tax dependent by a tax filer other than a parent or spouse (for example, a grandchild, niece, or tax filer's parent);

b. children living with two parents who do not expect to file a joint tax return (including step-parents); or

c. children claimed as a tax dependent by a non-custodial parent.

4. For individuals who do not file taxes nor expect to be claimed as a tax dependent (non-filer), the MAGI household consists of the following when they all live together:

a. for an adult:

i. the individual's spouse; and

ii. the individual's natural, adopted, and step-children under age 19; and

b. for a minor:

i. the individual's natural, adoptive, or step-parents; and

ii. the individual's natural, adopted, and step-siblings under age 19.

C. Parents and Caretaker Group

1. A caretaker relative is a relative of a dependent child by blood, adoption, or marriage with whom the child is living, and who assumes primary responsibility for the child's care. A caretaker relative must be one of the following:

a. parent;

b. grandparent;

c. sibling;

d. brother-in-law;

e. sister-in-law;

f. step-parent;

g. step-sibling;

h. aunt;

i. uncle;

j. first cousin;

k. niece; or

l. nephew.

2. The spouse of such parents or caretaker relatives may be considered a caretaker relative even after the marriage is terminated by death or divorce.

3. The assistance/benefit unit consists of the parent and/or caretaker relative and the spouse of the parent and/or caretaker relative, if living together, of child(ren) under age 18, or is age 18 and a full-time student in high school or vocational/technical training. Children are considered deprived if income eligibility is met for the parents and caretaker relatives group. Children shall be certified in the appropriate children's category.

D. Pregnant Women Group

1. Eligibility for the pregnant women group may begin:

a. at any time during a pregnancy; and

b. as early as three months prior to the month of application.

2. Eligibility cannot begin before the first month of pregnancy. The pregnant women group certification may extend through the calendar month in which the 60-day postpartum period ends.

3. An applicant/enrollee whose pregnancy terminated in the month of application or in one of the three months prior without a surviving child shall be considered a pregnant woman for the purpose of determining eligibility in the pregnant women group.

4. Certification shall be from the earliest possible month of eligibility (up to three months prior to application) through the month in which the 60-day postpartum period ends.

5. Retroactive eligibility shall be explored regardless of current eligibility status.

a. If the applicant/enrollee is eligible for any of the three prior months, she remains eligible throughout the pregnancy and 60-day postpartum period. When determining retroactive eligibility actual income received in the month of determination shall be used.

b. If application is made after the month the postpartum period ends, the period of eligibility will be retroactive but shall not start more than three months prior to the month of application. The start date of retroactive eligibility is determined by counting back three months prior to the date of application. The start date will be the first day of that month.

6. Eligibility may not extend past the month in which the postpartum period ends.

7. The applicant/enrollee must be income eligible during the initial month of eligibility only. Changes in income after the initial month will not affect eligibility.

E. Child Related Groups

1. Children under Age 19-CHAMP. CHAMP children are under age 19 and meet income and non-financial eligibility criteria. ACA expands mandatory coverage to all children under age 19 with household income at or below 133 percent federal poverty level (FPL). Such children are considered CHAMP children.

2. Children Under Age 19—LaCHIP. A child covered under the Louisiana state Children's Health Insurance Program (LaCHIP) shall:

a. be under age 19;

b. not be eligible for Medicaid under any other optional or mandatory eligibility group or eligible as medically needy (without spend-down liability);

c. not be eligible for Medicaid under the policies in the state's Medicaid plan in effect on April 15, 1997;

d. not have health insurance; and

e. have MAGI-based income at or below 212 percent (217 percent FPL with 5 percent disregard) of the federal poverty level.

3. Children Under Age 19-LaCHIP Affordable Plan. A child covered under the Louisiana state Children's Health Insurance Program (LaCHIP) Affordable Plan shall:

a. be under age 19;

b. not be income eligible for regular LaCHIP;

c. have MAGI-based income that does not exceed 250 percent FPL;

d. not have other insurance or access to the state employees health plan;

e. have been determined eligible for child health assistance under the state Child Health Insurance Plan; and

f. be a child whose custodial parent has not voluntarily dropped the child(ren) from employer sponsored insurance within last three months without good cause. Good cause exceptions to the three month period for dropping employer sponsored insurance are:

- i. lost insurance due to divorce or death of parent;
- ii. lifetime maximum reached;
- iii. COBRA coverage ends (up to 18 months);
- iv. insurance ended due to lay-off or business closure;
- v. changed jobs and new employer does not offer dependent coverage;
- vi. employer no longer provides dependent coverage;
- vii. monthly family premium exceeds 9.5 percent of household income; or
- viii. monthly premium for coverage of the child exceeds 5 percent of household income.

4. Children under Age 19-Phase IV LaCHIP (SCHIP). The state Child Health Insurance Program (SCHIP) provides prenatal care services, from conception to birth, for low income uninsured mothers who are not otherwise eligible for other Medicaid programs, including CHAMP pregnant women benefits. This program, phase IV LaCHIP, also covers non-citizen women who are not qualified for other Medicaid programs due to citizenship status only.

F. Regular and Spend Down Medically Needy MAGI. Regular and spend down medically needy shall use the MAGI determination methodology.

G. Foster Care Children. Foster care children are applicants/enrollees under 26 years of age, who were in foster care under the responsibility of the state at the time of their eighteenth birthday, and are not eligible or enrolled in another mandatory coverage category.

1. Foster care children may also be applicants/enrollees who:
 - a. have lost eligibility due to moving out of state, but re-established Louisiana residency prior to reaching age 26; or
 - b. currently reside in Louisiana, but were in foster care in another state's custody upon reaching age 18.
2. Foster care children must:
 - a. be at least age 18, but under age 26;
 - b. currently lives in Louisiana;
 - c. have been a child in foster care in any state's custody upon reaching age 18; and
 - d. not be eligible for coverage in another mandatory group.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 25. Eligibility Factors

§2529. Hospital Presumptive Eligibility

A. Effective December 31, 2013 any hospital designated by Louisiana Medicaid as a hospital presumptive eligibility qualified provider (HPEQP) may obtain information and determine hospital presumptive eligibility (HPE) for

individuals who are not currently enrolled in Medicaid and who are in need of medical services covered under the state plan.

1. Coverage groups eligible to be considered for hospital presumptive eligibility include:

- a. parents and other caretaker relatives;
- b. pregnant women;
- c. children under age 19;
- d. former foster care children;
- e. family planning; and
- f. certain individuals needing treatment for breast or cervical cancer.

B. Qualified Hospitals. Qualified hospitals shall be designated by the department as entities qualified to make presumptive Medicaid eligibility determinations based on preliminary, self-attested information obtained from individuals seeking medical assistance.

1. A qualified hospital shall:

- a. be enrolled as a Louisiana Medicaid provider under the Medicaid state plan or a Medicaid 1115 demonstration;
- b. not be suspended or excluded from participating in the Medicaid Program;
- c. have submitted a statement of interest in making presumptive eligibility determinations to the department; and
- d. agree to make presumptive eligibility determinations consistent with the state policies and procedures.

C. The qualified hospital shall educate the individuals on the need to complete an application for full Medicaid and shall assist individuals with:

1. completing and submitting the full Medicaid application; and
2. understanding any document requirements as part of the full Medicaid application process.

D. Eligibility Determinations

1. Household composition and countable income for HPE coverage groups are based on modified adjusted gross income (MAGI) methodology.

2. The presumptive eligibility period shall begin on the date the presumptive eligibility determination is made by the qualified provider.

3. The end of the presumptive eligibility period is the earlier of:

- a. the date the eligibility determination for regular Medicaid is made, if an application for regular Medicaid is filed by the last day of the month following the month in which the determination for presumptive eligibility is made; or
- b. the last day of the month following the month in which the determination of presumptive eligibility is made, if no application for regular Medicaid is filed by that date.

4. Those determined eligible for presumptive eligibility shall be limited to no more than one period of eligibility in a 12-month period, starting with the effective date of the initial presumptive eligibility period.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Subpart 5. Financial Eligibility

Chapter 103. Income

§10307. Modified Adjusted Gross Income—(MAGI)

Groups

A. MAGI Related Types of Income

1. Alimony shall be counted as unearned income payments made directly to the household from non-household members.

2. Alien sponsor's income shall be counted against the flat grant needs of the alien's household. If the income of the sponsor is equal to or greater than the flat grant amount for the number of people in the alien parent's family, the alien parent(s) is not eligible for inclusion in his children's Medicaid certification.

3. Business income or loss shall be countable net profit or loss from partnerships, corporations, etc.

4. Capital gain or loss shall be countable income.

5. A child's earned income is counted, except for the tax filer's budget when earnings are below the tax filing threshold.

6. Annual income received under an implied, verbal, or written contract in less than 12 months shall be averaged over the 12-month period it is intended to cover unless the income is received on an hourly or piecework basis.

7. Disability insurance benefits shall count as unearned income. If federal and/or state taxes are deducted, disability insurance benefits shall count as earned income.

8. Dividends shall count as unearned income. Dividends shall be averaged for the period they are intended to cover.

9. Interest, including tax-exempt interest, shall count as unearned income. Interest shall be averaged for the period it is intended to cover.

10. Irregular and unpredictable income shall count as income in the month of receipt. Annual income received under an implied, verbal, or written contract in less than 12 months shall be averaged over the 12-month period it is intended to cover unless the income is received on an hourly or piecework basis.

11. Income received from employment through the Job Training Partnership Act of 1982 (JTPA) program shall be counted as earned income. JTPA income received for training through JTPA program shall be counted as unearned income.

12. A non-recurring cash payment (lump sum) shall count as income only in the calendar month of receipt. This includes insurance settlements, back pay, state tax refunds, inheritance, IRA or other retirement distributions, and retroactive benefit payments.

13. Regular recurring income from oil and land leases shall be counted over the period it is intended to cover and counted as unearned income. Payments received in the first year of an oil lease, which are above the regular recurring rental and payments received when an oil lease is written for only one year, are treated as non-recurring lump sum payments.

14. Pensions and annuities shall count as unearned income.

15. Income is potentially available when the applicant/enrollee has a legal interest in a liquidated sum and has the legal ability to make this sum available for the support and maintenance of the assistance unit. Potential

income shall be counted when it is actually available as well as when it is potentially available but the applicant/enrollee chooses not to receive the income. If the agency representative is unable to determine the amount of benefits available, the application shall be rejected for failure to establish need.

16. Railroad retirement shall count as unearned income the amount of the entitlement including the amount deducted from the check for the Medicare premiums, less any amount that is being recouped for a prior overpayment.

17. Ownership of rental property is considered a self-employment enterprise. Income received from rental property may be earned or unearned. To be counted as earned income, the applicant/enrollee must perform some work related activity. If the applicant/enrollee does not perform work related activity, the money received shall be counted as unearned income. Only allowable expenses associated with producing the income may be deducted. If the income is earned, any other earned income deductions are allowed.

18. The gross amount of retirement benefits, including military retirement benefits, counts as unearned income.

19. Royalties shall count as unearned income. Royalties shall be prorated for the period they are intended to cover.

20. Scholarships, awards, or fellowship grants shall count as unearned income if used for living expenses such as room and board.

21. Seasonal earnings shall count as earned income in the month received. If contractual, such as a bus driver or teacher, the income shall be prorated over the period it is intended to cover. If earnings are self-employment seasonal income, they shall be treated as self-employment income as below in Paragraph 22.

22. Self-employment income is counted as earned income. Self-employment income is income received from an applicant/enrollee's own business, trade, or profession if no federal or state withholding tax or Social Security tax is deducted from his job payment. This may include earnings as a result of participation in Delta Service Corps and farm income.

a. Allowable expenses are those allowed when filing taxes on a schedule C or farm income schedule F.

23. Social Security retirement, survivors and disability insurance benefits (RSDI) shall count as unearned income. The amount counted shall be that of the entitlement including the amount deducted from the check for the Medicare premium, less any amount that is being recouped for a prior overpayment.

24. Income from taxable refunds, credits, or offsets of state and local income taxes if claimed on Form 1040 shall count as unearned income.

25. Income from income trust withdrawals, dividends, or interest which are or could be received by the applicant/enrollee shall count as unearned income.

26. Tutorship funds are any money released by the court to the applicant/enrollee and shall be counted as unearned income.

27. Unemployment compensation benefits (UCB) shall be counted as unearned income in the month of receipt.

28. Taxable gross wages, salaries, tips, and commissions, including paid sick and vacation leave, shall count as earned income. Included as earned income are:

- a. vendor payments made by the employer instead of all or part of the salary;
- b. the cash value of an in-kind item received from an employer instead of all or part of the salary; and
- c. foreign earnings.

29. The following types of income shall not be counted for MAGI budgeting:

- a. adoption assistance;
- b. Agent Orange settlement payments;
- c. American Indian and Native American claims and lands and income distributed from such ownership;
- d. Census Bureau earnings;
- e. child support payments received for anyone in the home;
- f. contributions from tax-exempt organizations;
- g. disaster payments;
- h. Domestic Volunteer Service Act;
- i. earned income credits;
- j. educational loans;
- k. energy assistance;
- l. foster care payments;
- m. Housing and Urban Development (HUD) block grant funds, payments, or subsidies;
- n. in-kind support and maintenance;
- o. loans;
- p. income from nutritional programs;
- q. income from radiation exposure;
- r. relocation assistance;
- s. scholarships, awards or fellowship grants used for education purposes and not for living expenses;
- t. supplemental security income (SSI);
- u. vendor payments;
- v. veterans' benefits;
- w. Women, Infants and Children Program (WIC) benefits;
- x. work-study program income;
- y. worker's compensation benefits; and
- z. cash contributions. Money which is contributed by the absent parent of a child in the assistance unit is considered child support and not counted. Small, non-recurring monetary gifts (e.g., Christmas, birthday, or graduation gifts) are not counted. Cash contributions include any money other than loans received by or for a member of the income unit if:

- i. the use is left to the discretion of the member of the income unit; or
- ii. the contribution is provided for the specific purpose of meeting the maintenance needs of a member of the assistance unit.

B. Financial eligibility for the MAGI groups shall be made using income received in the calendar month prior to the month of application or renewal as an indicator of anticipated income. The taxable gross income of each member of the MAGI household shall be used. Income eligibility of the household shall be based on anticipated income and circumstances unless it is discovered that there are factors that will affect income currently or in future months.

1. Income eligibility is determined by prospective income budgeting or actual income budgeting.
 - a. Prospective income budgeting involves looking at past income to determine anticipated future income.

Income earned in the calendar month prior to the month of application or renewal which the applicant/enrollee earned shall be used to determine expected income in the current and future months.

b. Actual income budgeting involves looking at income actually received within a specific month to determine income eligibility for that month. Actual income shall be used for all retroactive coverage. Actual income or the best estimate of anticipated actual income shall be used if:

- i. the income terminates during the month;
- ii. the income begins during the month; or
- iii. the income is interrupted during the month.

2. Income of a Tax Dependent. The earned income of a tax dependent including a child shall be counted when calculating the financial eligibility of a tax filer when the earned income meets the tax filing threshold. The unearned income of a tax dependent, including a child, shall be used when calculating MAGI based financial eligibility regardless of tax filing status (e.g., RSDI).

a. Cash contributions to a dependent shall be counted towards the dependent.

3. Allowable Tax Deductions for MAGI. The following deductions from an individual's income shall be used to determine the individual's adjusted gross income:

- a. educator expenses;
- b. certain business expenses of reservists, performing artists and fee basis government offices;
- c. health savings account deductions;
- d. moving expenses;
- e. the deductible part of self-employment tax;
- f. self-employed SEP, SIMPLE and qualified plans;
- g. self-employed health insurance deduction;
- h. the penalty on early withdrawal of savings;
- i. alimony paid outside the home;
- j. IRA deductions;
- k. student loan interest deduction;
- l. tuition and fees; and
- m. domestic production activities deductions.

4. A 5 percent disregard shall be allowed on MAGI budgets when it is the difference between eligibility or ineligibility for the individual in a child related program.

5. The net countable income for the individual's household shall be compared to the applicable income standard for the household size to determine eligibility.

a. If the countable income is below the income standard for the applicable MAGI group, the individual is income eligible.

b. If the countable income is above the income standard for the applicable MAGI group, the individual is income ineligible.

C. Federal Poverty Income Guidelines (FPIG). Eligibility shall be based upon the following guidelines using the federal poverty income guidelines and adjusted to account for the 5 percent disregard:

1. parents/caretakers, income is less or equal to 24 percent FPIG;
2. pregnant women, income is less or equal to 138 percent FPIG;
3. CHAMP (children 0-18), income is less or equal to 147 percent FPIG;

4. LaCHIP, income is less or equal to 217 percent FPIG;

5. LaCHIP IV (unborn option), income is less or equal to 214 percent FPIG; and

6. LaCHIP Affordable Plan, income does not exceed 255 percent FPIG.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Chapter 107. Resources

§10705. Resource Disregards

A. - C.2.

D. Modified Adjusted Gross Income (MAGI) Groups. Resources will be disregarded for those groups using the MAGI determinations methodology.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1899 (September 2009), amended LR 36:2867 (December 2010), LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#068

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Outpatient Hospital Services
Public-Private Partnerships
Reimbursement Methodology
(LAC 50:V.6703)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.6703 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing outpatient hospital services to establish supplemental Medicaid payments to non-state owned hospitals in order to encourage them to take over the operation and management of state-owned hospitals that have terminated or reduced services (*Louisiana Register*, Volume 38, Number 11). Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-private partnership initiative. The department promulgated an

Emergency Rule which amended the provisions of the November 1, 2012 Emergency Rule to revise the reimbursement methodology in order to correct the federal citation (*Louisiana Register*, Volume 39, Number 3).

The department promulgated an Emergency Rule which amended the provisions governing reimbursement for Medicaid payments for outpatient services provided by non-state owned major teaching hospitals participating in public-private partnerships which assume the provision of services that were previously delivered and terminated or reduced by a state owned and operated facility (*Louisiana Register*, Volume 38, Number 4). This Emergency Rule is being promulgated to continue the provisions of the April 15, 2013 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by maintaining recipient access to much needed hospital services.

Effective December 11, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing Medicaid payments for outpatient hospital services provided by non-state owned hospitals participating in public-private partnerships.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 5. Outpatient Hospital Services

Chapter 67. Public-Private Partnerships

§6703. Reimbursement Methodology

A. Payments to qualifying hospitals shall be made on a quarterly basis in accordance with 42 CFR 447.321.

B. Effective for dates of service on or after April 15, 2013, a major teaching hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to provide acute care hospital services to Medicaid and uninsured patients, and which assumes providing services that were previously delivered and terminated or reduced by a state owned and operated facility shall be reimbursed as follows.

1. Outpatient Surgery. The reimbursement amount for outpatient hospital surgery services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost.

2. Clinic Services. The reimbursement amount for outpatient clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost.

3. Laboratory Services. The reimbursement amount for outpatient clinical diagnostic laboratory services shall be the Medicaid fee schedule amount on file for each service.

4. Rehabilitative Services. The reimbursement amount for outpatient clinic services shall be an interim payment equal to the Medicaid fee schedule amount on file for each service, and a final reimbursement amount of 95 percent of allowable Medicaid cost.

5. Other Outpatient Hospital Services. The reimbursement amount for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be an interim payment equal to 95 percent of allowable Medicaid cost.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#069

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Pediatric Day Health Care Program
(LAC 48:I.Chapters 52 and 125 and LAC 50:XV.27503)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 48:I.5237, §5247, §5257, §12501-12503, adopts §12508, and amends LAC 50:XV.27503 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

In compliance with Act 432 of the 2004 Regular Session of the Louisiana Legislature, the Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions governing the licensing standards for pediatric day health care facilities (*Louisiana Register*, Volume 35, Number 12). The department subsequently adopted provisions to implement pediatric day health care (PDHC) services as an optional covered service under the Medicaid State Plan (*Louisiana Register*, Volume 36, Number 7).

The department promulgated an Emergency Rule which amended the licensing standards for PDHC facilities to revise the provisions governing provider participation, development and educational services and transportation requirements, and to adopt provisions for the inclusion of PDHC facilities in the Facility Need Review (FNR) Program. This Emergency Rule also amended the provisions governing pediatric day health care services in order to revise the recipient criteria which will better align the program's operational procedures with the approved Medicaid State Plan provisions governing these services (*Louisiana Register*, Volume 40, Number 3.)

The department promulgated an Emergency Rule which amended the March 1, 2014 Emergency Rule in order to revise the additional grandfather provisions for the Facility Need Review process for the Pediatric Day Health Care Program (*Louisiana Register*, Volume 40, Number 4). This Emergency Rule is being promulgated to continue the provisions of the April 20, 2014 Emergency Rule. This action is being taken to avoid sanctions or federal penalties

from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as the administrative rule is not consistent with the approved Medicaid State Plan for PDHC services, and to ensure that these optional services are more cost effective and appropriate.

Effective December 18, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the Facility Need Review Program for Pediatric Day Health Care Program.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensing and Certification

Chapter 52. Pediatric Day Health Care Facilities

Subchapter D. Participation Requirements

§5237. Acceptance Criteria

A. - D.1. ...

2. The medical director of the PDHC facility may provide the referral to the facility only if he/she is the child's prescribing physician, and only if the medical director has no ownership interest in the PDHC facility.

3. No member of the board of directors of the PDHC facility may provide a referral to the PDHC. No member of the board of directors of the PDHC facility may sign a prescription as the prescribing physician for a child to participate in the PDHC facility services.

4. No physician with ownership interest in the PDHC may provide a referral to the PDHC. No physician with ownership interest in the PDHC may sign a prescription as the prescribing physician for a child to participate in the PDHC facility services.

5. Notwithstanding anything to the contrary, providers are expected to comply with all applicable federal and state rules and regulations including those regarding anti-referral and the Stark Law.

E. - G.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193-40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2769 (December 2009), amended LR 40:

Subchapter E. Pediatric Day Health Care Services

§5247. Developmental and Educational Services

A. ...

B. For any child enrolled in the early intervention program (EarlySteps) or the local school district's program under the Individuals with Disabilities Act, the PDHC facility shall adhere to the following.

1. ...

2. The PDHC facility shall not duplicate services already provided through the early intervention program or the local school district. EarlySteps services cannot be provided in the PDHC unless specifically approved in writing by the DHH EarlySteps Program. Medicaid waiver services cannot be provided in the PDHC unless specifically approved in writing by the Medicaid waiver program. The PDHC shall maintain a copy of such written approval in the child's medical record.

B.3. - D.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193-40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2770 (December 2009), amended LR 40:

§5257. Transportation

A. The PDHC facility shall provide or arrange transportation of children to and from the facility; however, no child, regardless of his/her region of origin, may be in transport for more than one hour on any single trip. The PDHC facility is responsible for the safety of the children during transport. The family may choose to provide their own transportation.

1. - 1.b. Repealed.

B. Whether transportation is provided by the facility on a daily basis or as needed, the general regulations under this Section shall apply.

C. If the PDHC facility provides transportation for children, the PDHC facility shall maintain in force at all times current commercial liability insurance for the operation of PDHC facility vehicles, including medical coverage for children in the event of accident or injury.

1. This policy shall extend coverage to any staff member who provides transportation for any child in the course and scope of his/her employment.

2. The PDHC facility shall maintain documentation that consists of the insurance policy or current binder that includes the name of the PDHC facility, the name of the insurance company, policy number, and period of coverage and explanation of coverage.

3. DHH health standards shall specifically be identified as the certificate holder on the policy and any certificate of insurance issued as proof of insurance by the insurer or producer (agent). The policy must have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

D. If the PDHC facility arranges transportation for children through a transportation agency, the facility shall maintain a written contract which is signed by a facility representative and a representative of the transportation agency. The contract shall outline the circumstances under which transportation will be provided.

1. The written contract shall be dated and time limited and shall conform to these licensing regulations.

2. The transportation agency shall maintain in force at all times current commercial liability insurance for the operation of transportation vehicles, including medical coverage for children in the event of accident or injury. Documentation of the insurance shall consist of the:

- a. insurance policy or current binder that includes the name of the transportation agency;
- b. name of the insurance agency;
- c. policy number;
- d. period of coverage; and
- e. explanation of coverage.

3. DHH health standards shall specifically be identified as the certificate holder on the policy and any certificate of insurance issued as proof of insurance by the insurer or producer (agent). The policy must have a cancellation/change statement requiring notification of the certificate holder 30 days prior to any cancellation or change of coverage.

4. - 10. Repealed.

E. Transportation arrangements, whether provided by the PDHC facility directly or arranged by the PDHC facility through a written contract with a transportation agency shall meet the following requirements.

1. Transportation agreements shall conform to state laws, including laws governing the use of seat belts and child restraints. Vehicles shall be accessible for people with disabilities or so equipped to meet the needs of the children served by the PDHC facility.

2. The driver or attendant shall not leave the child unattended in the vehicle at any time.

2.a. - 6. Repealed.

F. Vehicle and Driver Requirements

1. The requirements of Subsection F of this Section shall apply to all transportation arrangements, whether provided by the PDHC facility directly or arranged by the PDHC facility through a written contract with a transportation agency.

2. The vehicle shall be maintained in good repair with evidence of an annual safety inspection.

3. The following actions shall be prohibited in any vehicle while transporting children:

- a. the use of tobacco in any form;
- b. the use of alcohol;
- c. the possession of illegal substances; and
- d. the possession of firearms, pellet guns, or BB guns (whether loaded or unloaded).

4. The number of persons in a vehicle used to transport children shall not exceed the manufacturer's recommended capacity.

5. The facility shall maintain a copy of a valid appropriate Louisiana driver's license for all individuals who drive vehicles used to transport children on behalf of the PDHC facility. At a minimum, a class "D" chauffeur's license is required for all drivers who transport children on behalf of the PDHC facility.

6. Each transportation vehicle shall have evidence of a current safety inspection.

7. There shall be first aid supplies in each facility or contracted vehicle. This shall include oxygen, pulse oximeter, and suction equipment. Additionally, this shall include airway management equipment and supplies required to meet the needs of the children being transported.

8. Each driver or attendant shall be provided with a current master transportation list including:

- a. each child's name;
- b. pick up and drop off locations; and
- c. authorized persons to whom the child may be released.

i. Documentation shall be maintained on file at the PDHC facility whether transportation is provided by the facility or contracted.

9. The driver or attendant shall maintain an attendance record for each trip. The record shall include:

- a. the driver's name;
- b. the date of the trip;
- c. names of all passengers (children and adults) in the vehicle; and
- d. the name of the person to whom the child was released and the time of release.

10. There shall be information in each vehicle identifying the name of the administrator and the name,

telephone number, and address of the facility for emergency situations.

G. Child Safety Provisions

1. The requirements of Subsection G of this Section shall apply to all transportation arrangements, whether provided by the PDHC facility directly or arranged by the PDHC facility through a written contract with a transportation agency.

2. The driver and one appropriately trained staff member shall be required at all times in each vehicle when transporting any child. Staff shall be appropriately trained on the needs of each child, and shall be capable and responsible for administering interventions when appropriate.

3. Each child shall be safely and properly:

- a. assisted into the vehicle;
- b. restrained in the vehicle;
- c. transported in the vehicle; and
- d. assisted out of the vehicle.

4. Only one child shall be restrained in a single safety belt or secured in any American Academy of Pediatrics recommended age appropriate safety seat.

5. The driver or appropriate staff person shall check the vehicle at the completion of each trip to ensure that no child is left in the vehicle.

a. The PDHC facility shall maintain documentation that includes the signature of the person conducting the check and the time the vehicle is checked. Documentation shall be maintained on file at the PDHC facility whether transportation is provided by the facility or contracted.

6. During field trips, the driver or staff member shall check the vehicle and account for each child upon arrival at, and departure from, each destination to ensure that no child is left in the vehicle or at any destination.

a. The PDHC facility shall maintain documentation that includes the signature of the person conducting the check and the time the vehicle was checked for each loading and unloading of children during the field trip. Documentation shall be maintained on file at the PDHC facility whether transportation is provided by the facility or contracted.

7. Appropriate staff person(s) shall be present when each child is delivered to the facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2193-40:2193.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2771 (December 2009), amended LR 40:

Subpart 5. Health Planning

Chapter 125. Facility Need Review

Subchapter A. General Provisions

§12501. Definitions

A. Definitions. When used in this Chapter the following terms and phrases shall have the following meanings unless the context requires otherwise.

* * *

Pediatric Day Health Care (PDHC) Providers—a facility that may operate seven days a week, not to exceed 12 hours a day, to provide care for medically fragile children under the age of 21, including technology dependent children who require close supervision. Care and services to be provided by the pediatric day health care facility shall include, but not be limited to:

- a. nursing care, including, but not limited to:

- i. tracheotomy and suctioning care;
 - ii. medication management; and
 - iii. intravenous (IV) therapy;
- b. respiratory care;
 - c. physical, speech, and occupational therapies;
 - d. assistance with activities of daily living;
 - e. transportation services; and
 - f. education and training.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004), LR 32:845 (May 2006), LR 34:2611 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2437 (November 2009), amended LR 36:323 (February 2010), LR 38:1961 (August 2012), LR 40:

§12503. General Information

A. - B. ...

C. The department will also conduct a FNR for the following provider types to determine if there is a need to license additional units, providers or facilities:

1. - 3. ...
4. hospice providers or inpatient hospice facilities;
5. outpatient abortion facilities; and
6. pediatric day health care facilities.

D. - F.4. ...

G. Additional Grandfather Provision. An approval shall be deemed to have been granted under FNR without review for HCBS providers, ICFs-DD, ADHC providers, hospice providers, outpatient abortion facilities, and pediatric day health care centers that meet one of the following conditions:

1. - 3. ...
4. hospice providers that were licensed, or had a completed initial licensing application submitted to the department, by March 20, 2012;
5. outpatient abortion facilities which were licensed by the department on or before May 20, 2012; or
6. pediatric day health care providers that were licensed by the department before March 1, 2014, or an entity that meets all of the following requirements:

a. has a building site or plan review approval for a PDHC facility from the Office of State Fire Marshal by March 1, 2014;

b. has begun construction on the PDHC facility by April 30, 2014, as verified by a notarized affidavit from a licensed architect submitted to the department, or the entity had a fully executed and recorded lease for a facility for the specific use as a PDHC facility by April 30, 2014, as verified by a copy of a lease agreement submitted to the department;

c. submits a letter of intent to the department's Health Standards Section by April 30, 2014, informing the department of its intent to operate a PDHC facility; and

d. becomes licensed as a PDHC by the department no later than December 31, 2014.

H. - H.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995),

amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), amended LR 35:2437 (November 2009), LR 36:323 (February 2010), LR 38:1593 (July 2012), LR 38:1961 (August 2012), LR 40:

Subchapter B. Determination of Bed, Unit, Facility or

Agency Need

§12508. Pediatric Day Health Care Providers

A. No PDHC provider shall be licensed to operate unless the FNR Program has granted an approval for the issuance of a PDHC provider license. Once the FNR Program approval is granted, a PDHC provider is eligible to be licensed by the department, subject to meeting all of the requirements for licensure.

B. For purposes of facility need review, the service area for a proposed PDHC shall be within a 30 mile radius of the proposed physical address where the provider will be licensed.

C. Determination of Need/Approval

1. The department will review the application to determine if there is a need for an additional PDHC provider in the geographic location and service area for which the application is submitted.

2. The department shall grant FNR approval only if the FNR application, the data contained in the application, and other evidence effectively establishes the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed.

3. In reviewing the application, the department may consider, but is not limited to, evidence showing:

a. the number of other PDHC providers in the same geographic location, region, and service area servicing the same population; and

b. allegations involving issues of access to health care and services.

4. The burden is on the applicant to provide data and evidence to effectively establish the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed. The department shall not grant any FNR approvals if the application fails to provide such data and evidence.

D. Applications for approvals of licensed providers submitted under these provisions are bound to the description in the application with regard to the type of services proposed as well as to the site and location as defined in the application. FNR approval of licensed providers shall expire if these aspects of the application are altered or changed.

E. FNR approvals for licensed providers are non-transferable and are limited to the location and the name of the original licensee.

1. A PDHC provider undergoing a change of location in the same licensed service area shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. A PDHC provider undergoing a change of location outside of the licensed service area shall submit a new FNR application and appropriate fee and undergo the FNR approval process.

2. A PDHC provider undergoing a change of ownership shall submit a new application to the department's FNR Program. FNR approval for the new owner shall be granted upon submission of the new

application and proof of the change of ownership, which must show the seller's or transferor's intent to relinquish the FNR approval.

3. FNR Approval of a licensed provider shall automatically expire if the provider is moved or transferred to another party, entity or location without application to and approval by the FNR program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 19. Pediatric Day Health Care Program

Chapter 275. General Provisions

§27503. Recipient Criteria

A. In order to qualify for PDHC services, a Medicaid recipient must meet the following criteria. The recipient must:

1. be from birth up to 21 years of age;

2. require ongoing skilled medical care or skilled nursing care by a knowledgeable and experienced licensed professional registered nurse (RN) or licensed practical nurse (LPN);

3. have a medically complex condition(s) which require frequent, specialized therapeutic interventions and close nursing supervision. Interventions are those medically necessary procedures provided to sustain and maintain health and life. Interventions required and performed by individuals other than the recipient's personal care giver would require the skilled care provided by professionals at PDHC centers. Examples of medically necessary interventions include, but are not limited to:

a. suctioning using sterile technique;

b. provision of care to a ventilator dependent and/or oxygen dependent recipients to maintain patent airway and adequate oxygen saturation, inclusive of physician consultation as needed;

c. monitoring of blood pressure and/or pulse oximetry level in order to maintain stable health condition and provide medical provisions through physician consultation;

d. maintenance and interventions for technology dependent recipients who require life-sustaining equipment; or

e. complex medication regimen involving, and not limited to, frequent change in dose, route, and frequency of multiple medications, to maintain or improve the recipient's health status, prevent serious deterioration of health status and/or prevent medical complications that may jeopardize life, health or development;

4. have a medically fragile condition, defined as a medically complex condition characterized by multiple, significant medical problems that require extended care. Medically fragile individuals are medically complex and potentially dependent upon medical devices, experienced medical supervision, and/or medical interventions to sustain life;

a. medically complex may be considered as chronic, debilitating diseases or conditions, involving one or more physiological or organ systems, requiring skilled medical care, professional observation or medical intervention;

b. examples of medically fragile conditions include, but are not limited to:

- i. severe lung disease requiring oxygen;
- ii. severe lung disease requiring ventilator or tracheotomy care;
- iii. complicated heart disease;
- iv. complicated neuromuscular disease; and
- v. unstable central nervous system disease;

5. have a signed physician's order, not to exceed 180 days, for pediatric day health care by the recipient's physician specifying the frequency and duration of services; and

6. be stable for outpatient medical services.

B. If the medical director of the PDHC facility is also the child's prescribing physician, the department reserves the right to review the prescription for the recommendation of the child's participation in the PDHC Program.

1. - 1.j. Repealed.

C. Re-evaluation of PDHC services must be performed, at a minimum, every 120 days. This evaluation must include a review of the recipient's current medical plan of care and provider agency documented current assessment and progress toward goals.

D. A face-to-face evaluation shall be held every four months by the child's prescribing physician. Services shall be revised during evaluation periods to reflect accurate and appropriate provision of services for current medical status.

E. Physician's orders for services are required to individually meet the needs of each recipient and shall not be in excess of the recipient's needs. Physician orders prescribing or recommending PDHC services do not, in themselves, indicate services are medically necessary or indicate a necessity for a covered service. Eligibility for participation in the PDHC Program must also include meeting the medically complex provisions of this Section.

F. When determining the necessity for PDHC services, consideration shall be given to all of the services the recipient may be receiving, including waiver services and other community supports and services. This consideration must be reflected and documented in the recipient's treatment plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1557 (July 2010), amended LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#070

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Psychiatric Residential Treatment Facilities Licensing Standards (LAC 48:I.Chapter 90)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 48:I.Chapter 90 as authorized by R.S. 40:2179-2179.1. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing amended the provisions governing the licensing of psychiatric residential treatment facilities (PRTFs) in order to revise the licensing standards as a means of assisting PRTFs to comply with the standards (*Louisiana Register*, Volume 39, Number 9). The department promulgated an Emergency Rule which amended the provisions governing the licensing standards for PRTFs in order to remove service barriers, clarify appeal opportunities, avoid a reduction in occupancy of PRTFs in rural locations, and clarify the process for cessation of business (*Louisiana Register*, Volume 40, Number 8). This Emergency Rule is being promulgated to continue the provisions of the August 20, 2014 Emergency Rule. This action is being taken to avoid imminent peril to the public health, safety and welfare of the children and adolescents who need these services.

Effective December 19, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the licensing of psychiatric residential treatment facilities.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensing

Chapter 90. Psychiatric Residential Treatment Facilities (under 21)

Subchapter A. General Provisions

§9003. Definitions

A. ...

Cessation of Business—Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:54 (January 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:371 (February 2012), LR 39:2510 (September 2013), LR 40:

Subchapter B. Licensing

§9015. Licensing Surveys

A. - D. ...

E. If deficiencies have been cited during a licensing survey, regardless of whether an acceptable plan of

correction is required, the department may issue appropriate sanctions, including, but not limited to:

1. civil fines;
2. directed plans of correction;
3. provisional licensure;
4. denial of renewal; and/or
5. license revocations.

F. - F.2 ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 40:

§9017. Changes in Licensee Information or Personnel

A. - D.2. ...

3. A PRTF that is under provisional licensure, license revocation or denial of license renewal may not undergo a CHOW.

E. - F.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 40:

§9019. Cessation of Business

A. Except as provided in §9089 of these licensing regulations, a license shall be immediately null and void if a PRTF ceases to operate.

1. - 3. Repealed.

B. A cessation of business is deemed to be effective the date on which the PRTF stopped offering or providing services to the community.

C. Upon the cessation of business, the provider shall immediately return the original license to the Department.

D. Cessation of business is deemed to be a voluntary action on the part of the provider. The provider does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the PRTF shall:

1. give 30 days' advance written notice to:
 - a. HSS;
 - b. the prescribing physician; and
 - c. the parent(s) or legal guardian or legal representative of each client; and

2. provide for an orderly discharge and transition of all of the clients in the facility.

F. In addition to the advance notice of voluntary closure, the PRTF shall submit a written plan for the disposition of clients' medical records for approval by the Department. The plan shall include the following:

1. the effective date of the voluntary closure;
2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed provider's clients' medical records;
3. an appointed custodian(s) who shall provide the following:
 - a. access to records and copies of records to the client or authorized representative, upon presentation of proper authorization(s); and
 - b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least 15 days prior to the effective date of closure.

G. If a PRTF fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a PRTF for a period of two years.

H. Once the PRTF has ceased doing business, the PRTF shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:375 (February 2012), amended LR 40:

§9023. Denial of License, Revocation of License, Denial of License Renewal

A. - C.3. ...

D. Revocation of License or Denial of License Renewal. A PRTF license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. - 13. ...

14. bribery, harassment, or intimidation of any resident or family member designed to cause that resident or family member to use or retain the services of any particular PRTF; or

15. failure to maintain accreditation or failure to obtain accreditation.

16. Repealed.

E. If a PRTF license is revoked or renewal is denied, or the license is surrendered in lieu of an adverse action, any owner, officer, member, director, manager, or administrator of such PRTF may be prohibited from opening, managing, directing, operating, or owning another PRTF for a period of two years from the date of the final disposition of the revocation, denial action, or surrender.

F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:376 (February 2012), amended LR 40:

§9025. Notice and Appeal of License Denial, License Revocation, License Non-Renewal, and Appeal of Provisional License

A. - B. ...

1. The PRTF shall request the informal reconsideration within 15 calendar days of the receipt of the notice of the license denial, license revocation, or license non-renewal. The request for informal reconsideration must be in writing and shall be forwarded to the Health Standards Section.

B.2. - D. ...

E. If a timely administrative appeal has been filed by the facility on a license denial, license non-renewal, or license revocation, the Division of Administrative Law shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

E.1. - G.2. ...

3. The provider shall request the informal reconsideration in writing, which shall be received by the Health Standards Section within five days of receipt of the notice of the results of the follow-up survey from the department.

a. Repealed.

4. The provider shall request the administrative appeal within 15 days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law, or its successor.

a. Repealed.

H. - H.1. ...

I. If a timely administrative appeal has been filed by a facility with a provisional initial license that has expired or by an existing provider whose provisional license has expired under the provisions of this Chapter, the Division of Administrative Law shall conduct the hearing pursuant to the Louisiana Administrative Procedure Act.

1. - 2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:377 (February 2012), amended LR 40:

§9027. Complaint Surveys

A. - J.1. ...

a. The offer of the administrative appeal, if appropriate, as determined by the Health Standards Section, shall be included in the notification letter of the results of the informal reconsideration. The right to administrative appeal shall only be deemed appropriate and thereby afforded upon completion of the informal reconsideration.

2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:378 (February 2012), amended LR 40:

§9029. Statement of Deficiencies

A. - C.1. ...

2. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section and will be considered timely if received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies.

3. - 5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:379 (February 2012), amended LR 40:

Subchapter H. Additional Requirements for Mental Health PRTFs

§9093. Personnel Qualifications, Responsibilities, and Requirements

A. - A.2. ...

b. The clinical director is responsible for the following:

i. providing clinical direction for each resident at a minimum of one hour per month, either in person on-site, or via telemedicine pursuant to R.S. 37:1261-1292, et seq. and LAC 46:XLV.408 and Chapter 75, et seq.;

(a). - 3.a.iv. ...

b. A LMHP or MHP shall provide for each resident a minimum weekly total of 120 minutes of individual therapy.

A.3.c. - B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:397 (February 2012), amended LR 39:2511 (September 2013), LR 40:

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#071

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

Recovery Audit Contractor Program
(LAC 50:I.Chapter 85)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:I.Chapter 85 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Patient Protection and Affordable Care Act (PPACA), U.S. Public Law 111-148, and 111-152 directed states to establish a Recovery Audit Contractor (RAC) program to audit payments to Medicaid providers. Act 568 of the 2014 Regular Session of the Louisiana Legislature directed the Department of Health and Hospitals to implement a Recovery Audit Contractor program. In compliance with the Patient Protection and Affordable Care Act (PPACA) and Act 568, the department adopts provisions to establish the RAC program.

This action is being taken to avoid federal sanctions. It is anticipated that the implementation of this Emergency Rule will have no programmatic costs to the Medicaid Program for state fiscal year 2014-2015.

Effective November 20, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing adopts

provisions establishing the Recovery Audit Contractor program.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part I. Administration

Subpart 9. Recovery

Chapter 85. Recovery Audit Contractor

§8501. General Provisions

A. Pursuant to the provisions of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, 111-152, and Act 562 of the Regular Session of the Louisiana Legislature, the Medicaid Program adopts provisions to establish a recovery audit contractor (RAC) program.

B. These provisions do not prohibit or restrict any other audit functions that may be performed by the department or its contractors. This rule shall only apply to Medicaid RACs as they are defined in applicable federal law.

C. This Rule shall apply to RAC audits that begin on or after November 20, 2014, regardless of dates of claims reviewed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8503. Definitions

Adverse Determination—any decision rendered by the recovery audit contractor that results in a payment to a provider for a claim or service being reduced either partially or completely.

Department—Department of Health and Hospitals (DHH) or any of its sections, bureaus, offices, or its contracted designee.

Provider—any healthcare entity enrolled with the department as a *provider* in the Medicaid program.

Recovery Audit Contractor (RAC)—a Medicaid recovery audit contractor selected by the department to perform audits for the purpose of ensuring Medicaid program integrity in accordance with the provisions of 42 CFR 17 455 et seq.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8505. Contractor Functions

A. Notwithstanding any law to the contrary, the RAC shall perform all of the following functions.

1. The RAC shall ensure it is reviewing claims within three years of the date of its initial payment. For purposes of this requirement, the three year look back period shall commence from the beginning date of the relevant audit.

2. The RAC shall send a determination letter concluding an audit within 60 days of receipt of all requested materials from a provider.

3. For any records which are requested from a provider, the RAC shall ensure proper identification of which records it is seeking. Information shall include, but is not limited to:

- a. recipient name;
- b. claim number;
- c. medical record number (if known); and
- d. date(s) of service.

B. Pursuant to applicable statute, the RAC program's scope of review shall exclude the following:

1. all claims processed or paid within 90 days of implementation of any Medicaid managed care program that relates to said claims. This shall not preclude review of claims not related to any Medicaid managed care program implementation;

2. claims processed or paid through a capitated Medicaid managed care program. This scope restriction shall not prohibit any audits of per member per month payments from the department to any capitated Medicaid managed care plan utilizing such claims; and

3. medical necessity reviews in which the provider has obtained prior authorization for the service.

C. The RAC shall refer claims it suspects to be fraudulent directly to the department for investigation.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8507. Reimbursement and Recoupment

A. The department has in place, and shall retain, a process to ensure that providers receive or retain the appropriate reimbursement amount for claims within any look back period in which the RAC determines that services delivered have been improperly billed, but reasonable and necessary. It shall be the provider's responsibility to provide documentation to support and justify any recalculation.

B. The RAC and the department shall not recoup any overpayments identified by the RAC until all informal and formal appeals processes have been completed. For purposes of this Section, a final decision by the Division of Administrative Law shall be the conclusion of all formal appeals processes. This does not prohibit the provider from seeking judicial review and any remedies afforded thereunder.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8509. Provider Notification

A. The RAC shall provide a detailed explanation in writing to a provider for any adverse determination as defined by state statute. This notification shall include, but not be limited to the following:

1. the reason(s) for the adverse determination;
2. the specific medical criteria on which the determination was based, if applicable;
3. an explanation of any provider appeal rights; and
4. an explanation of the appropriate reimbursement determined in accordance with §8507, if applicable.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8511. Records Requests

A. The RAC shall limit records requests to not more than 1 percent of the number of claims filed by the provider for the specific service being reviewed in the previous state fiscal year during a 90 day period. The 1 percent shall be further limited to 200 records. For purposes of this Chapter, each specific service identified for review within the requested time period will be considered a separate and distinct audit.

B. The provider shall have 45 calendar days to comply with any records request unless an extension is mutually agreed upon. The 45 days shall begin on the date of receipt of any request.

1. *Date of Receipt*—two business days from the date of the request as confirmed by the post office date stamp.

C. If the RAC demonstrates a significant provider error rate relative to an audit of records, the RAC may make a request to the department to initiate an additional records request relative to the issue being reviewed for the purposes of further review and validation.

1. The provider shall be given an opportunity to provide written objections to the secretary or his/her designee of any subsequent records request. Decisions by the secretary or his/her designee in this area are final and not subject to further appeal or review.

2. This shall not be an adverse determination subject to the Administrative Procedures Act process.

3. A significant provider error rate shall be defined as 25 percent.

4. The RAC shall not make any requests allowed above until the time period for the informal appeals process has expired.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8513. Audits and Records Submission

A. The RAC shall utilize provider self-audits only if mutually agreed to by the provider and the RAC.

B. If the provider is determined to be a low-risk provider, the RAC shall schedule any on-site audits with advance notice of not less than 10 business days. The RAC shall make a reasonable good-faith effort to establish a mutually agreed upon date and time, and shall document such efforts.

C. In association with an audit, providers shall be allowed to submit records in electronic format for their convenience. If the RAC requires a provider to produce records in any non-electronic format, the RAC shall make reasonable efforts to reimburse the provider for the reasonable cost of medical records reproduction consistent with 42 CFR 476.78.

1. The cost for medical record production shall be at the current federal rate at the time of reimbursement to the provider. This rate may be updated periodically, but in no circumstance shall it exceed the rate applicable under Louisiana statutes for public records requests.

2. Any costs associated with medical record production may be applied by the RAC as a credit against any overpayment or as a reduction against any underpayment. A tender of this amount shall be deemed a reasonable effort.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8515. Appeals Process

A. A provider shall have a right to an informal and formal appeals process for adverse determinations made by the RAC.

B. The informal appeals process shall be conducted as follows.

1. Beginning on the date of issuance of any initial findings letter by the RAC, there shall be an informal discussion and consultation period. During this period the provider and RAC may communicate regarding any audit determinations.

2. Within 45 calendar days of receipt of written notification of an adverse determination from the RAC, a provider shall have the right to request an informal hearing relative to such determination. The department's Program Integrity Section shall be involved in this hearing. Any such request shall be in writing and the date of receipt shall be deemed to be two days after the date of the adverse determination letter.

3. The informal hearing shall occur within 30 days of receipt of the provider's request.

4. At the informal hearing the provider shall have the right to present information orally and in writing, the right to present documents, and the right to have the department and the RAC address any inquiry the provider may make concerning the reason for the adverse determination. A provider may be represented by an attorney or authorized representative, but any such individual must provide written notice of representation along with the request for informal hearing.

5. The RAC and the Program Integrity Section shall issue a final written decision related to the informal hearing within 15 calendar days of the hearing closure.

C. Within 30 days of issuance of an adverse determination of the RAC, if an informal hearing is not requested or there is a determination pursuant to an informal hearing, a provider may request an administrative appeal of the final decision by requesting a hearing before the Division of Administrative Law. A copy of any request for an administrative appeal shall be filed contemporaneously with the Program Integrity Section. The date of issuance of a final decision or determination pursuant to an informal hearing shall be two days from the date of such decision or determination.

D. The department shall report on its website the number of adverse determinations overturned on informal or formal appeals at the end of the month for the previous month.

E. If the department or the Division of Administrative Law hearing officer finds that the RAC determination was unreasonable, frivolous or without merit, then the RAC shall reimburse the provider for its reasonable costs associated with the appeals process. Reasonable costs include, but are not limited to, cost of reasonable attorney's costs and other reasonable expenses incurred to appeal the RAC's determination. The fact that a decision has been overturned or partially overturned via the appeals process shall not mean the determination was without merit.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

§8517. Penalties and Sanctions

A. If the department determines that the RAC inappropriately denied a claim(s), the department may impose a penalty or sanction. A claim has been inappropriately denied when the:

1. adverse determination is not substantiated by applicable department policy or guidance and the RAC fails to utilize guidance provided by the department; or

2. RAC fails to follow any programmatic or statutory rules.

B. If more than 25 percent of the RAC's adverse determinations are overturned on informal or formal appeal, the department may impose a monetary penalty up to 10 percent of the cost of the claims to be awarded to the providers of the claims inappropriately determined, or a monetary penalty up to 5 percent of the RAC's total collections to the department.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#065

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

State Children's Health Insurance Program
Coverage of Prenatal Care Services
(LAC 50:III.20301 and 20303)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:III.20301 and 20303 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XXI of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgated a Rule which adopted provisions to expand coverage to children under Title XXI of the Social Security Act by implementing a stand-alone State Children's Health Insurance Program (SCHIP) to provide coverage of prenatal care services to low-income, non-citizen women and to clarify the service limits and prior authorization criteria for SCHIP prenatal care services (*Louisiana Register*, Volume 35, Number 1).

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions of the January 20, 2009 Rule in order to include Medicaid coverage for the unborn

child(ren) of any pregnant woman with income between 138 percent and 214 percent of the Federal Poverty Level (FPL) (*Louisiana Register*, Volume 40, Number 1). The department promulgated an Emergency Rule which amended the December 31, 2013 Emergency Rule in order to clarify these provisions (*Louisiana Register*, Volume 40, Number 4). This Emergency Rule is being promulgated to continue the provisions of the April 20, 2014 Emergency Rule. This action is being taken to promote the health and welfare of pregnant women by increasing access to prenatal care services that will support better health outcomes for babies.

Effective December 18, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the State Children's Health Insurance Program coverage of prenatal care services.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part III. Eligibility

Subpart 11. State Children's Health Insurance Program Chapter 203. Prenatal Care Services

§20301. General Provisions

A. ...

B. Effective December 31, 2013, coverage of SCHIP prenatal care services shall be expanded to include any pregnant woman with income between 138 percent and 214 percent of the FPL.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:72 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR: 40:

§20303. Eligibility Criteria

A. - B.1. ...

C. Recipients must have family income at or below 214 percent of the FPL.

D. - E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:72 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR: 40:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#072

DECLARATION OF EMERGENCY

Department of Health and Hospitals Bureau of Health Services Financing

State Children's Health Insurance Program
Modified Adjusted Gross Income
(LAC 50:III.20103)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:III.20103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XXI of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Section 1004(a)(2) of the Patient Protection and Affordable Care Act (ACA) of 2010 and Section 36B (d)(2)(B) of the *Internal Revenue Code* mandate that Medicaid eligibility use the Modified Adjusted Gross Income (MAGI) methodology for eligibility determinations for certain eligibility groups. In compliance with the ACA and *Internal Revenue Code*, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing Medicaid eligibility to adopt the MAGI methodology for eligibility groups covered under Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program) of the Social Security Act (*Louisiana Register*, Volume 40, Number 1). The department also adopted provisions which allow qualified hospitals to make determinations of presumptive eligibility for individuals who are not currently enrolled in Medicaid.

The department promulgated an Emergency Rule which amended the provisions of the December 31, 2013 Emergency Rule in order to make technical revisions to ensure that these provisions are appropriately promulgated in a clear and concise manner (*Louisiana Register*, Volume 40, Number 4). The provisions governing the MAGI eligibility changes for the Louisiana Children's Health Insurance Program (LaCHIP) were repromulgated independent of the provisions governing the Title XIX eligibility groups. This action is being taken to avoid federal sanctions.

Effective December 18, 2014, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing Medicaid eligibility.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part III. Eligibility

Subpart 11. State Children's Health Insurance Program

Chapter 201. Louisiana Children's Health Insurance Program (LaCHIP) - Phases 1-3

§20103. Eligibility Criteria

A. - A.1. ...

2. are from families with income at or below 217 percent of the federal poverty level; and

A.3. - D.1.f. ...

E. Effective December 31, 2013 eligibility for LaCHIP shall be determined by modified adjusted gross income (MAGI) methodology in accordance with section 1004(a)(2) of the Patient Protection and Affordable Care Act (ACA) of

2010 and section 36B (d)(2)(B) of the *Internal Revenue Code*.

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:659 (April 2008), amended by the Department of Health and Hospitals, LR 40:

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Kathy H. Kliebert
Secretary

1411#073

DECLARATION OF EMERGENCY

Department of Health and Hospitals Licensed Professional Counselors Board of Examiners

Required Continuing Education in Diagnosis for LMFTs
(LAC 46:LX.3503)

The Louisiana Department of Health and Hospitals, Louisiana Professional Counselors Board of Examiners has exercised the emergency provisions of the Administrative Procedures Act, specifically R.S. 49:953(B), to adopt rules relative to continuing education for LMFTs in diagnosis and to revise Section 3503 of board rules. This Emergency Rule is effective November 20, 2014 for a period of 120 days. This action is necessary to ensure licensed marriage and family therapists obtain the appropriate continuing education to be in compliance with Act 736 of the 2014 Regular Legislative Session. The Louisiana Licensed Professional Counselors Board of Examiners is in the process of developing the permanent Rule associated with Act 736 of the 2014 Regular Legislative Session and will revise Section 3503 as part of this larger Rule change.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LX. Licensed Professional Counselors Board of Examiners

Subpart 2. Professional Standards for Licensed Marriage and Family Therapists

Chapter 35. Renewal of License

§3503. Continuing Education Requirements

A. - A.8. ...

9. A licensee must accrue six clock hours of training in diagnosis every renewal period that specifically addresses the assessment, diagnosis, and treatment of clinical conditions under the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), as published by the American Psychiatric Association on May 18, 2013. This required training may be specific to the diagnosis, assessment, and treatment of a particular condition and/or may be general training in diagnosis, assessment, and treatment under the *Diagnostic and Statistical Manual of*

Mental Disorders, Edition (DSM-5), published on May 18, 2013.

10. Those licensed marriage and family therapists who hold another license that requires continuing education hours may count the continuing education hours obtained for that license toward their LMFT CEU requirements. Of the 40 CEUs submitted, however, 20 hours must be in the area of marriage and family therapy with an emphasis upon systemic approaches or the theory, research, or practice of systemic psychotherapeutic work with couples or families including three hours of ethics specific to marriage and family therapy.

11. The approval of and requirements for continuing education are specified in Subsection C.

B. - C.3.g. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1101-1123.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Licensed Professional Counselors Board of Examiners, LR 29:160 (February 2003), repromulgated LR 29:581 (April 2003), amended LR 29:2789 (December 2003), LR 40:

Mary Alice Olsan
Executive Director

1411#017

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office for Citizens with Developmental Disabilities

Certification of Medication Attendants (LAC 48:IX.Chapter 9)

The Office for Citizens with Developmental Disabilities (OCDD) adopts LAC 48:IX.Chapter 9, Guidelines for Certification of Medication Attendants (CMA). R.S. 37:1021-1025 authorizes the establishment of “a medication administration course for the purpose of training and certifying unlicensed personnel to administer certain medication to residents of intermediate care facilities for the mentally retarded (ICFs/MR) and community homes for the mentally retarded either operated by the Office for Citizens with Developmental Disabilities (OCDD) or funded through the Department of Health and Hospitals (DHH); and to individuals in programs/agencies contracting for services with DHH except as prohibited in §911.B.5.”

Based on an opinion given by the Louisiana State Board of Medical Examiners, the Department of Health and Hospitals has discontinued the use of physician delegation forms in intermediate care facilities and home and community-based settings. Unlicensed personnel must now complete minimum training requirements in order to administer medication to individuals with intellectual and developmental disabilities. The termination of physician delegation has resulted in a large influx of individuals seeking CMA training and certification. This has created an administrative burden to providers as well as OCDD to timely process a steadily increasing number of certifications. This is also an unfunded training mandate, which incurs significant costs to provider agencies and requires annual continuing education for re-certification. Due to limited funding, provider agencies who cannot afford to maintain

the certification will experience a reduction in unlicensed personnel who are qualified to give medication to clients, thus increasing the risk for medication errors, critical incidents, and mortality for medically compromised and vulnerable clients. The Office for Citizens with Developmental Disabilities seeks to extend the certification period for certified medication attendants to two years, effective October 30, 2014. Provider agencies must determine CMA competency annually during the two-year period.

Also effective October 30, 2014, OCDD will allow CMAs who have not worked directly with medication administration for 12 months or more to be administered the statewide exam and a competency evaluation rather than requiring that they repeat the training. The opportunity for this will also decrease administrative burden and allow qualified individuals to more quickly re-enter the work force which will in turn, help assure client health and safety. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Title 48

PUBLIC HEALTH—GENERAL

Part IX. Mental Retardation/Developmental Disabilities Services

Chapter 9. Guidelines for Certification of Medication Attendants

§915. Certification Requirements and Process

A. Effective upon rule promulgation, all existing active CMA certificates will expire on October 31, 2015. CMA certificates issued after rule promulgation will expire two years from the last day of the month that the certificate was printed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:696 (July 1995), amended LR 23:1147 (September 1997), LR 41:

§917. Re-Certification Requirements and Process

A. Bi-annual Requirements. On a bi-annual basis each CMA must be recertified. The requirements for re-certification are:

1. completion of a total of nine hours of in service training. Two of the nine hours must directly relate to the agency's medication administration policy and procedure. The remaining seven hours on in-service must relate to medication administration. A CMA working in multiple agencies may combine training to meet these requirements with the exception that the two hour training on agency medication administration policy and procedure is required for each employer. Each agency must have documentation of each CMA's required nine hours of in service training;

2. pass with proficiency, either by physical or verbal demonstration, the 25 skills on the practical checklist on an annual basis. The annual cycle is based on the last day of the month that the certificate was printed. If a CMA changes employers within the certification period and training records are not available for the first year, the new employer must determine competency by assessing the 25 skills upon

hire, in addition to meeting these requirements for re-certification.

B. - C. ...

D. The re-certification requirements must be met prior to the month of expiration of the CMA's certification.

E. A CMA who has not worked directly with medication administration in a facility, program, or agency for the intellectually/developmentally disabled for 12 months or more must take the OCDD CMA state exam again and pass with proficiency the 25 skills checklist. If the CMA does not pass the state exam, then the CMA must repeat the 60 hour course and pass the exam prior to being recertified. Failure to pass the state exam will result in de-certification.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:697 (July 1995), amended LR 23:1147 (September 1997), LR 41:

§919. De-certification of Medication Attendants

A. ...

B. De-certification may occur under the following conditions:

1. failure of CMA to obtain re-certification requirements. The CMA may be reinstated if the re-certification requirements are met within six months of expiration of the certificate. During this six month period the CMA's authorized functions shall be suspended.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:697 (July 1995), amended LR 41:

§925. Provider Responsibility

A. - A.2. ...

3. documentation of annual successful completion of the 25 skills checklist and bi-annual completion of continuing education necessary for re-certification of CMA.

B. The provider is legally responsible for the level of competency of its personnel and for ensuring that unlicensed staff administering medication have successfully completed the medication administration course curriculum. Additionally, the provider is responsible for maintaining re-certification requirements of their CMA's and that their CMA's perform their functions in a safe manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1021-1025.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities, LR 21:699 (July 1995), amended LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Mark A. Thomas, Office for Citizens with Developmental Disabilities, P.O. Box 3117, Baton Rouge, LA 70821-3117. He is responsible for responding to inquiries regarding this proposed Rule.

Kathy H. Kliebert
Secretary

1411#007

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of Public Health

Added Controlled Dangerous Substances
(LAC 46:LIII.2704)

The Department of Health and Hospitals, Office of Public Health (DHH/OPH), pursuant to the rulemaking authority granted to the secretary of DHH by R.S. 40:962(C) and (H), hereby immediately adopts the following Emergency Rule for the protection of public health. This Rule, effective October 29, 2014, is being promulgated in accordance with the Administrative Procedure Act (R.S. 49:950 et seq.).

Based on the criteria, factors, and guidance set forth in R.S. 40:962(C) and 40:963, the secretary, under this rulemaking, has determined that the below listed substances have a high potential for abuse and should be scheduled as controlled dangerous substances to avoid an imminent peril to the public health, safety, or welfare. In reaching the decision to designate the below listed substances as controlled dangerous substances under schedule I, the secretary has considered the criteria provided under R.S. 40:963 and the specific factors listed under R.S. 40:962(C). The secretary has determined that schedule I is the most appropriate due to her findings that the substances added herein have a high potential for abuse, the substances have no currently accepted medical use for treatment in the United States, and there is a lack of accepted safety for use of the substances under medical supervision. Unless rescinded or terminated earlier, this Emergency Rule shall remain in effect for the maximum period authorized under state law.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LIII. Pharmacists

Chapter 27. Controlled Dangerous Substances

Subchapter A. General Provisions

§2704. Added Controlled Dangerous Substances

A. The following drugs or substances are added to schedule I of the Louisiana Uniform Controlled Dangerous Substances Law, R.S. 40:961 et seq.:

1. methyl (1-(4-fluorobenzyl)-1 H-indazole-3-carbonyl)valinate; and

2. methyl 2-(1-(5-fluoropentyl)-1H-indazole-3-carboxamido)-3-methylbutanoate;

3. N-(1-amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:962, R.S. 40:963, and R.S. 49:953(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 41:

Kathy H. Kliebert, Secretary
and
Jimmy Guidry, M.D., State Health Officer

1411#008

DECLARATION OF EMERGENCY

Department of Health and Hospitals Office of Public Health

Minimum Disinfectant Residual Levels
in Public Water Systems
(LAC 51:XII.311, 355, 357, 361, 363,
367, 903, 1102, 1105, 1113, 1117, 1119,
1125, 1133, 1135, 1139 and 1503)

The state health officer, acting through the Department of Health and Hospitals, Office of Public Health (DHH-OPH), pursuant to the rulemaking authority granted by R.S. 40:4(A) (8) and (13) and in accordance with the intent of Act 573 of 2014, hereby adopts the following Emergency Rule to prevent an imminent peril to the public health and safety. This Rule is being promulgated in accordance with the Administrative Procedure Act (R.S. 49:950 et seq.).

The state health officer, through DHH-OPH, finds it necessary to promulgate an Emergency Rule effective November 3, 2014. This Emergency Rule increases the minimum disinfection residual levels that are required for public water systems. Among other items addressed as well, the rule increases the number of residual measurements taken monthly by 25 percent. The Rule clarifies that daily residual measurements are required at the point of maximum residence time in the distribution system and records of chlorine residual measurements taken in the distribution system, besides from the treatment plant(s) itself, shall be recorded and retained by the public water system as required by the national primary drinking water regulations (as this term is defined in Part XII). This Rule is based upon scientific data and recommendations from the federal Centers for Disease Control and Prevention (CDC) relative to the control of the *Naegleria fowleri* (brain-eating amoeba) parasite, which has been found in four public water systems in Louisiana. Unless rescinded or terminated earlier, this Emergency Rule shall remain in effect for the maximum period authorized under state law. This Emergency Rule may be amended as additional research and science data becomes available.

Title 51

PUBLIC HEALTH—SANITARY CODE

Part XII. Water Supplies

Chapter 3. Water Quality Standards

§311. Records

[formerly paragraph 12:003-2]

A. Complete daily records of the operation of a public water system, including reports of laboratory control tests and any chemical test results required for compliance determination, shall be kept and retained as prescribed in the national primary drinking water regulations on forms approved by the state health officer. When specifically requested by the state health officer or required by other requirements of this Part, copies of these records shall be provided to the office designated by the state health officer within 10 days following the end of each calendar month. Additionally, all such records shall be made available for review during inspections/sanitary surveys performed by the state health officer.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4(A)(8) and 40:5(2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1321 (June 2002), amended LR 30:1195 (June 2004), LR 41:

§355. Mandatory Disinfection

[formerly paragraph 12:021-1]

A. Routine, continuous disinfection is required of all public water systems.

1. Where a continuous chloramination (i.e., chlorine with ammonia addition) method is used, water being delivered to the distribution system shall contain a minimum concentration of 0.5 mg/l of chloramine residual (measured as total chlorine).

2. Where a continuous free chlorination method is used, water being delivered to the distribution system shall contain a minimum concentration of free chlorine residual in accordance with the following table.

pH Value	Free Chlorine Residual
up to 7.0	0.5 mg/l
7.0 to 8.0	0.6 mg/l
8.0 to 9.0	0.8 mg/l
over 9.0	1.0 mg/l

a. Table 355.A.2 does not apply to systems using chloramines.

b. pH values shall be measured in accordance with the methods set forth in §1105.D of this Part.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4 (A)(8)(13) and R.S. 40:5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1326 (June 2002), amended LR 28:2514 (December 2002), LR 35:1240 (July 2009), LR 38:2376 (September 2012), LR 41:

§357. Minimum Disinfection Residuals

[formerly paragraph 12:021-2]

A. Disinfection equipment shall be operated to maintain disinfectant residuals in each finished water storage tank and at all points throughout the distribution system at all times in accordance with the following minimum levels:

1. a free chlorine residual of 0.5 mg/l; or
2. a chloramine residual (measured as total chlorine) of 0.5 mg/l for those systems that feed ammonia.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4 (A)(8)(13) and R.S. 40:5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1327 (June 2002), amended LR 41:

§361. Implementation of Disinfection Requirements

A. A public water system not holding a disinfection variance on November 6, 2013 shall comply with the requirements of §355.A, §357, §367.C, and §367.G of this Part on the later of:

1. February 1, 2014; or
2. the expiration date of any additional time for compliance beyond February 1, 2014 granted by the state health officer. A request for additional time may be submitted in writing prior to February 1, 2014 only, and shall provide detailed justification and rationale for the additional time requested. The state health officer may grant such additional time if significant infrastructure improvements are required to achieve compliance with said requirements.

B. A public water system holding a disinfection variance on November 6, 2013 shall comply with one of the following options by February 1, 2014:

1. implement continuous disinfection that complies with the requirements of §355.A, §357, §367.C, and §367.G of this Part;

2. request additional time for complying with the requirements of §355.A, §357, §367.C, and §367.G of this Part by submitting a written request, if significant infrastructure improvements are required to achieve compliance therewith or extraordinary circumstances exist with regard to the introduction of disinfection to the system. Such written request shall provide detailed justification and rationale for the additional time requested;

3. (This option shall be available only if the public water system's potable water distribution piping is utilized for onsite industrial processes.) notify the state health officer in writing that in lieu of implementing continuous disinfection, the PWS has provided, and will thereafter provide on a quarterly basis, notification to all system users, in a manner compliant with §1907 of this Part, that the system does not disinfect its water. The notification shall state that because the water is not disinfected, the water quality is unknown in regard to the *Naegleria fowleri* amoeba. A public water system selecting this option must sign an acknowledgement form, to be developed by the state health officer, stating that the public water system understands the risks presented by the lack of disinfection and that the public water system maintains responsibility for ensuring the safety of its water for end users; or

4. (This option shall be available only if the public water system's potable water distribution piping is utilized for onsite industrial processes.) request approval of an alternate plan providing water quality and public health protection equivalent to the requirements of §355.A and §357 of this Part. The state health officer may approve such a plan only if it is supported by peer reviewed, generally accepted research and science.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4 (A)(8)(13) and R.S. 40:5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1327 (June 2002), amended LR 41:

§363. Revocation of Variances

[formerly paragraph 12:021-5]

A. A variance from mandatory disinfection shall be revoked when a public water system has a bacteriological MCL violation. When a variance is revoked, the system shall install mandatory continuous disinfection as stated in §355 of this Part within the times specified in a compliance schedule submitted to and approved by the state health officer. Such schedule shall be submitted within 10 days of receipt of notice of revocation.

B. Except for variances held by qualifying public water systems that comply with §361.B.3 of this Part or receive approval of an alternate plan under §361.B.4 of this Part, any variance concerning the mandatory disinfection requirements of §355 and/or §357 of this Part held by a public water system as of November 6, 2013 shall be automatically revoked on the later of:

1. February 1, 2014;

2. the expiration date of any additional time for compliance granted by the state health officer under §361.B.2 of this Part; or

3. the denial of a request for approval of an alternate plan submitted under §361.B.4 of this Part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4 (A)(8)(13) and R.S. 40:5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1327 (June 2002), amended LR 41:

§367. Disinfectant Residual Monitoring and Record Keeping

[formerly paragraph 12:021-7]

A. Disinfectant Residual Monitoring in Treatment Plant. A public water system (PWS) shall measure the residual disinfectant concentration in water being delivered to the distribution system at least once per day.

B. Disinfectant Residual Monitoring in Distribution System. A PWS shall measure the residual disinfectant concentration within the distribution system:

1. by sampling at the same points in the distribution system and at the same times that samples for total coliforms are required to be collected by the PWS under this Part;

2. by sampling at an additional number of sites calculated by multiplying 0.25 times the number of total coliform samples the PWS is required under this Part to take on a monthly or quarterly basis, rounding any mixed (fractional) number product up to the next whole number. These additional residual monitoring samples shall be taken from sites in low flow areas and extremities in the distribution system at regular time intervals throughout the applicable monthly or quarterly sampling period; and

3. by sampling at the site that represents the maximum residence time (MRT) in the distribution system at least once per day.

C. A PWS shall increase sampling to not less than daily at any site in the distribution system that has a measured disinfectant residual concentration of less than 0.5 mg/l free chlorine or 0.5 mg/l chloramine residual (measured as total chlorine) until such disinfectant residual concentration is achieved at such site.

D. The records of the measurement and sampling required under Subsections A and B of this Section shall be maintained on forms approved by the state health officer and shall be retained as prescribed in the National Primary Drinking Water Regulations, and shall be made available for review upon request by the state health officer.

E. Each PWS shall submit a written monitoring plan to the state health officer for review and approval. The monitoring plan shall be on a form approved by the state health officer and shall include all the total coliform and disinfectant residual monitoring sites required under this Section and §903.A of this Part. Each PWS shall also submit a map of the distribution system depicting all total coliform and disinfectant residual monitoring sites required under this Section. The sites shall be identified along with a 911 street address (if there is no 911 street address, then the latitude/longitude coordinates shall be provided). A PWS in existence as of November 6, 2013 shall submit such a monitoring plan no later than January 1, 2014.

F. Chlorine residuals shall be measured in accordance with the analytical methods set forth in §1105.C of this Part.

G. Where a continuous chloramination (*i.e.*, chlorine with ammonia addition) method is used, a nitrification control plan shall be developed and submitted to the state health officer. A PWS in existence as of November 6, 2013 shall submit such a nitrification control plan no later than March 1, 2014.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4(A)(8)(13) and 40:5(2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1327 (June 2002), amended LR 30:1195 (June 2004), LR 41:

**Chapter 9. Louisiana Total Coliform Rule
[formerly Appendix C]**

**§903. Coliform Routine Compliance Monitoring
[formerly Coliform Routine Compliance
Monitoring of Appendix C]**

A. Public water systems shall collect routine total coliform samples at sites which are representative of water throughout the distribution system in accordance with a written monitoring plan approved by the state health officer. Each public water system (PWS) shall submit a written monitoring plan on a form approved by the state health officer. The monitoring plan shall include a minimum number of point of collection (POC) monitoring sites calculated by multiplying 1.5 times the minimum number of samples required to be routinely collected in accordance with Subsections C and D of this Section, rounding any mixed (fractional) number product up to the next whole number. The monitoring plan shall include a map of the system with each POC sampling site identified along with a 911 street address (if there is no 911 street address, then the latitude/longitude coordinates shall be provided). In accordance with requirements of Subsection E of this Section, the plan shall also indicate how the PWS will alternate routine sampling between all of the approved POC sampling sites.

B. - D. ...

E. Unless the state health officer specifies otherwise, the public water supply shall collect routine samples at regular time intervals throughout the month and shall alternate routine sampling between all of the approved POC sites. Routine samples shall not be collected from the same POC more than once per month.

F. - G. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4(A)(8)(13) and 40:5(2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1333 (June 2002), amended LR 41:

**Chapter 11. Surface Water Treatment Rule
Subchapter A. General Requirements and Definitions**

§1102. Relationship with this Part

A. In those instances where the requirements of this Chapter are stricter than or conflict with the requirements of this Part generally, a public water system utilizing surface water or ground water under the direct influence of surface water (GWUDISW) shall comply with the requirements of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4 (A)(8)(13) and R.S. 40:5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 41:

§1105. Analytical Requirements

A. Analysis for total coliform, fecal coliform, or HPC which may be required under this Chapter shall be conducted by a laboratory certified by DHH to do such analysis. Until laboratory certification criteria are developed, laboratories certified for total coliform analysis by DHH are deemed certified for fecal coliform and HPC analysis.

B. - B.3. ...

C. Public water systems shall conduct analysis for applicable residual disinfectant concentrations in accordance with one of the analytical methods in Table 1.

Residual	Methodology	Standard Methods¹	ASTM Methods²	Other Methods
Free Chlorine	Amperometric Titration	4500-Cl D, 4500-Cl D-00	D 1253-03	
	DPD Ferrous Titrimetric	4500-Cl F, 4500-Cl F-00		
	DPD Colorimetric	4500-Cl G, 4500-Cl G-00		
	Syringaldazine (FACTS)	4500-Cl H, 4500-Cl H-00		
	On-line Chlorine Analyzer			EPA 334.0 ³
Total Chlorine	Amperometric Sensor			ChloroSense ⁴
	Amperometric Titration	4500-Cl D, 4500-Cl D-00	D 1253-03	
	Amperometric Titration (low level measurement)	4500-Cl E, 4500-Cl E-00		
	DPD Ferrous Titrimetric	4500-Cl F, 4500-Cl F-00		
	DPD Colorimetric	4500-Cl G, 4500-Cl G-00		
	Iodometric Electrode	4500-Cl I, 4500-Cl I-00		
	On-line Chlorine Analyzer			EPA 334.0 ³
Chlorine Dioxide	Amperometric Sensor			ChloroSense ⁴
	Amperometric Titration	4500-ClO ₂ C		
	DPD Method	4500-ClO ₂ D		
	Amperometric Titration II	4500-ClO ₂ E, 4500-ClO ₂ E-00		
	Lissamine Green Spectrophotometric			EPA 327.0 Rev 1.1 ⁵
Ozone	Indigo Method	4500-O ₃ B, 4500-O ₃ B-97		

1. All the listed methods are contained in the 18th, 19th, 20th, 21st, and 22nd Editions of *Standard Methods for the Examination of Water and Wastewater*; the cited methods published in any of these editions may be used.

2. *Annual Book of ASTM Standards*, Vol. 11.01, 2004; ASTM International; any year containing the cited version of the method may be used. Copies of this method may be obtained from ASTM International, 100 Barr Harbor Drive, P.O. Box C700 West Conshohocken, PA 19428-2959.

3. EPA Method 334.0. "Determination of Residual Chlorine in Drinking Water Using an On-line Chlorine Analyzer," August 2009. EPA 815-B-09-013. Available at http://epa.gov/safewater/methods/analyticalmethods_ogwdw.html.

4. ChloroSense. "Measurement of Free and Total Chlorine in Drinking Water by Palintest ChloroSense," September 2009. Available at <http://www.nemi.gov> or from Palintest Ltd, 21 Kenton Lands Road, PO Box 18395, Erlanger, KY 41018.

5. EPA Method 327.0, Revision 1.1, "Determination of Chlorine Dioxide and Chlorite Ion in Drinking Water Using Lissamine Green B and Horseradish Peroxidase with Detection by Visible Spectrophotometry," USEPA, May 2005, EPA 815-R-05-008. Available online at <http://www.epa.gov/safewater/methods/sourcalt.html>.

D. - E.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4(A)(8)(13) and 40:5 (5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1337 (June 2002), amended LR 28:2516 (December 2002), LR 41:

Subchapter B. Treatment Technique Requirements and Performance Standards

§1113. Treatment Technique Requirements

A. - A.3. ...

4. the total reductions to be required by the DHH may be higher and are subject to the source water concentration of *Giardia lamblia*, viruses, and *Cryptosporidium*;

5. the residual disinfectant concentration in the water delivered to the distribution system is not less than 0.5 mg/l free chlorine or 0.5 mg/l total chlorine for more than 4 hours in any 24-hour period; and

6. the residual disinfectant concentration is not less than 0.5 mg/l free chlorine or 0.5 mg/l total chlorine in more than 5 percent of the samples collected each month from the distribution system for any two consecutive months.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4(A)(8) and R.S. 40:5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1340 (June 2002), amended LR 28:2518 (December 2002), LR 35:1241 (July 2009), LR 41:

§1117. Non-Filtering Systems

A. - C.1. ...

a. A system shall demonstrate compliance with the inactivation requirements based on conditions occurring during peak hourly flow. Residual disinfectant measurements shall be taken hourly. Continuous disinfectant residual monitors are acceptable in place of hourly samples provided the accuracy of the disinfectant measurements are validated at least weekly in accord with §1109.B or C, as applicable, of this Chapter. If there is a failure in the continuous disinfectant residual monitoring equipment, the system shall collect and analyze a grab sample every hour in lieu of continuous monitoring.

b. ...

2. To avoid filtration, the system shall maintain minimum disinfectant residual concentrations in accordance

with the requirements of §355 and §357 of this Part. Performance standards shall be as presented in §1119.B and C of this Chapter.

3. - 3.a. ...

b. an automatic shut off of delivery of water to the distribution system when the disinfectant residual level drops below 0.5 mg/l free chlorine residual or 0.5 mg/l chloramine residual (measured as total chlorine).

D. - D.7. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40: 4 (A)(8)(13) and 40: 5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1341 (June 2002), amended LR 28:2520 (December 2002), LR 35:1242 (July 2009), LR 41:

§1119. Disinfection Performance Standards

A. ...

B. Except as otherwise specified by this Section and Chapter, disinfection treatment shall comply with the minimum standards and requirements set forth in §355.A and §357 of this Part.

C. - C.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40: 4 (A)(8)(13) and 40: 5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1341 (June 2002), amended LR 28:2522 (December 2002), LR 35:1242 (July 2009), LR 41:

Subchapter C. Monitoring Requirements

§1125. Disinfection Monitoring

A. ...

B. Disinfectant Residual Monitoring at Plant. To determine compliance with the performance standards specified in §§1115 or 1119 of this Chapter, the disinfectant residual concentrations of the water being delivered to the distribution system shall be measured and recorded continuously. The accuracy of disinfectant measurements obtained from continuous disinfectant monitors shall be validated at least weekly in accord with §1109.B or C, as applicable, of this Chapter. If there is a failure of continuous disinfectant residual monitoring equipment, grab sampling every two hours shall be conducted in lieu of continuous monitoring, but for no more than five working days following the failure of the equipment. Failure to have the continuous monitoring equipment replaced or repaired and put back into continuous service following the five working days allowed herein shall be deemed to constitute a violation of this Chapter. Systems shall maintain the results of disinfectant residual monitoring for at least 10 years.

C. Small System Disinfectant Residual Monitoring at Plant. Suppliers serving fewer than 3,300 people may collect and analyze grab samples of the water being delivered to the distribution system for disinfectant residual determination each day in lieu of the continuous monitoring, in accordance with Table 4 of this Chapter, provided that any time the residual disinfectant falls below 0.5 mg/l free chlorine or 0.5 mg/l chloramine residual (measured as total chlorine), the supplier shall take a grab sample every two hours until the residual concentrations is equal to or greater than 0.5 mg/l free chlorine or 0.5 mg/l chloramine residual (measured as total chlorine).

* * *

D. Disinfectant Residual Monitoring in Distribution System. The residual disinfectant concentrations in the distribution system shall be measured, recorded, and maintained in accordance with §367.B, C, D and E of this Part. A monitoring plan shall be developed, submitted, reviewed, and approved in accordance with §367.E of this Part.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40: 4 (A)(8)(13) and R.S. 40: 5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:1342 (June 2002), amended LR 28:2523 (December 2002), LR 35:1243 (July 2009), LR 41:

Subchapter E. Reporting

§1133. DHH Notification

A. - A.4. ...

5. the disinfectant residual measured from any sample collected from water being delivered to the distribution system is found to be less than 0.5 mg/l free chlorine or 0.5 mg/l chloramine residual (measured as total chlorine). The notification shall indicate whether the disinfectant residual was restored to at least 0.5 mg/l free chlorine or 0.5 mg/l chloramine residual (measured as total chlorine) within 4 hours;

A.6. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40: 4 (A)(8)(13) and 40: 5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:2525 (December 2002), amended LR 35:1244 (July 2009), LR 41:

§1135. Monthly Report

A. - B.5. ...

C. Disinfection Monitoring Results. The monthly report shall include the following disinfection monitoring results.

1. The date and duration of each instance when the disinfectant residual in water supplied to the distribution system is less than 0.5 mg/l free chlorine or 0.5 mg/l chloramine residual (measured as total chlorine) and when the DHH was notified of the occurrence.

2. The following information on samples taken from the distribution system:

a. the number of samples where the disinfectant residual is measured; and

b. the number of measurements where the disinfectant residual is less than 0.5 mg/l free chlorine or 0.5 mg/l chloramine residual (measured as total chlorine).

D. - F.2.a. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40: 4 (A)(8)(13) and R.S. 40: 5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:2526 (December 2002), amended LR 35:1244 (July 2009), LR 41:

Subchapter F. Public Notification

§1139. Consumer Notification

A. Treatment Technique/Performance Standard Violations. The supplier shall notify persons served by the system whenever there is a failure to comply with the treatment technique requirements specified in §§1113 or 1141, or a failure to comply with the performance standards specified in §§1115, 1117, 1119.A or 1119.C of this Chapter. The notification shall be given in a manner approved by the DHH, and shall include the following mandatory language.

A.1. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4 (A)(8)(13) and R.S. 40:5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 28:2527 (December 2002), amended LR 35:485 (March 2009), LR 35:1246 (July 2009), LR 41:

Chapter 15. Approved Chemical Laboratories/Drinking Water

Subchapter A. Definitions and General Requirements

§1503. General Requirements

A. - C. ...

D. - D.1. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40: 4 (A)(8)(13) and 40: 5 (2)(3)(5)(6)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 30:1199 (June 2004), amended LR 41:

Public Comments

Interested persons may submit written comments to Jake Causey, Chief Engineer, Engineering Services Section, Office of Public Health, P.O. Box 4489, Baton Rouge, LA 70821-4489. He is responsible for responding to inquiries regarding this Emergency Rule.

Kathy Kliebert
Secretary

1411#009

DECLARATION OF EMERGENCY

Department of the State Elections Division

Merit Evaluation for Registrars of Voters
(LAC 31:II.Chapter 1)

The Department of State, pursuant to the emergency provisions of the Administrative Procedure Act [R.S. 49:953(B)], and under the authority of R.S. 18:18, R.S. 18:55, R.S. 18:59, and R.S. 36:742, has adopted an Emergency Rule to amend LAC 31:II.Chapter 1, Section 107 to modify the procedure for merit evaluations of the registrars of voters, adopt LAC 31:II.Chapter 1, Section 108 to codify the appeal process for merit evaluations of the registrars of voters, and amend LAC 31:II.Chapter 1, Section 109 to modify the procedure for merit evaluations of the chief deputies and confidential assistants on an emergency basis. The adoption of the Rule on an emergency basis is necessary, as the registrars of voters will be sent their merit evaluation forms on November 1, the evaluations will be due to the Department of State on December 15, and the appeals process needs to be codified to give the registrars of voters the opportunity to appeal evaluations that result in the registrars of voters not receiving their merit increases.

The Emergency Rule shall become effective on October 24, 2014 and shall remain in effect for the maximum period allowed under the Administrative Procedure Act or until final rules are promulgated in accordance with law, whichever occurs first.

**Title 31
ELECTIONS**

Part II. Voter Registration and Voter Education

Chapter 1. Registrar of Voters

§107. Merit Evaluation for the Registrar of Voters

A. The secretary of state hereby designates the director of registration in the Department of State to conduct the annual evaluation of each parish registrar of voters by reviewing the completed evaluation and data submitted by each registrar of voters. The evaluation will consider the timely performance of the registrar's job responsibilities as required by title 18 of the *Louisiana Revised Statutes*. Upon completion of the rating of a registrar by the director of registration, the director of registration shall submit the evaluation to the commissioner of elections for review and either approval or disapproval depending on the information submitted. If the commissioner of elections does not approve the rating given by the director of registration, the registrar will be given the rating recommended by the commissioner of elections. The registrar's evaluation is then submitted to the Department of State Human Resources Office. If the registrar receives an "excellent" rating, Human Resources will process the merit increase. If the registrar receives a "satisfactory" rating, Human Resources will not process the merit increase.

B. Annually, the criteria and procedure for the merit evaluation shall be determined by the secretary of state or his designee in conjunction with the Registrar of Voters Association. The secretary of state or his designee shall prepare written instructions and forms to be utilized for the evaluation. Evaluation forms with instructions shall be submitted to the registrars of voters no later than November 1 for completion. The form shall include mandated duties required of the registrar's office in accordance with title 18 of the *Louisiana Revised Statutes* and other applicable laws with input from the Board of Review for Evaluation of the Registrar of Voters Association; however, the form is not intended to be all inclusive of all of the duties mandated in title 18 of the *Louisiana Revised Statutes* and other applicable laws. If a registrar receives an "excellent" rating, the registrar is eligible for a merit increase in January. If a registrar does not receive an "excellent" rating, the registrar will be rated "satisfactory" and is not eligible to receive a January merit increase. Also, if a registrar is a certified elections registration administrator (CERA) and does not receive an "excellent" rating, the registrar is not eligible to receive the 7 percent CERA certification pay increase for that year pursuant to R.S. 18:59.4.

C. The parish registrar of voters will have until December 15 to submit a completed evaluation form with supporting documentation to the Department of State.

AUTHORITY NOTE: Promulgated in accordance with R.S. 18:18, R.S. 18:55, and R.S. 36:742.

HISTORICAL NOTE: Promulgated by the Department of State, Elections Division, LR 34:705 (April 2008), amended LR 41:

§108. Appeal of Merit Evaluation for the Registrar of Voters

A. Submission of a Request for Appeal

1. A registrar of voters who does not receive an "excellent" rating on his or her annual merit evaluation may appeal that rating to the Registrars of Voters Evaluation Appeals Committee.

2. The request for appeal shall be in writing and shall be postmarked or received by the human resources director in the Department of State, or the human resources director's designee, no later than January 30.

3. The request for appeal shall explain the reasons for the request and may provide supporting documentation.

4. If the request for appeal is timely and contains the required explanation, the human resources director shall submit a notification of the request to the chairperson of the Registrars of Voters Evaluation Appeals Committee and to the director of registration. The notification of request for appeal shall include copies of the written request of the registrar of voters, the original annual merit evaluation, and any supporting documentation provided by the registrar of voters with his or her written request for appeal.

5. The Department of State grievance process shall not be used to review or reconsider evaluations or a procedural violation of the evaluation process.

B. The Registrars of Voters Evaluation Appeals Committee

1. All written requests for appeal of annual merit evaluations that meet the requirements of Subsection A of this Section shall be considered by the Registrars of Voters Evaluation Appeals Committee.

2. The Registrars of Voters Evaluation Appeals Committee shall consist of seven members. Three members shall be registrars of voters appointed by the Registrar of Voters Association. Four members shall be appointed by the secretary of state, one of which shall be a registrar of voters who shall act as chairperson of the committee. The chairperson shall vote only to break a tie. The director of registration and the commissioner of elections shall not be appointed to the committee.

3. The chairperson shall convene a meeting of the Registrars of Voters Evaluation Appeals Committee within 15 days of receipt of notification of the request for appeal to discuss the request and render a decision regarding the rating. The committee may vote to uphold the "satisfactory" rating or to change the rating to "excellent".

4. The chairperson of the committee shall give written notice of the committee's decision to the affected registrar of voters, the director of registration, and the human resources director within 15 days.

C. The annual merit evaluation form, the written request for appeal of the registrar of voters, the written notice of the committee's decision, and all supporting documentation shall be maintained in the official confidential personnel file of the registrar of voters on file in the Department of State Human Resources Office.

AUTHORITY NOTE: Promulgated in accordance with R.S. 18:18, R.S. 18:55, and R.S. 36:742.

HISTORICAL NOTE: Promulgated by the Department of State, Elections Division, LR 41:

§109. Merit Evaluations of the Chief Deputy and Confidential Assistant

A. The parish registrar of voters shall perform the annual evaluation of the chief deputy and confidential assistant.

B. Annually, the criteria and procedure for the merit evaluation shall be determined by the Registrar of Voters Association. The association shall prepare written instructions and forms to be utilized for the evaluation. The forms and instructions shall be submitted to the registrars of

voters for reviewing the chief deputy and confidential assistant's performance no later than November 1.

C. The parish registrar of voters shall be responsible for evaluating his or her chief deputy and confidential assistant. These evaluations shall be submitted to the Department of State Human Resources Office no later than December 15 of each year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 18:18, R.S. 18:59, and R.S. 36:742.

HISTORICAL NOTE: Promulgated by the Department of State, Elections Division, LR 34:705 (April 2008), amended LR 41:

The Emergency Rule does not have any known or unforeseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Tom Schedler
Secretary of State

1411#006

DECLARATION OF EMERGENCY

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Louisiana Fisheries Forward Program (LAC 76:VII.347)

The Wildlife and Fisheries Commission hereby adopts LAC 76:VII.347 establishing the Louisiana Fisheries Forward Program to increase and elevate professionalism in the commercial crab industry as authorized by R.S. 56:305.6 and Act 540 of the 2014 Regular Legislative Session. Act 540 of the 2014 Regular Legislative Session limits entry into the commercial crab fishery and mandates that the Wildlife and Fisheries Commission establish a program to increase and elevate professionalism in the commercial crab industry no later than November 15, 2014. The Wildlife and Fisheries Commission finds that an imminent peril to the public welfare requires adoption of a Rule upon shorter notice than that provided in R.S. 49:953(A), since failure to establish the program timely would prevent potential entrants into the fishery from obtaining a commercial crab trap license and inhibit their ability to earn a living. It is necessary to adopt these Emergency Rules to have this program in place until the corresponding permanent rules can be adopted.

This Rule establishes the requirements needed to complete the program, including education in the proper fishing techniques necessary for the health and sustainability of the species; proper techniques for the best capture and presentation of the crabs for marketability; proper instructions regarding the placement, tending, and maintenance of crab traps to reduce potential conflicts with

other user groups; and authorizes the program to include a mandatory apprenticeship program. This Emergency Rule is promulgated in accordance with the emergency provisions of the Administrative Procedures Act, R.S. 49:953(B)(1) et seq., and shall be effective beginning November 15, 2014 and shall remain in effect for the maximum period allowed under the Act (120 days) or until adoption of the final Rule, whichever occurs first.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic Life

Chapter 3. Saltwater Sport and Commercial Fishery §347. Louisiana Fisheries Forward Program

A. The following defines the requirements necessary to complete the program to increase and elevate professionalism in the commercial crab industry pursuant to R.S. 56:305.6. This program shall hereafter be referred to as the Louisiana Fisheries Forward Program.

B. For the purposes of this section, the following will be defined as:

Applicant—licensed commercial fishermen attempting to obtain a commercial crab trap gear license through the program.

Mentor—a fisherman holding a valid commercial crab trap gear license who mentors an applicant in completing the apprenticeship path.

Sponsor—a fisherman or wholesale/retail seafood dealer holding a valid commercial crab trap gear license who sponsors an applicant in completing sponsorship path.

C. Policy

1. Applicants that do not qualify for a commercial crab trap gear license under provisions defined in R.S. 56:305.6 shall fulfill all the basic requirements and complete one of two field-training paths; the apprenticeship path, or the sponsorship path, to complete the program, and receive a crab trap gear license.

2. Before beginning a training path, an applicant must possess a valid Louisiana Commercial Fisherman's License. This license number will be used to track participation in the program.

3. The basic requirements and chosen training path shall be completed within one consecutive 12-month period.

4. Applicants who wish to change their mentor or sponsor during the process shall submit a new application containing the new mentor's or sponsor's information along with a written explanation for the change. Applicants shall not lose credit for hours or trips logged under the previous mentor or sponsor provided they are verified pursuant to Paragraph F.3 and G.3 of this Section.

5. In the event an applicant completes the field training path prior to the availability (release) of the required training videos, the applicant shall be issued a conditional commercial crab trap license. Completion of the field training path shall be evidenced by submission of 20 trip tickets under the sponsorship path or submission of completed log forms showing 200 hours of work under the apprenticeship path. The applicant shall be notified via certified mail when the required training videos are available. The applicant shall complete the entire program

including the required video training within 30 days of the date of this notice. Failure to complete the program and submit the required affidavit within 30 days shall result in the suspension of the applicant's commercial crab trap gear license.

D. Eligibility

1. Any person who has been convicted of a Class 3 or greater fisheries violation in the last five years shall not be eligible to participate as an applicant, mentor, or sponsor.

2. Any person choosing to participate as a mentor shall possess a valid commercial crab trap gear license and have documented a minimum of six trip tickets showing crab landings in any two of the previous four years.

3. Any person choosing to participate as a sponsor shall possess a valid commercial crab trap gear license and have documented a minimum of six trip tickets showing crab landings as a commercial fisherman or wholesale/retail dealer in any two of the previous four years.

E. Basic Requirements

1. Each applicant must successfully complete a NASBLA approved boating safety class as required by R.S. 34:851.36.

2. Each applicant must successfully complete and receive a certificate in the following Louisiana Fisheries Forward online courses. The applicant will be required to view 100 percent of the content and score a minimum of 80 percent in order to receive a certificate.

a. Course providing a detailed overview of state and federal statutes governing legal harvest of major seafood commodities, including but not limited to, licensing and permitting, harvest regulations, reporting requirements, and responsible and safe fishing.

b. Course covering the legalities and best management practices of crab fishing, including but not limited to, licensing and permitting requirements, crab harvest regulations, reporting requirements, best handling practices, responsible fishing, and vessel operation.

c. Course covering fundamental financial concepts targeted to Louisiana's commercial fishing industry, including but not limited to, budgeting, cash flow, taxes, insurance, loans, grants, and business plans.

d. Course covering the fundamental concepts for producing high quality seafood, including but not limited to, quality loss, temperature control, icing, chilling, freezing, and proper handling and storage.

F. Apprenticeship Path

1. To initiate the apprenticeship training path the applicant and applicant's mentor must complete and submit an application to the department. The application shall state the intent to participate in apprenticeship training and include the social security numbers, names, addresses, commercial fishing license numbers, and photocopies of the state issued photo identification of both the applicant and the applicant's mentor. Additionally, the mentor's valid commercial crab trap gear license number must be provided.

2. The applicant shall complete a minimum of 200 hours of apprenticeship training related to crab fishing under supervision of the applicant's designated mentor. Training

hours shall be recorded daily on training log forms provided by the department. Copies of the training logs shall be submitted to the department on a quarterly basis. A minimum of 100 hours of training shall be performed and logged on days when the applicant's mentor has harvested and reported trip ticket sales of crabs. Any previous work or training experience in the crab fishery conducted prior to the date the apprenticeship is initiated shall not count toward the applicant's total required hours.

3. Upon completion, the applicant and mentor must complete and submit a notarized affidavit signed by both the applicant and the mentor and include the original signed training log forms. The affidavit shall be provided by the department and indicate the completion of the apprenticeship, affirm the accuracy of the associated log forms, and include the name, address, and commercial fishing license numbers of both the applicant and the mentor.

G. Sponsorship Path

1. To initiate the sponsorship training path the applicant and applicant's sponsor must complete and submit an application to the department. The application shall state the intent to participate in sponsorship training and include the social security numbers, names, addresses, commercial fishing license numbers, and photocopies of state issued photo identification of both the applicant and the applicant's sponsor. Additionally, the sponsor's valid commercial crab trap gear license number must be provided.

2. The department shall issue a special crab trap permit allowing the applicant to actively fish crabs under the sponsor's crab trap gear license and report trip ticket sales of crabs using the applicant's name and commercial fisherman's license number. This permit shall only be issued once and shall only be valid for the duration of the sponsorship. The applicant must complete a minimum of 20 crab fishing trips evidenced by trip tickets. Any trips or landings conducted prior to the date the sponsorship is initiated shall not count toward the applicant's total required crab fishing trips.

3. Upon completion, the applicant and sponsor must complete and submit a notarized affidavit signed by both the applicant and the sponsor and include copies of the trip tickets used to evidence the required crab fishing trips. The affidavit shall be provided by the department and indicate the completion of the sponsorship, affirm the accuracy of the associated trip tickets, and include the name, address, and commercial fishing license numbers of both the applicant and the sponsor.

H. Optional Training

1. Applicants may substitute attendance at the following department approved meetings or educational events for required apprenticeship hours and sponsorship trips: Louisiana Crab Task Force meetings, Crab Dock Days, and annual Louisiana Fisheries Summits. The department may identify additional meetings and events eligible for substitution.

a. Each hour of meeting attendance shall substitute for one hour of the apprenticeship requirement. Every 10 hours of meeting attendance shall substitute for one fishing trip of the sponsorship requirement.

b. A maximum 50 hours of meeting attendance may be substituted for the apprenticeship requirements, or a maximum five fishing trips may be substituted for the sponsorship requirements.

2. Attendance at meetings or educational events shall be documented by a designated department employee or agent. The applicant shall sign-in upon arrival, present valid photo identification and provide their commercial license number. Upon departure, the applicant shall sign-out.

a. Applicants who sign in prior to the start of an event and sign out after the conclusion of an event shall receive substitution credit hours equal only to the length of the event. Applicants shall not receive extra credit hours for arriving early or staying late at an event.

b. Applicants who fail to sign-in or sign-out shall not receive credit hours for attending an event.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:305.6.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 41:

Robert J. Barham
Secretary

1411#028

DECLARATION OF EMERGENCY

Department of Wildlife and Fisheries Wildlife and Fisheries Commission

Oyster Season Delay—Public Seed Grounds East of the Mississippi River and North of the Mississippi River Gulf Outlet (MRGO)

In accordance with the emergency provisions of Louisiana Revised Statutes (R.S.) 49:953, under the authority of R.S. 56:433, R.S. 56:435.1 and R.S. 56:435.1.1(D), and under the authority of a Declaration of Emergency passed by the Wildlife and Fisheries Commission on August 7, 2014, notice is hereby given that the secretary of Wildlife and Fisheries declares that the October 20, 2014 opening of the 2014/2015 oyster season in that portion of the public oyster seed grounds east of the Mississippi River and north of the Mississippi River Gulf Outlet is delayed until further notice, adopted October 17, 2014.

This oyster season delay is necessary to protect the recent spat set so as to increase the likelihood of spat survival in areas where oyster resources continue to be low and spatfall has been below normal in recent years. Protection of spat is in the long-term best interest of the public oyster seed grounds in this area.

Notice of any opening, delaying or closing of a season will be made by public notice at least 72 hours prior to such action, unless such closure is ordered by the Louisiana Department of Health and Hospitals for public health concerns.

Robert J. Barham
Secretary

1411#005

Rules

RULE

Department of Economic Development Office of the Secretary

Ports of Louisiana Tax Credits: Import-Export Tax Credit Program (LAC 13:I.Chapter 39)

The Department of Economic Development, Office of the Secretary, as authorized by and pursuant to the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and in accordance with R.S. 36:104, hereby adopts the following rules of the Ports of Louisiana Tax Credits: Import-Export Credit Program as LAC 13:I.Chapter 39, Subchapter B.

Title 13

ECONOMIC DEVELOPMENT

Part I. Financial Incentive Programs

Chapter 39. Ports of Louisiana Tax Credits

Subchapter B. Import-Export Tax Credit

§3921. Purpose and Definitions

A. Purpose

1. The primary purpose of this Subchapter is to encourage the use of state port facilities in Louisiana. The utilization of public port facilities for the import and export of cargo to or from distribution, manufacturing, fabrication, assembly, processing, or warehousing sites in Louisiana is essential to Louisiana's economic health and the ability of business and industry associated with the maritime industry to compete cost effectively on a regional, national and global scale.

B. Definitions

Applicant—the international business entity submitting application for certification of tax credits.

Application—information provided by the applicant that is required to participate in the import-export tax credit program that has been verified by an independent certified public accountant or other third party approved by Louisiana Economic Development, which shall be filed annually for the prior calendar year's qualified cargo.

Application Date—the date an application for preliminary certification of a project is received by LED.

Baseline Tonnage—any breakbulk or containerized machinery, equipment, materials, products, or commodities owned by an international business entity receiving the credit, which are imported or exported to or from a Louisiana facility and which are so moved by way of an oceangoing vessel berthed at a Louisiana public port facility during the 2013 calendar year.

Breakbulk Cargo—machinery, equipment, materials, products, or commodities, including but not limited to palletized or unpalletized bagged, packaged, wrapped, drummed, baled, or crated goods and commodities, or offshore drilling platforms and equipment, and shall not include bulk cargo.

Bulk Cargo—loose, unpackaged, non-containerized cargo or any liquid or dry commodities that are handled in bulk.

Certified Tonnage—the number of tons of qualified cargo in a calendar year minus the number of tons of baseline tonnage.

COA—the commissioner of administration of the state of Louisiana.

Containerized Cargo—any machinery, equipment, materials, products, or commodities shipped in containers which are rigid, sealed, reusable metal boxes in which merchandise is shipped by vessel, truck, or rail.

DOTD—the Louisiana Department of Transportation and Development.

Export Cargo—any breakbulk or containerized cargo brought from the state of Louisiana to a foreign country, excluding bulk cargo.

Import Cargo—any breakbulk or containerized cargo brought to the state of Louisiana from a foreign country, excluding bulk cargo.

International Business Entity—a taxpayer corporation, partnership, limited liability company, or other commercial entity, all or a portion of whose activities involve the import or export of breakbulk or containerized cargo to or from a Louisiana facility.

JLCB—the Joint Legislative Committee on the Budget.

LED—the Louisiana Department of Economic Development.

LDR—the Louisiana Department of Revenue.

Louisiana Expenditures—shipping costs incurred in the transporting, warehousing, storing, and blast freezing of qualified cargo between the Louisiana facility and the cargo's point of entry to or exit from the state.

Louisiana Facility—manufacturing, fabrication, assembly, distribution, processing, or warehousing facilities located within Louisiana.

Oceangoing Vessel—any vessel, ship, barge, or watercraft that floats, including offshore oil exploration platforms.

Public Port—any deep-water port commission or port, harbor and terminal district as defined in article VI, section 44 of the Constitution of Louisiana, and any other port, harbor, and terminal district established under title 34 of the *Louisiana Revised Statutes* of 1950.

Qualified Cargo—any breakbulk or containerized machinery, equipment, materials, products, or commodities owned by an international business entity, that are imported or exported to or from a Louisiana facility by means of an oceangoing vessel berthed at a public port facility.

Significant Positive Economic Benefit—net positive tax revenue that shall be determined by taking into account direct, indirect, and induced impacts of the project based on a standard economic impact methodology utilized by the COA, and the value of the credit, and any other state tax and financial incentives that are used by LED to secure the project or activity.

State—the state of Louisiana.

SBC—the Louisiana State Bond Commission.

Ton—a net *ton* of 2000 pounds and in the case of containerized cargo it shall exclude the weight of the container.

Verified Statement—information required by Section 3923.D, verified by the applicant's chief executive officer or most senior officer responsible for shipping and distribution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6036.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 40:2238 (November 2014).

§3923. Application

A. An international business entity submitting an application is eligible to receive tax credits for certified tonnage following preliminary certification by LED, certification of significant positive economic benefit by the COA, approval of JLCB, approval by SBC and final certification by LED.

B. No applications will be received for import-export tax credits prior to July 1, 2014.

C. Applications may be filed after January 1 of each year for qualified cargo shipped during the immediately preceding calendar year.

D. No more than one application may be filed by an applicant for a calendar year, and shall include all qualified cargo for that calendar year.

E. The application shall include the following information:

1. a verified statement of baseline tonnage;
2. a verified statement of qualified cargo specifically including:
 - a. total annual volume and tons of breakbulk or containerized cargo exported from or imported to a Louisiana facility;
 - b. all shipping Louisiana expenditures directly associated with imports or exports through Louisiana public ports, and general freight charges, or a distribution of those expenditures that can be identified as Louisiana expenditures across the following six key shipping-related categories:
 - i. international shipping, which are those Louisiana expenditures for shipping between the Louisiana port and international locations such as pilotage, tugs, harbor fees, linement and dockage;
 - ii. water transportation, which are those Louisiana expenditures for intrastate shipping by barge or other vessel;
 - iii. truck transportation, which are those Louisiana expenditures for intrastate transportation by road;
 - iv. rail transportation, which are those Louisiana expenditures for intrastate transportation by rail;
 - v. warehousing and storage, which are those Louisiana expenditures for wharfage, stevedoring, drayage, warehousing, storage, and other loading and unloading charges;
 - vi. blast freezing, which are those specific Louisiana expenditures for freezing or other cold storage;
 - c. any additional information required by LED.

3. The applicant must retain documentation supporting the information in the verified statement for a three-year period. Upon good cause, all books and records of the applicant relating to the application shall be subject to audit by LED, at applicant's expense.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6036.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 40:2239 (November 2014).

§3925. Preliminary Certification

- A. LED shall review the application and determine:
1. eligibility of the applicant;
 2. certified tonnage; and
 3. the estimated significant positive economic benefit of the cargo shipment, taking into consideration:
 - a. the nature of the cargo as either containerized or breakbulk;
 - b. transit of the cargo across the docks of a Louisiana public port;
 - c. the origination and terminus of the cargo from or to a Louisiana or international location;
 - d. the impact of the cargo shipment in promoting port and harbor activity;
 - e. the impact of the cargo shipment on the employment of Louisiana residents;
 - f. the impact of the cargo shipment on the overall economy of the state.

B. If LED determines that the applicant is eligible, LED shall issue a preliminary certification of the certified tonnage, the maximum amount of tax credits that could be issued (no more than \$5 per ton of certified tonnage), a recommended finding as to significant positive economic benefit and, if less than the maximum, the recommended amount of tax credits warranted by the estimated significant positive economic benefit.

C. LED shall send the preliminary certification and economic analysis to the COA.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6036.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 40:2239 (November 2014).

§3927. Certification of Significant Positive Economic Benefit

A. The COA shall review the application, LED preliminary certification and economic analysis, and determine whether a certification of significant positive economic benefit may be issued.

1. COA may issue a certification if he finds that there will be significant positive economic benefit received by the state to offset the effect to the state of the tax credits as a result of either:

- a. increased port activity because of grant; or
- b. otherwise.

2. The COA's certification shall state the amount of tax credits for which significant positive economic benefit is determined.

3. The COA's certification shall be submitted to the JLCB and the SBC for approval.

4. If the COA's certification is approved by both the JLCB and the SBC, it shall be delivered to the Secretary of LED for final certification.

a. Approval by the JLCB shall not be granted earlier than July 1, 2014.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6036.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 40:2239 (November 2014).

§3929. Final Certification

A. The secretary of LED (or his designated program administrator) shall issue a final certification of tax credits in the amount certified by the COA and approved by JLCB and SBC, and deliver copies to the applicant and LDR.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6036.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 40:2240 (November 2014).

§3931. Tax Credit Limitations

A. Tax credits shall be issued on a first come, first served basis, based upon the date of final certification.

B. No applicant shall receive a final certification of tax credits under this program in an amount greater than two million five hundred thousand dollars for certified cargo in any calendar year.

C. LED shall not issue final certification of tax credits under this program in a total amount for all applicants greater than \$6,250,000 in any single fiscal year.

D. Applications exceeding the limitations provided in this section will be deemed reduced to the applicable limits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6036.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 40:2240 (November 2014).

§3933. Claiming Tax Credits

A. There shall be allowed a credit against the individual income, corporate income, and corporation franchise tax liability of a taxpayer who has received a final certification from LED, provided that the credit shall be allowed only against the tax liability of the international business entity which receives the certification.

B. Tax credits are earned in the tax year in which LED issues final certification.

C. The first year in which tax credits may be claimed against taxes is the tax year in which the tax credits are earned.

D. If the tax credit allowed exceeds the amount of taxes due for the tax period, then any unused credit may be carried forward as a credit against subsequent tax liability for a period not to exceed five years.

E. The applicant shall attach the final certification to its return when claiming the credits.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6036.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 40:2240 (November 2014).

§3935. Audit, Recapture and Recovery of Tax Credits

A. Recapture. If LED finds that tax credits have been improperly issued, LED shall issue a revised final certification disallowing the improperly issued tax credits and send copies thereof to the applicant and LDR. The applicant's state income tax liability for such taxable period shall be increased by an amount necessary for the recapture of the tax credits allowed.

B. Recovery. Credits previously granted to an applicant, but later disallowed, may be recovered by LDR through any collection remedy authorized by R.S. 47:1561 and initiated

within three years from December 31 of the year in which the credits were earned.

C. Interest. Interest may be assessed and collected, at a rate of three percentage points above the rate provided in R.S. 39:3500(B)(1), which shall be computed from the original due date of the return on which the credit was taken.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6036.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 40:2240 (November 2014).

§3937 Termination of Program

A. No import-export credits shall be granted after January 1, 2020. Applications for certification of tax credits for all certified tonnage through December 31, 2018 must be submitted no later than July 1, 2019 to allow sufficient time for final certification of the tax credits by December 31, 2019.

AUTHORITY NOTE: Promulgated in accordance with R.S. 47:6036.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of the Secretary, LR 40:2240 (November 2014).

Anne G. Villa
Assistant Secretary

1411#032

RULE

Board of Elementary and Secondary Education

Bulletin 111—The Louisiana School, District and State Accountability System (LAC 28:LXXXIII.3503 and 3505)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education has amended *Bulletin 111—The Louisiana School, District and State Accountability System*: §3503, Alternative Schools Including Alternative Charter Schools; and §3505, Alternative Programs. These revisions enable the delay of the initial release of the alternative program and alternative school performance report for one year. This also allows the LDE to collaborate with districts in developing metrics for the performance report and evaluate student progress relative to performance indicators from the 2014-2015 academic year.

Title 28

EDUCATION

Part LXXXIII. Bulletin 111—The Louisiana School, District and State Accountability System Chapter 35. Inclusion of Alternative Education Schools and Students in Accountability

§3503. Alternative Schools Including Alternative Charter Schools [Formerly §3501]

A. - C.3. ...

D. Starting with evidence of student progress from the 2014-2015 academic year, all alternative schools shall receive a performance report that shall include, but not be limited to, data pertaining to academic progress, credit accumulation, completion, and behavior modification.

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

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2753 (December 2003), amended 31:423 (February 2005), LR 34:868 (May 2008), LR 35:1472 (August 2009), LR 37:2119 (July 2011), LR 37:3202 (November 2011), LR 38:1213 (May 2012), LR 39:472 (March 2013), LR 40:2240 (November 2014).

§3505. Alternative Programs

A. - B.1. ...

C. Starting with evidence of student progress from the 2014-2015 academic year, all alternative programs shall receive a performance report that shall include, but not be limited to, data pertaining to academic progress, credit accumulation, completion, and behavior modification.

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

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education LR 39:472 (March 2013), amended LR 40:2241 (November 2014).

Kimberly Tripeaux
Interim Executive Director

1411#046

RULE

Board of Elementary and Secondary Education

Bulletin 741—Louisiana Handbook for
School Administrators (LAC 28: CXV.523)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education has adopted *Bulletin 741—Louisiana Handbook for School Administrators*: §523, Foreign Associate Program. The policy provides the process by which the Louisiana Department of Education can enter into an agreement with school systems and schools employing foreign associate teachers to secure the cost of the visa through a one-time reduction of their Minimum Foundation Program (MFP) funding annually and remit the funds to the Louisiana Department of Culture, Recreation, and Tourism for processing.

Title 28 EDUCATION

Part CXV. Bulletin 741—Louisiana Handbook for School Administrators

Chapter 5. Personnel

§523. Foreign Associate Program

A. The Foreign Associate Program supported through the Minimum Foundation Program requires visas be obtained for all teachers.

1. Foreign associate teachers shall not be employed unless a visa is obtained.

2. The Minimum Foundation Program formula may provide funding to pay for the expense of the visa.

B. In order to ensure the proper processing of the visa on behalf of each foreign associate teacher, the Louisiana Department of Education may enter into an agreement with school systems and schools employing the teacher to secure the cost of the visa through a one-time reduction of their Minimum Foundation Program annually and remit the funds to the Louisiana Department of Culture, Recreation, and Tourism for processing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 40:2241 (November 2014).

Kimberly Tripeaux
Interim Executive Director

1411#045

RULE

Board of Elementary and Secondary Education

Bulletin 741—Louisiana Handbook for
School Administrators (LAC 28: CXV.2905)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education amended *Bulletin 741—Louisiana Handbook for School Administrators*: §2905, Evaluation of Alternative Schools/Programs. This revision will enable the delay of the initial release of the alternative program and alternative school performance report for one year. This will also allow the LDE to collaborate with districts in developing metrics for the performance report and evaluate student progress relative to performance indicators from the 2014-2015 academic year.

Title 28 EDUCATION

Part CXV. Bulletin 741—Louisiana Handbook for School Administrators

Chapter 29. Alternative Schools and Programs

§2905. Evaluation of Alternative Schools/Programs

A. Each LEA annually shall evaluate each alternative school/program. The evaluation shall be based upon the standards for approval of alternative schools/programs and shall include testing of basic skills for student participants. The process of evaluation shall also include teacher, parent, and student input from the alternative school. The annual report shall be made to the LDE on or before the date prescribed by the LDE.

B. Starting with evidence of student progress from the 2014-2015 academic year, all alternative schools and programs will receive a performance report that shall include, but not be limited to, data pertaining to academic progress, credit accumulation, completion, and behavior modification.

NOTE: Refer to the alternative education handbook for program operation guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:100.5.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1308 (June 2005), amended LR 35:2319 (November 2009), LR 39:2226 (August 2013), LR 40:2241 (November 2014).

Kimberly Tripeaux
Interim Executive Director

1411#044

RULE

Board of Elementary and Secondary Education

Bulletin 746—Louisiana Standards for State Certification of School Personnel (LAC 28:CXXXI.601)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education amended Bulletin 746—Louisiana Standards for State Certification of School Personnel: §601. Introduction. The policy allows non-university providers of educator preparation programs, including local education agencies that are approved by the Board of Elementary and Secondary Education (BESE), to offer courses (equivalent contact hours) that lead to certification endorsements.

Title 28

EDUCATION

Part CXXXI. Bulletin 746—Louisiana Standards for State Certification of School Personnel

Chapter 6. Endorsements to Existing Certificates

§601. Introduction

A. Endorsement areas are permanent authorizations added to a teaching certificate. Upon completion of requirements for an additional area of certification, as outlined in this bulletin, the holder of a valid Louisiana teaching certificate may have the endorsement added. For endorsement purposes, the following notes apply.

1. - 4. ...

5. Semester hours earned from a regionally accredited institution or equivalent contact hours from a non-university private provider of teacher and/or educational leader preparation program are acceptable for endorsement purposes. One semester hour is equivalent to 15 contact hours.

6. Non-university private providers of teacher and/or educational leader preparation programs must submit proposals for approval by LDE and BESE, as outlined in Chapter 5 of Bulletin 996: Standards for Approval of Teacher and/or Educational Leader Preparation Programs.

B. A formal request for an additional authorization on a certificate shall be directed to the LDE. An official transcript from a regionally accredited institution verifying successful completion of endorsement requirements (semester hours) or documentation from the non-university private provider verifying successful completion of endorsement requirements (contact hours) shall accompany the request. The final authority for approval of an additional authorization is the LDE.

C. - C.3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, R.S. 17:22(6), R.S. 17:391.1-391.10, and R.S. 17:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 32:1814 (October 2006), amended LR 37:1381 (May 2011), LR 40:2242 (November 2014).

Kimberly Tripeaux
Interim Executive Director

1411#043

RULE

Board of Elementary and Secondary Education

Bulletin 1566—Pupil Progression Policies and Procedures (LAC 28:XXXIX.707)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education amended *Bulletin 1566—Pupil Progression Policies and Procedures*: §707. Exceptions to High Stakes Policy. The policy eliminates the requirement that students eighth grade students who do not meet the passing requirement for the LEAP test in English or math must pass a remediation course prior to earning Carnegie credit in that subject. This revision aligns this policy with other policies passed by BESE in December.

Title 28

EDUCATION

Part XXXIX. Bulletin 1566—Pupil Progression Policies and Procedures

Chapter 7. High Stakes Testing Policy

§707. Exceptions to High Stakes Policy

A. - A.3. ...

B. U/B Waiver—Eighth Grade. The LEA may waive the state policy for eighth grade students scoring at the *Unsatisfactory* level in English language arts or mathematics, if the student scores at the *basic* level in the other, provided that the following criteria are met:

1. the student scored *approaching basic* or above on the science and social studies components of LEAP;

2. the student had an overall 2.5 grade point average on a 4.0 scale;

3. the student had a minimum 92 percent attendance during the school year;

4. the decision is made in accordance with the local pupil progression plan, which may include a referral to the School Building Level Committee (SBLC);

5. the student has participated in both the spring and summer administrations of LEAP and has attended the summer remediation program offered by the LEA (the student shall participate in the summer retest only on the subject that he/she scored at the *Unsatisfactory* level during the spring test administration); and

6. parental consent is granted.

7. Repealed.

C. - H.1. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7; R.S. 17:24.4.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 36:2006 (September 2010), amended LR 40:2242 (November 2014).

Kimberly Tripeaux
Interim Executive Director

1411#042

RULE

Board of Elementary and Secondary Education

Operations—Board and Committee Meeting Protocol
(LAC 28:I.709)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Board of Elementary and Secondary Education amended the *Louisiana Administrative Code*, Title 28, Part I, §709, Board and Committee Protocol. These changes establish a policy related to the handling of non-technical amendments to written documents raised during the course of a BESE meeting and prior to a BESE or BESE committee vote.

Title 28

EDUCATION

Part I. Board of Elementary and Secondary Education

Chapter 7. Operations

§709. Board and Committee Meeting Protocol

A. - C.4. ...

5. Prior to voting on written documents, including, but not limited to, regulatory bulletins and legislative reports, members must be provided copies of any proposed non-technical revisions in writing. Non-technical revisions are those that alter the sense, meaning, or effect of the item.

D. - D.14 ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), R.S. 42:13, R.S. 17:3(C), R.S. 42:14, and R.S. 42:16.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 34:421 (March 2008), amended LR 37:2141 (July 2011), LR 38:3153 (December 2012), LR 39:3264 (December 2013), LR 40:2243 (November 2014)

Kimberly Tripeaux
Interim Executive Director

1411#041

RULE

Department of Environmental Quality Office of the Secretary Legal Division

Surface Water Quality
(LAC 33:IX.Chapter 11)(WQ088)

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 Water Quality regulations, LAC 33:IX.1105, 1109 and 1119 (WQ088).

This Rule contains revisions to LAC 33:IX.Chapter 11, that will correct outdated and unclear language in Sections 1109 and 1119. A definition is being removed from Section 1119 and replaced with a more appropriated definition in Section 1105. Other minor changes include correcting punctuation, grammar and misspelled words. This Rule is necessary to update language in the Water Quality regulations that is unclear, outdated or inaccurate. This Rule will also provide consistency in state language. The basis and rationale for this Rule is to enhance and protect the waters of the state. This Rule meets an exception listed in R.S. 30:2019(D)(2) and R.S. 49:953(G)(3); therefore, no

report regarding environmental/health benefits and social/economic costs is required.

Title 33

ENVIRONMENTAL QUALITY

Part IX. Water Quality

Subpart 1. Water Pollution Control

Chapter 11. Surface Water Quality Standards

§1105. Definitions

Degradation—a lowering of water quality, as demonstrated by data analysis, water quality models, or other scientifically defensible method.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2074(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 10:745 (October 1984), amended LR 15:738 (September 1989), LR 17:264 (March 1991), LR 20:883 (August 1994), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 25:2401 (December 1999), LR 26:2545 (November 2000), LR 29:557 (April 2003), LR 30:1473 (July 2004), amended by the Office of the Secretary, Legal Affairs Division, LR 33:456 (March 2007), LR 33:827 (May 2007), LR 35:445 (March 2009), amended by the Office of the Secretary, Legal Division, LR 40:2243 (November 2014).

§1109. Policy

Water quality standards policies concerned with the protection and enhancement of water quality in the state are discussed in this Section. Policy statements on antidegradation, water use, water body exception categories, compliance schedules and variances, short-term activity authorization, errors, severability, revisions to standards, and sample collection and analytical procedures are described.

A. Antidegradation Policy

1. State policy is that all waters of the state, including interstate, intrastate, and coastal waters, and any portions thereof, whose existing quality exceeds the specifications of the approved water quality standards or otherwise supports an unusual abundance and diversity of fish and wildlife resources, such as waters of national and state parks and refuges, will be maintained at their existing high quality. After completion of appropriate analysis and after completion of the public participation processes outlined in the water quality management plan and the continuing planning process, the state may choose to allow lower water quality in waters that exceed the standards to accommodate justifiable economic and/or social development in the areas in which the waters are located, but not to the extent of violating the established water quality standards. No such changes, however, will be allowed if they impair the existing water uses. No lowering of water quality will be allowed in waters where designated water uses are not currently being attained.

2. Waste discharges shall comply with applicable state and federal laws for the attainment of water quality goals. Any new, existing, or expanded point source or nonpoint source discharging into state waters, including any land clearing which is the subject of a federal permit application, shall be required to provide the necessary level of waste treatment to protect state waters as determined by the administrative authority. Further, the highest statutory and regulatory requirements shall be achieved for all existing

point sources and best management practices (BMPs) for nonpoint sources. Additionally, no degradation shall be allowed in high-quality waters designated as *outstanding natural resource waters*, as defined in LAC 33:IX.1111.A. Waters included in the Louisiana Natural and Scenic Rivers System, under the administration of the Louisiana Department of Wildlife and Fisheries, will be considered by the department for designation as outstanding natural resource waters. Those water bodies presently designated as outstanding natural resource waters are listed in LAC 33:IX.1123. The administrative authority shall not approve any wastewater discharge or certify any activity for federal permit that would impair water quality or use of state waters, including waters in the Natural and Scenic Rivers System that are waters of the state.

A.3. - J.6. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2074(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 10:745 (October 1984), amended LR 15:738 (September 1989), LR 17:264 (March 1991), LR 17:966 (October 1991), LR 20:883 (August 1994), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2546 (November 2000), LR 29:557 (April 2003), amended by the Office of the Secretary, Legal Affairs Division, LR 33:457 (March 2007), LR 33:828 (May 2007), amended by the Office of the Secretary, Legal Division, LR 40:2243 (November 2014).

§1119. Implementation Plan for Antidegradation Policy

A. Summary and Purpose

1. As stated in LAC 33:IX.1109.A of these regulations, the antidegradation policy provides a legal framework for the basic maintenance and protection of all designated water uses. It also outlines methods that the state uses to protect state waters from water quality degradation and some of the state and federal rules and regulations that authorize them.

2. ...

B. Implementation of Louisiana's Water Quality Management Process

1. Procedures and methods by which the antidegradation policy is implemented are described in this Section. Additional implementation procedures may be incorporated into the water quality management plan after appropriate public participation and intergovernmental coordination.

2. - 2.g. ...

C. Specific Implementation Procedures for the Antidegradation Policy. The antidegradation policy is implemented by ensuring that for all new or increased discharges which may impact water quality and are permitted by the state, or for which there must be a permit on which the state comments, consideration is given to requirements of the policy. The basic principle of the policy is that water quality criteria specified in the standards shall not be exceeded and that designated uses will not be adversely impacted.

1. ...

2. If a new or increased activity will impact water quality by either a point or nonpoint source discharge of pollutants, the state shall ensure that the activity will not impair the existing uses. If water quality will be degraded, the state shall ensure that an analysis consistent with the

antidegradation policy is completed, and the intergovernmental coordination and public participation provisions of the state's continuing planning process are met. In the case of state or federal wastewater discharge permits, intergovernmental coordination and public participation may be accomplished through public notice of the permit. As with any permitted discharge to a water body not designated as an outstanding natural resource water, some change in existing water quality may occur; however, existing uses shall be maintained.

3. If a new or increased wastewater discharge or activity is proposed for an outstanding natural resource water body, the administrative authority shall not approve that discharge or activity if it will cause *degradation*, as defined in LAC 33:IX.1105, of the water body. A facility identified by the administrative authority as having an unpermitted discharge will be required to apply for an LPDES permit in accordance with LAC 33:IX.2501.A. The unpermitted discharge may be permitted if the discharge existed before the designation as an outstanding natural resource water body. Additionally, an existing unpermitted discharge of treated sanitary wastewater may also be permitted if no reasonable alternative discharge location is available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2074(B)(1).

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Water Resources, LR 15:738 (September 1989), amended by the Office of Environmental Assessment, Environmental Planning Division, LR 26:2548 (November 2000), amended by the Office of the Secretary, Legal Affairs Division, LR 33:831 (May 2007), amended by the Office of the Secretary, Legal Division, LR 40:2244 (November 2014).

Herman Robinson, CPM
Executive Counsel

1411#040

RULE

Office of the Governor Real Estate Commission

Disclosures and Representations (LAC 46:LXVII.2501)

Under the authority of the Louisiana Real Estate License Law, R.S. 37:1430 et seq., and in accordance with the provisions of the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., notice is hereby given that the Louisiana Real Estate Commission amended LAC 46:LXVII.Subpart 1, §2501.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXVII. Real Estate Subpart 1. Real Estate

Chapter 25. Advertising; Disclosures; Representations §2501. Disclosures and Representations

A. - G.2. ...

3. a group or team name, as long as the advertising complies with all other applicable provisions of this Chapter and LAC 46:LXVII.Chapter 19 of these rules and regulations; and

4. a slogan that may not be construed as that of a company name.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1431 et seq.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Commission, LR 26:42 (January 2000), amended by the Office of the Governor, Real Estate Commission, LR 28:829 (April 2002), LR 29:127 (February 2003), LR 32:1450 (August 2006), LR 37:3003 (October 2011), LR 40:2244 (November 2014).

Bruce Unangst
Executive Director

1411#024

RULE

Office of the Governor Real Estate Commission

Real Estate Teams and Groups
(LAC 46:LXVII.Chapter 19)

Under the authority of the Louisiana Real Estate License Law, R.S. 37:1430 et seq., and in accordance with the provisions of the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., the Louisiana Real Estate Commission adopted LAC 46:LXVII.Chapter 19, Real Estate Teams and Groups.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXVII. Real Estate

Subpart 1. Real Estate

Chapter 19. Real Estate Teams and Groups

§1901. Definitions

A. For the purpose of this Chapter, *team* or *group* shall mean a collective name used by two or more real estate licensees, who represent themselves to the public as a part of one entity that performs real estate license activities under the supervision of the same sponsoring broker.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1430 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Real Estate Commission, LR 40:2245 (November 2014).

§1903. Sponsorship

A. Team or group members shall be sponsored by the same broker and, if applicable, shall conduct all real estate license activity from the office or branch office where their individual license is held.

B. Licensees shall not form a team or group without written approval from the sponsoring broker.

C. The sponsoring broker shall designate a member of each approved team or group as the contact member responsible for all communications between the broker and the team.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1430 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Real Estate Commission, LR 40:2245 (November 2014).

§1905. Team or Group Names

A. Team or group names shall not contain terms that could lead the public to believe that the team or group is offering real estate brokerage services independent of the

sponsoring broker. These terms shall include, but are not limited to:

1. real estate;
2. brokerage or real estate brokerage;
3. realty;
4. company.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1430 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Real Estate Commission, LR 40:2245 (November 2014).

§1907. Team or Group Leaders

A. The sponsoring broker shall be responsible for all license activity of team or group members sponsored by the broker.

B. The designated contact member of each team or group shall maintain a current list of all team or group members, which shall be provided to the sponsoring broker upon formation of the team or group and immediately upon any change thereafter.

C. A current record of all team or group names, and the members thereof, shall be maintained by the sponsoring broker in a manner that can be made readily available to the LREC upon request, including record inspections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1430 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Real Estate Commission, LR 40:2245 (November 2014).

§1909. Team Advertising

A. A team or group name shall not be used in advertising without the written approval of the sponsoring broker.

B. The term “team” or “group” may be used to advertise real estate license activities provided that:

1. the use of the term does not constitute the unlawful use of a trade name and is not deceptively similar to a name under which any other person or entity is lawfully doing business;

2. the team or group is composed of more than one licensee;

3. the advertising complies with all other applicable provisions of this Chapter and LAC 46:LXVII.Chapter 25 of these rules and regulations.

C. An unlicensed person shall not be named, acknowledged, referred to, or otherwise included in any team or group advertising.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1430 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Real Estate Commission, LR 40:2245 (November 2014).

§1911. Disputes

A. The commission shall not intervene or become otherwise involved in team or group disputes, including those pertaining to financial obligations that are the result of a business relationship between a team or group, team or group member, branch manager, sponsoring broker, or any combination thereof, including the payment of commissions and dues to professional organizations. Such disputes shall be settled by the respective parties or by a court of competent jurisdiction.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1430 et seq.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Real Estate Commission, LR 40:2245 (November 2014).

Bruce Unangst
Executive Director

1411#025

RULE

**Department of Health and Hospitals
Board of Medical Examiners**

Physician Practice; Office-Based Surgery
(LAC 46:XLV.Chapter 73)

In accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et. seq., and pursuant to the authority of the Louisiana Medical Practice Act, R.S. 37:1270, the Louisiana State Board of Medical Examiners has amended its rules governing office-based surgery, LAC 46XLV.7301 et seq. The amendments are set forth below.

Title 46

**PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

**Part XLV. Medical Profession
Subpart 3. Practice**

**Chapter 73. Office-Based Surgery
Subchapter A. General Provisions**

§7303. Definitions

A. As used in this Chapter, unless the content clearly states otherwise, the following terms and phrases shall have the meanings specified.

Anesthesia—moderate sedation or deep sedation, as such terms are defined in this Section.

* * *

Certified Registered Nurse Anesthetist (CRNA)—an advanced practice registered nurse certified according to the requirements of a nationally recognized certifying body approved by the Louisiana State Board of Nursing ("Board of Nursing") who possesses a current license or permit duly authorized by the Board of Nursing to select and administer anesthetics or provide ancillary services to patients pursuant to R.S. 37:911 et seq., and who, pursuant to R.S. 37:911 et seq., administers anesthetics and ancillary services under the direction and supervision of a physician who is licensed to practice under the laws of the state of Louisiana.

Deep Sedation/Analgesia—a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Monitoring of patients undergoing deep sedation shall only be performed by an anesthesia provider.

General Anesthesia—a drug-induced loss of consciousness, by use of any anesthetic induction agent or otherwise, during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. General anesthesia shall only be performed by an anesthesia provider.

* * *

Moderate Sedation/Analgesia (conscious sedation)—a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Monitoring of the patients undergoing moderate sedation shall be performed by qualified monitoring personnel or an anesthesia provider.

* * *

Qualified Monitoring Personnel—an appropriately trained, qualified and licensed health care provider in this state, who is currently certified in advanced cardiac life support, or pediatric advanced life support for pediatric patients, and designated to monitor and attend to the patient during the pre-operative, intra-operative and post-operative periods.

* * *

Single Oral Dose—one dosage unit of a medication in an amount recommended by the manufacturer of the drug for oral administration to the patient.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 30:424 (March 2004), amended LR 40:2246 (November 2014).

§7305. Exemptions

A. This Chapter shall not apply to the following surgical procedures or clinical settings:

1. exempt surgical procedures include those:

a. that do not involve a drug induced alteration of consciousness and do not require the use of anesthesia or an anesthetic agent, those using only local, topical or regional anesthesia or those using a single oral dose of a sedative or analgesic which is appropriate for the unsupervised treatment of anxiety or pain; and/or

b. ...

2. exempt clinical settings include:

a. - d.iii. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 30:425 (March 2004), amended LR 40:2246 (November 2014).

§7307. Prohibitions

A. ...

B. The level of sedation utilized for office-based surgery shall be appropriate to the procedure. Under no circumstances shall a physician withhold appropriate sedation or under-sedate a patient for the purpose of avoiding compliance with the requirements of this Chapter.

C. General anesthesia shall not be utilized in office-based surgery. Any surgery or surgical procedure that employs general anesthesia shall only be performed in an exempted clinical setting as described in Section 7305 of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 30:425 (March 2004), amended LR 40:2246 (November 2014).

§7308. Required Information

A. Each physician shall report to the board annually as a condition to the issuance or renewal of medical licensure, whether or not and the location(s) where the physician performs office-based surgery, along with such other information as the board may request.

B. The information shall be reported in a format prepared by the board, which shall be made a part of or accompany each physician’s renewal application for medical licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 40:2247 (November 2014).

§7309. Prerequisite Conditions

A. - A.2.a.i. ...

ii. have completed residency training in a specialty that encompasses the procedure performed in an office-based surgery setting;

b. ...

c. physician performing office-based surgery shall ensure that all individuals who provide patient care in the office-based surgery setting are duly qualified, trained and possess a current valid license or certificate to perform their assigned duties.

3. - 4a. ...

5. Patient Care

a. A physician performing office-based surgery shall remain physically present throughout surgery and be immediately available for diagnosis, treatment and management of complications or emergencies. The physician shall also insure the provision of indicated post-anesthesia care.

b. The anesthesia provider or qualified monitoring personnel shall be physically present throughout the surgery.

c. The anesthesia provider or qualified monitoring personnel shall remain in the facility until all patients have been released from anesthesia care by a CRNA or a physician.

d. Discharge of a patient shall be properly documented in the medical record and include:

- i. confirmation of stable vital signs;
- ii. return to pre-surgical mental status;
- iii. adequate pain control;
- iv. minimal bleeding, nausea and vomiting;
- v. confirmation that the patient has been discharged in the company of a competent adult; and
- vi. time of discharge.

6. - 6.b....

c. In the event of an electrical outage which disrupts the capability to continuously monitor all specified patient parameters, heart rate and breath sounds shall be monitored using a precordial stethoscope or similar device and blood pressure measurements shall be re-established using a non-electrical blood pressure measuring device until power is restored.

6.d. - 7.c. ...

8. Medical Records

a. A complete medical record shall be documented and maintained by the physician performing office-based surgery of the patient history, physical and other

examinations and diagnostic evaluations, consultations, laboratory and diagnostic reports, informed consents, preoperative, inter-operative and postoperative anesthesia assessments, the course of anesthesia, including monitoring modalities and drug administration, discharge and any follow-up care.

9. Policies and Procedures

a. A written policy and procedure manual for the orderly conduct of the facility shall be prepared, maintained on-site and updated annually, as evidenced by the dated signature of a physician performing office-based surgery at the facility for the following areas:

i. - iii.(c). ...

b. All facility personnel providing patient care shall be familiar with, appropriately trained in and annually review the facility's written policies and procedures. The policy and procedure manual shall specify the duties and responsibilities of all facility personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 30:425 (March 2004), amended LR 40:2247 (November 2014).

§7311. Administration of Anesthesia

A. Evaluation of the Patient. All patients shall have a pre-surgical evaluation (history and physical) to screen for and identify any medical condition that could adversely affect the patient’s response to the medications utilized for moderate or deep sedation.

B. - C. ...

D. Administration of Anesthesia. Deep sedation/analgesia shall be administered by an anesthesia provider who shall not participate in the surgery.

E. Monitoring. Monitoring of the patient shall include continuous monitoring of ventilation, oxygenation and cardiovascular status. Monitors shall include, but not be limited to, pulse oximetry, electrocardiogram continuously, non-invasive blood pressure measured at appropriate intervals, an oxygen analyzer and an end-tidal carbon dioxide analyzer. A means to measure temperature shall be readily available and utilized for continuous monitoring when indicated. An audible signal alarm device capable of detecting disconnection of any component of the breathing system shall be utilized. The patient shall be monitored continuously throughout the duration of the procedure. Post-operatively, the patient shall be evaluated by continuous monitoring and clinical observation until stable. Monitoring and observations shall be documented in the patient's medical record. Qualified monitoring personnel assigned to monitor a patient shall not participate in the surgery.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 30:427 (March 2004), amended LR 40:2247 (November 2014).

§7314. Creation of Log; Board Access to Log and Facilities

A. A physician shall create and maintain a continuous log by calendar date of all office-based surgical procedures. The log shall include patient identifiers and the type and duration of each procedure and remain at the physician’s office-based surgery facility. The log shall be provided to the board’s staff or its agents upon request.

B. A physician who performs office-based surgery shall respond to the inquiries and requests of, and make his or her office-based surgery facility available for inspection by, the board's staff or its agents at any reasonable time without the necessity of prior notice. The failure or refusal to respond or comply with such inquiries or requests, or make an office-based surgery facility available for inspection, shall be deemed a violation of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 37:1270(B)(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 40:2247 (November 2014).

Cecilia Mouton, M.D.
Executive Director

1411#026

RULE

Department of Health and Hospitals Board of Nursing

Disaster Permits for APRNs (LAC 46:XLVII.3328 and 4513)

Notice is hereby given in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 37:918, that the Louisiana State Board of Nursing (LSBN) amends Chapter 33 and 45 of its rules particular, by amending Sections 3328 and 4513. The changes to the rules provide for the issuance of temporary prescriptive authority to those who request to apply for and provide services as advanced practice registered nurses/APRNs in Louisiana during the event of a formal, declared disaster. Current rules require that an applicant for prescriptive authority hold a valid APRN license which excludes and prevents APRNs from other states working under a disaster permit from providing a full range of services to Louisianans since a permit is not full APRN licensure. There is no request to expand the scope of practice of APRNs in the state nor is there a request for exceptions to current requirements for prescriptive authority. The addition of language to Section 3328 and an exception to Section 4513 of current rules allows APRNs with a disaster permit issued in Louisiana to work to their maximum scope of practice permitted by current laws and regulations in Louisiana during this temporary period.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XLVII. Nurses: Practical Nurses and Registered Nurses

Subpart 2. Registered Nurses

Chapter 33. General

§3328. Temporary Permits

A. - G. ...

H. Prescriptive and Distributing Authority of Advanced Practice Registered Nurses (APRNs) Issued a Disaster Permit. As public health emergencies and disasters can be

sudden and unpredictable, the Department of Health and Hospitals, Office of Public Health and the Louisiana State Board of Nursing shall jointly develop guidelines for the collaborative practice agreement and collaborating physicians or dentists, and the processes required for granting disaster permits and temporary prescriptive authority for APRNs in the event of such emergencies when gratuitous services are provided. Any APRN issued a disaster permit who engages in medical diagnosis and management shall have prescriptive authority issued by the Louisiana State Board of Nursing. In accord with LAC 46:XLVII.4513.D, with the exception of controlled substances, an APRN may be granted temporary prescriptive authority to prescribe assessment studies, including pharmaceutical diagnostic testing, legend drugs, therapeutic regimens, medical devices and appliances, receiving and distributing a therapeutic regimen of prepackaged drugs prepared and labeled by a licensed pharmacist, and free samples supplied by a drug manufacturer, and distributing drugs for administration to and use by other individuals within the scope of practice as defined by the board in R.S. 37.913(3)(b).

1. The applicant shall:

a. hold a current, unencumbered, unrestricted and valid APRN license or APRN disaster relief permit issued in Louisiana with no pending disciplinary proceedings as stated in R.S. 37:921;

b. submit an application for temporary prescriptive authority on a form provided by the board;

c. submit evidence of current, unrestricted certification issued by a nationally recognized certifying body approved by the board;

d. submit evidence of current and active prescriptive authority granted in another state;

e. submit a collaborative practice agreement as defined in §4513.B.1, 2 and 3 and the guidelines established and approved by the Department of Health and Hospitals, Office of Public Health and the Louisiana State Board of Nursing.

i. The collaborating physician shall include the state health officer of the Department of Health and Hospital, Office of Public Health and/or his designee;

ii. The designee shall meet all requirements set forth by the board and as delineated in the guidelines.

2. Any deviation from any provisions in this Part shall be submitted to the board for review and approval;

3. APRNs currently licensed and holding active prescriptive authority in Louisiana are eligible to apply for additional temporary prescriptive authority privileges under the provisions of this Section;

4. Nothing herein provides for the authorization to prescribe controlled substances

5. If allegations of acts or omissions which constitute grounds for disciplinary action as defined in R.S. 37:911 et seq., or any Rule promulgated by the board is received during the permit interval or during the time prescriptive authority has been granted, the permit and prescriptive authority issued pursuant to this Section shall be recalled.

RULE

**Department of Health and Hospitals
Board of Optometry Examiners**

Authorized Ophthalmic Surgery Procedures
(LAC 46:LI.107, 503 and 801)

6. The Louisiana State Board of Nursing shall review the application and collaborative practice agreement for temporary prescriptive authority and all related materials, and shall approve, modify, or deny the application for prescriptive authority. An APRN with temporary prescriptive authority approved by the board shall only prescribe drugs and therapeutic devices as recommended within the parameters of the collaborative practice agreement.

7. If temporary prescriptive authority is granted through the provisions of this part relative to the issuance of an APRN disaster permit, prescriptive authority shall become inactive immediately upon expiration or inactivation of the APRN disaster permit, and the APRN must immediately cease exercising prescriptive authority at that time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918, 919 and 920.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Nursing, LR 33:460 (March 2007), amended LR 39:2280 (August 2013), LR 40:2248 (November 2014).

§4513. Authorized Practice

A. - C.8. ...

D. Prescriptive and Distributing Authority. An advanced practice registered nurse (APRN) shall practice in a manner consistent with the definition of advanced practice set forth in R.S. 37:913(3). An APRN may be granted prescriptive authority to prescribe assessment studies, including pharmaceutical diagnostic testing (e.g., dobutamine stress testing) legend and certain controlled drugs, therapeutic regimens, medical devices and appliances, receiving and distributing a therapeutic regimen of prepackaged drugs prepared and labeled by a licensed pharmacist, and free samples supplied by a drug manufacturer, and distributing drugs for administration to and use by other individuals within the scope of practice as defined by the board in R.S. 37.913(3)(b).

1. The applicant shall:

a. hold a current, unencumbered, unrestricted and valid registered nurse license in Louisiana with no pending disciplinary proceedings as stated in R.S. 37:921, except as provided in LAC 46:XLVII.3328.A-H;

1.b. - 14.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:918(K) and R.S. 37:1031-1034.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Nursing, LR 10:598 (August 1984), amended by the Department of Health and Hospitals, Board of Nursing, LR 22:283 (April 1996), amended by the Department of Health and Hospitals, Board of Nursing and Board of Medical Examiners, LR 22:981 (October 1996), LR 25:1245 (July 1999), LR), amended by the Department of Health and Hospitals, Board of Nursing, 27:727 (May 2001), amended by the Department of Health and Hospitals, Board of Nursing and Board of Medical Examiners, LR 28:487 (March 2002), repromulgated LR 28:1205 (June 2002), amended by the Department of Health and Hospitals, Board of Nursing, LR 31:2023 (August 2005), LR 33:1870 (September 2007), amended by the Department of Health and Hospitals, Board of Nursing, LR 40:63 (January 2014), LR 40:2249 (November 2014).

Karen C. Lyon, PhD, APRN, ACNS, NEA
Executive Director

1411#001

In accordance with the Administrative Procedures Act, R.S. 49:950 et seq., the Louisiana State Board of Optometry Examiners, pursuant to authority vested in the Louisiana State Board of Optometry Examiners by the Optometry Practice Act, R.S. 37:1041-1068, has amended LAC 46:LI.107, 503 and 801 by adopting the following amendments to the rules set forth below.

Title 46

**PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part LI. Optometrists

Chapter 1. General Provisions

§107. Organization of the Board

A. ...

B. Definitions

1. As used in this Part, the following terms have the meaning ascribed to them in this Section, unless the context clearly indicates otherwise.

2. Masculine terms shall include the feminine and, when the context requires, shall include partnership and/or professional corporations.

3. Where the context requires, singular shall include the plural or plural shall include the singular.

Act—the Optometry Practice Act, R.S. 37:1041 et seq.

Board—the Louisiana State Board of Optometry Examiners.

Diagnostic and Therapeutic Pharmaceutical Agent—any chemical in solution, suspension, emulsion, ointment base, or other form when used topically or orally that has the property of assisting in prescription or nonprescription drug delivered by any route of administration, used or prescribed for the diagnosis, prevention, treatment, or mitigation of abnormal conditions and pathology of the human eye and its adnexa, or those which may be used for such purposes, and certain approved narcotics, only when used in treatment of disorders or diseases of the eye and its adnexa. Licensed pharmacists of this state shall fill prescriptions for such pharmaceutical agents of licensed optometrists certified by the board to use such pharmaceutical agents.

i. Any *diagnostic and therapeutic pharmaceutical agent* as defined above listed in schedules III, IV and V of the uniform controlled dangerous substances law shall be limited to use or to be prescribed by a licensed optometrist for a maximum of 48 hours when used in treatment or disorders or diseases of the eye and its adnexa.

ii. *Diagnostic and therapeutic pharmaceutical agent* shall not include any drug or other substances listed in schedules I and II of the uniform controlled dangerous substances law provided in R.S. 40:963 and 964 which shall be prohibited from use by a licensed optometrist.

iii. A licensed optometrist may prescribe one additional 48-hour prescription only if warranted by a follow-up exam.

Licensed Optometrist—a person licensed and holding a certificate issued under the provisions of the Act.

Optometry—that practice in which a person employs primary eye care procedures or applies any means other than including ophthalmic surgery such as YAG laser capsulotomy, laser peripheral iridotomy, and laser trabeculoplasty, for the measurement of except for those surgery procedures specifically excluded in subsection D of section 1041 of the Optometry Practice Act; measures the power and testing the range of vision of the human eye, and determines using subjective or objective means, including the use of lenses and prisms before the eye and autorefractors or other automated testing devices to determine its accommodative and, refractive state, and general scope of function; and the adaptation of frames and lenses, in all their phases, including plano and zero power contact lenses, to overcome errors of refraction and restore as near as possible normal human vision, or for orthotic, or prosthetic, therapeutic or cosmetic purposes, or cosmetic purposes with respect to the adaption of contact lenses. *Optometry* also includes the examination and diagnosis, and treatment, other than by ophthalmic surgery, of abnormal conditions and pathology of the human eye and its adnexa, including the use and prescription or prescription of vision therapy, ocular exercises, rehabilitation therapy, subnormal vision therapy, ordering of appropriate diagnostic lab or imaging tests; the dispensing of samples to initiate treatment; and the use or prescription of diagnostic and therapeutic pharmaceutical agents. Optometrists shall issue prescriptions, directions and orders regarding medications and treatments which may be carried out by other health care personnel including optometrists, physicians, dentists, osteopaths, pharmacists, nurses, and others.

i. *Ophthalmic Surgery*—a procedure upon the human eye or its adnexa in which in vivo human tissue is injected, cut, burned, frozen, sutured, vaporized, coagulated, or photodisrupted by the use of surgical instrumentation such as, but not limited to, a scalpel, cryoprobe, laser, electric cautery, or ionizing radiation. Nothing in this Optometry Practice Act shall limit an optometrist's ability to use diagnostic or therapeutic instruments utilizing laser or ultrasound technology in the performance of primary eye care or limit an optometrist's ability to perform *ophthalmic surgery* procedures other than those specifically excluded in subsection D of section 1041 of the Optometry Practice Act. Only persons licensed to practice medicine by the Louisiana State Board of Medical Examiners under the laws of this state may perform the *ophthalmic surgery* procedures specified in subsection D of the Optometry Practice Act.

ii. *Authorized Ophthalmic Surgery Procedures*—any procedure upon the human eye or its adnexa in which in vivo human tissue is injected, cut, burned, frozen, vaporized, coagulated, photodisrupted, or otherwise altered by the use of surgical instrumentation such as, but not limited to, a scalpel, needle, cryoprobe, laser, cautery, ultrasound, or ionizing radiation, other than procedures listed in subsection D of section 1041 of the Optometry Practice Act.

iii. Nothing in the Optometry Practice Act shall prohibit the dilation and irrigation of lacrimal ducts, insertion and removal of lacrimal plugs, foreign body removal from superficial ocular tissue, suture removal,

removal of eyelashes, drainage of superficial lesions of the eye and its adnexa, or corneal shaping with external ophthalmic devices such as contact lenses by optometrists, provided, however, no optometrist shall carry out any such procedures referenced in this Paragraph unless certified by the board to treat those abnormal conditions and pathology of the human eye and its adnexa.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1048.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Optometry Examiners, LR 32:629 (April 2006), amended LR 34:872 (May 2008), LR 40:2249 (November 2014).

Chapter 5. Practicing Optometry

§503. License to Practice Optometry

A. - F.5. ...

G. Certification to Use Diagnostic Drugs to Treat Ocular Pathology. An optometrist may be certified to use diagnostic and therapeutic pharmaceutical agents and to diagnose and treat ocular pathology. In order to obtain such certification, an optometrist shall comply with the following requirements.

1. - 1.c. ...

2. Certification to Treat Pathology and to Use and Prescribe Diagnostic and Therapeutic Pharmaceutical Agents

a. Definitions. For purposes of this Paragraph 2 the following definitions shall apply.

* * *

Therapeutic Pharmaceutical Agents—any chemical in solution, suspension, emulsion, ointment base, or other form that when used topically or orally has the property of assisting in the diagnosis, prevention, treatment, or mitigation of abnormal conditions and pathology of the human eye and its adnexa, or those which may be used for such purposes, and certain approved narcotics when used in the treatment of disorders or diseases of the eye and its adnexa.

* * *

b. Requirements for Certification. In order to be approved as an optometrist authorized to treat pathology and use and prescribe diagnostic and *therapeutic pharmaceutical agents*, an optometrist shall present to the secretary of the Louisiana State Board of Optometry Examiners for approval by the board, the following:

i. a certified transcript from an approved educational institution evidencing satisfaction of the educational prerequisites for certification to use diagnostic and *therapeutic pharmaceutical agents* as set forth in LAC 46:LI.503.G.1.a.ii or evidence of current certification by the board for the use of diagnostic and *therapeutic pharmaceutical agents* under LAC 46:LI.503.G.1; and

ii. certification from a source acceptable to the board evidencing current qualification to perform cardiopulmonary resuscitation (CPR) or basic life support, which certification shall be current as of the time of application to the board for certification to treat pathology and use and prescribe diagnostic and *therapeutic pharmaceutical agents*;

iii. a signed statement from the applicant stating that he or she possesses child and adult automatic epinephrine injector kits in every office location in which the applicant practices, which injector kits shall be operable and

unexpired as of the date of application to the board for certification to treat pathology and use and prescribe diagnostic and *therapeutic pharmaceutical agents*;

2.b.iv. - 3. ...

H. Qualifications for a Louisiana-Licensed Optometrist to be Credentialed to Utilize and Perform Authorized Ophthalmic Surgery Procedures

1. Louisiana licensed optometrists shall be credentialed to perform authorized ophthalmic surgery procedures if:

a. the applicant provides proof of holding a Louisiana license to practice therapeutic optometry and is in good standing;

b. the applicant provides proof of satisfactory completion of a course of instruction approved by the board that may include:

- i. the following didactic classroom instructions:
 - (a). laser physics, hazards, and safety;
 - (b). biophysics of lasers;
 - (c). laser application on clinical optometry;
 - (d). laser tissue interactions;
 - (e). laser indications, contraindications, and potential complications;
 - (f). gonioscopy;
 - (g). laser therapy for open angle glaucoma;
 - (h). laser therapy for angle closure glaucoma;
 - (i). posterior capsulotomy;
 - (j). common complications: lids, lashes, lacrimal

system;

(k). medicolegal aspects of anterior segment procedures;

- (l). peripheral iridotomy;
- (m). laser trabeculoplasty;
- (n). minor surgical procedures;
- (o). overview of surgical instruments, asepsis, and O.S.H.A.;
- (p). surgical anatomy of the eyelids;
- (q). emergency surgical procedures;
- (r). chalazion management;
- (s). epiluminescence microscopy;
- (t). local anesthesia: techniques and complications;

- (u). anaphylaxis and other office emergencies;
- (v). radiofrequency surgery;
- (w). post-operative wound care;

c. the applicant satisfactorily completes a written test approved by the board on aspects of the Louisiana Optometry Practice Act pertaining to authorized ophthalmic surgery procedures.

2. A board-approved course of instruction shall be:

- a. provided by an accredited optometry, osteopathy or medical school;
- b. a minimum of 32 clock hours in length; and
- c. sponsored by an organization approved by the board.

3. Prohibitions and Referrals

a. Performing authorized ophthalmic surgery procedures without credentialing based upon the education requirements outlined in this administrative regulation shall be grounds for suspension or revocation of an optometry

license and/or credentialing to perform authorized ophthalmic surgery procedures as per section 1061 of the Optometry Practice Act.

4. Outcomes Reporting

a. Every optometrist who has met the requirements for certification to perform authorized ophthalmic surgery procedures shall report to the board the outcome of authorized ophthalmic surgery procedures performed in such form as required or directed by the board.

5. Beginning with the graduating class of 2015 any optometrist who provides proof that he/she graduated from an optometry school whose program includes all of the training and testing requirements established by the board may be deemed to have met the requirements for certification to perform authorized ophthalmic surgery procedures.

6. Performance of authorized ophthalmic surgery procedures by any person without a valid and current certificate issued by the board to perform such procedures shall be considered a violation of section 1061(A)(1) of the Optometry Practice Act.

I. Prescriptions for Eyeglasses or Contact Lenses

1. Every written prescription shall contain an expiration date and the signature of the optometrist issuing the prescription. The expiration date may not exceed 18 months, unless the optometrist documents a valid medical reason in the chart for doing so.

2. Contact lenses may not be sold or dispensed without a written, signed, unexpired prescription. Every contact lens prescription shall contain information specifying the curvature, diameters, refractive power, pertinent measurement, and the number of lenses to be dispensed. An optometrist, when filling a prescription for contact lenses, shall issue to the patient a notice that states the number of refills allowed and the expiration date of the prescription.

3. An optometrist, when filling a prescription for eyeglasses or contact lenses, shall be required to keep the original prescription. An optometrist may not refuse to release to a patient a copy of the patient's prescription if requested by the patient; provided, however, an optometrist shall not be required to release a prescription that has expired.

4. A spectacle prescription shall not be construed to be or substituted for a contact lens prescription nor shall a contact lens prescription be construed to be or substituted for a spectacle prescription.

J. Participation in Student Extern Program. An optometrist may participate in student extern programs in accordance with rules and regulations promulgated from time to time by the board.

1. The level of responsibility assigned to a student extern shall be at the discretion of the supervising optometrist who shall be ultimately responsible for the duties, actions or work performed by such student extern.

2. The duties, actions and work performed by a student extern in accordance with the provisions of this §503 and §603 shall not be considered the practice of optometry without a license as set forth in R.S. 37:1061(14).

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1048.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Optometry Examiners, LR 32:632 (April 2006), amended LR 34:873 (May 2008), LR 38:1590 (July 2012), LR 40:2250 (November 2014).

Chapter 8. Fees and Expenses

§801. Fees

A. - A.11. ...

12. Original Authorized Ophthalmic Surgery Procedures Certificate—\$50

13. Authorized Ophthalmic Surgery Procedures Certificate renewal fee—\$50

14. Authorized Ophthalmic Surgery Procedures Certificate delinquency fee—\$50

15. Authorized Ophthalmic Surgery Procedures Certificate reinstatement fee—\$50

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1048.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Optometry Examiners, LR 32:636 (April 2006), amended LR 40:2252 (November 2014).

James D. Sandefur, O.D.
Secretary

1411#100

RULE

Department of Health and Hospitals Board of Pharmacy

Pharmacy Records
(LAC 46:LIII.Chapter 11 and 1213, 1503, and 1509)

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950 et seq.) and the Pharmacy Practice Act (R.S. 37:1161 et seq.), the Louisiana Board of Pharmacy hereby amends several Sections within Chapter 11, Pharmacies, as well as Section 1213 in Chapter 12, Automated Medication Systems, and Sections 1503 and 1509 in Chapter 15, Hospital Pharmacy, to update the rules relative to pharmacy records and recordkeeping requirements.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LIII. Pharmacists

Chapter 11. Pharmacies

Subchapter B. Pharmacy Records

§1119. Definitions

A. As used in this Chapter, the following terms shall have the meaning ascribed to them in this Section:

Department—the Louisiana Department of Health and Hospitals or its successor.

Password—a private identification that is created by a user to obtain access to an electronic pharmacy information system.

Personal Identifier—a unique user name or number for identifying and tracking a specific user's access to a pharmacy information system such as Social Security number, user identification number, or employee number.

Positive Identification—a method of identifying an individual who prescribes, administers, or dispenses a prescription drug.

a. A method may not rely solely on the use of a private personal identifier such as a password, but must also include a secure means of identification such as the following:

- i. a manual signature on a hard copy record;
- ii. a magnetic card reader;
- iii. a bar code reader;
- iv. a thumbprint reader or other biometric method;
- v. a proximity badge reader;
- vi. a register in which each individual pharmacist

dispensing a prescription shall sign a log each day, attesting to the fact that the information entered into the electronic record keeping system has been reviewed that day, and is correct as stated;

vii. a printout of every transaction that is verified and manually signed within a reasonable period of time by the individual who prescribed, administered, or dispensed the prescription drug. The printout must be maintained for two years and made available on request to an agent of the board.

b. A method relying on a magnetic card reader, a bar code reader, or a proximity badge reader must also include a private personal identifier, such as a password, for entry into a secure mechanical or electronic system.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 40:2252 (November 2014), effective January 1, 2015.

§1121. General Requirements

A. Requirements

1. All records relating to the practice of pharmacy shall be uniformly maintained for a period of two years, be readily available, and promptly produced upon request for inspection by an agent of the board during regular business hours.

2. All records required by the laws and regulations of the board shall be provided to the board, or its agents, within 72 hours of request, unless a shorter period is required, as determined by the board or its agent.

3. The failure to produce any pharmacy records requested by the board or its agent within 72 hours of such request shall substantiate a violation of R.S. 37:1241(A)(22).

B. Accountability. The holder of the pharmacy permit and the pharmacist-in-charge shall account for all prescription drug transactions, consisting of:

1. acquisition records—invoice receipts of drugs acquired;

2. disposition records—drugs dispensed pursuant to prescription orders, administered pursuant to medical orders, or distributed pursuant to purchase orders; and

3. inventory records—drugs in current possession.

C. Retention. Except as provided in §1123, all records required by this Chapter and by Louisiana law shall be retained for a minimum of two years from the most recent transaction. The failure to retain such records for at least two years shall substantiate a violation of R.S. 37:1229.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 23:1312 (October 1997), amended LR 29:2090 (October 2003), effective January 1, 2004, LR 40:2252 (November 2014), effective January 1, 2015.

§1123. Records

A. There shall be positive identification of the pharmacist, intern, technician, or technician candidate responsible for performing all activities related to the practice of pharmacy including, but not limited to:

1. prescription information entered into the pharmacy information system;
2. prospective drug utilization review;
3. prescription dispensing;
4. administration of immunizations.

B. A pharmacy may use one of the following types of pharmacy information systems:

1. a system that utilizes the original hard copy prescription to document the initial dispensing of a prescription, but utilizes a computerized system to dispense refills that does not document the positive identification of the pharmacist responsible for the practice of pharmacy. In order to document positive identification, this system shall require the manual signature or initials of a pharmacist on a hard copy record as specified in Subsection E of this Section;

2. an electronic recordkeeping system that complies with the provisions of 21 CFR 1311 and documents the positive identification of the pharmacist responsible for the practice of pharmacy. Such systems shall provide for routine backups at least once per day.

C. All pharmacy information systems shall be capable of providing immediate retrieval (via display and hard copy printout or other mutually agreeable transfer media) of patient profile information for all prescriptions dispensed within the previous two years. This information shall include the following minimum data:

1. the original prescription number;
2. date of issuance of the original prescription order by the prescriber;
3. date of dispensing by the pharmacist;
4. full name and address of the patient;
5. full name and address of the prescriber;
6. directions for use;
7. the name, strength, dosage form, and quantity of the drug prescribed;
8. the quantity dispensed if different from the quantity prescribed;
9. the pharmacist responsible for prescription information entered into the computer system, the pharmacist responsible for prospective drug utilization review as defined in §515 of these rules, and the pharmacist responsible for dispensing;
10. the total number of refills authorized by the prescriber; and
11. the refill history of the prescription as defined in Subsection D of this Section.

D. The refill history of the prescription record maintained in the pharmacy information system shall include, but is not limited to:

1. the prescription number;
2. the name and strength of the drug dispensed;

3. the date of the refill or partial fill;
4. the quantity dispensed;
5. the pharmacist responsible for prospective drug utilization review as defined in §515 of these rules, and the pharmacist responsible for dispensing each refill;
6. the total number of refills or partial fills dispensed to date for that prescription order.

E. The hard copy documentation required pursuant to Paragraph B.1 of this Section shall be provided by each individual pharmacist who makes use of such system by signing a statement attesting to the fact that the prescription information entered into the computer is correct as displayed.

F. Backup Support System

1. The pharmacy information system shall be capable of being reconstructed in the event of an electronic or computer malfunction or unforeseen accident resulting in the destruction of the system or the information contained therein. To prevent the accidental loss of electronic records, an adequate backup system shall be maintained. Backup support systems shall be updated at least once daily.

2. In the event the pharmacy information system experiences down time, a record of all refills dispensed during such time shall be recorded and then entered into the pharmacy information system as soon as it is available for use. During the time the pharmacy information system is not available, prescriptions may only be refilled if, in the professional judgment of the pharmacist, the number of refills authorized by the prescriber has not been exceeded.

G. A pharmacy purging a pharmacy information system of prescription records shall develop a method of recordkeeping capable of providing retrieval (via display, hard copy printout, or other mutually agreeable transfer media) of prescription order information for all prescriptions filled or refilled within the previous two years. This information shall include, at a minimum, the following data:

1. pharmacy name and address;
2. original prescription number;
3. date of issuance of the original prescription order by the prescriber;
4. date of original dispensing by the pharmacist;
5. full name and address of the patient;
6. full name and address of the prescriber;
7. directions for use;
8. name, strength, dosage form, and quantity of the drug prescribed;
9. quantity dispensed if different from the quantity prescribed;
10. total number of refills authorized by the prescriber;
11. total number of refills dispensed to date for that prescription order;
12. date of each refill;
13. name or initials of each individual dispensing pharmacist.

H. A log shall be maintained of all changes made to a prescription record after the prescription has been dispensed. Such log may be accessible to the pharmacist for review, but shall be protected from being altered in any way. At a minimum, the log shall contain the following information:

1. date and time of change;
2. change(s) made;
3. pharmacist making the change.

I. Prescriptions entered into a pharmacy information system but not dispensed shall meet all of the following requirements:

1. the complete prescription information shall be entered in the computer system;
2. the information shall appear in the patient's profile; and
3. there is positive identification, in the pharmacy information system or on the hard copy prescription, of the pharmacist who is responsible for entering the prescription information into the system.

J. With respect to oral prescriptions received in the pharmacy and then transcribed to written form in the pharmacy, or written prescriptions received by facsimile in the pharmacy, or written prescriptions presented to the pharmacy, a pharmacy may use an electronic imaging system to preserve such prescriptions, but only if:

1. the system is capable of capturing, storing, and reproducing the exact image of a prescription, including the reverse side of the prescription form;
2. any notes of clarification of and alterations to a prescription shall identify the author and shall be directly associated with the electronic image of the prescription form;
3. the image of the prescription form and any associated notes of clarification to or alterations to a prescription are retained for a period of not less than two years from the date the prescription is last dispensed;
4. policies and procedures for the use of an electronic imaging system are developed, implemented, reviewed, and available for board inspection; and
5. the prescription is not for a controlled dangerous substance listed in schedule II.

K. Filing and Retention of Prescription Forms

1. Written prescription forms (including transcriptions of verbal prescriptions received in the pharmacy, prescriptions received by facsimile in the pharmacy, as well as written prescription forms presented to the pharmacy) shall be assembled and stored in prescription number sequence. Prescriptions for controlled dangerous substances listed in schedule II shall be filed separately from all other prescriptions. Where multiple medications are ordered on a single prescription form and includes one or more controlled dangerous substances listed in schedule II, then such forms shall be filed with other schedule II prescriptions. These original hard copy prescription forms shall be retained in the prescription department for a minimum of two years following the most recent transaction.

2. For those pharmacies utilizing an electronic imaging system as described in Subsection J of this Section, written prescription forms may be assembled and stored in prescription number sequence, or in the alternative, a date scanned sequence. Further, these original hard copy prescriptions shall be retained in the prescription department for a minimum of one year following the most recent transaction.

3. Prescription forms received as an electronic image or electronic facsimile directly within the pharmacy information system shall be retained within the information system for a minimum of two years following the most recent transaction. Further, the pharmacy may produce a

hard copy of the prescription form but shall not be required to do so merely for recordkeeping purposes.

4. Electronic prescriptions, those generated electronically by the prescriber, transmitted electronically to the pharmacy, and then received electronically directly into the pharmacy information system, shall be retained within the information system for a minimum of two years following the most recent transaction. The pharmacy may produce a hard copy of the prescription, but shall not be required to do so merely for recordkeeping purposes.

L. Patient Profiles. All pharmacies shall maintain a patient profile system which shall provide for immediate retrieval of information regarding those patients who have received prescriptions from that pharmacy.

1. The dispensing pharmacist shall be responsible for ensuring that a reasonable effort has been made to obtain, document, and maintain at least the following records:

- a. the patient's data record, which should consist of, but is not limited to, the following information:
 - i. full name of the patient for whom the drug is intended;
 - ii. residential address and telephone number of the patient;
 - iii. patient's date of birth;
 - iv. patient's gender;
 - v. a list of current patient specific data consisting of at least the following:

- (a) known drug related allergies;
- (b) previous drug reactions;
- (c) history of or active chronic conditions or disease states;
- (d) other drugs and nutritional supplements, including nonprescription drugs used on a routine basis, or devices;

vi. the pharmacist's comments relevant to the individual patient's drug therapy, including any other necessary information unique to the specific patient or drug;

b. the patient's drug therapy record, which shall contain at least the following information for all the prescriptions that were filled at the pharmacy:

- i. name and strength of the drug or device;
- ii. prescription number;
- iii. quantity dispensed;
- iv. date dispensed;
- v. name of the prescriber;
- vi. directions for use;

c. any information that is given to the pharmacist by the patient or caregiver to complete the patient data record shall be presumed to be accurate, unless there is reasonable cause to believe the information is inaccurate.

M. Exceptions. The provisions of this Section shall not apply to the following.

1. Pharmacies permitted as hospital pharmacies by the board shall comply with the provisions of Chapter 15 of these rules.

2. Other pharmacies providing medications and services to patients within facilities other than hospitals licensed by the department shall comply with the provisions of §1124 of these rules for those activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 23:1312 (October 1997), amended LR 29:2090 (October 2003), effective January 1, 2004, LR 36:755 (April 2010), LR 40:2253 (November 2014), effective January 1, 2015.

§1124. Records of Pharmacy Services for Patients in Licensed Healthcare Facilities Other than Hospitals

A. Definitions

Dispensing of a Drug Pursuant to an Inpatient Prescription—the professional review by a pharmacist required to place a specific drug in final association with the name of a particular inpatient pursuant to the lawful order of a prescriber. In the case of an automated medication system meeting the requirements of Chapter 12 of these rules, the final association with the name of a particular inpatient will be deemed to have occurred when the pharmacist has given the final approval to the patient specific order in the system.

Electronic Drug Record Keeping System—a system of storing drug records electronically and capturing the positive identification of the person responsible for a specific drug transaction including, but not limited to, the prescribing, administering, or dispensing of a drug.

Inpatient—a person receiving health care services within a healthcare facility other than a hospital licensed by the department.

Inpatient Prescription—a written, electronic or oral order for a drug for use in treating a patient within a healthcare facility other than a hospital licensed by the department.

Password—a private identification that is created by a user to obtain access to an electronic drug record keeping system.

Personal Identifier—a unique user name or number for identifying and tracking a specific user's access to an electronic drug record keeping system such as Social Security number, user identification number, or employee number.

Positive Identification—

a. has the same meaning as defined in §1119 of these rules, except that a specific facility having a closed electronic drug record keeping system may be permitted to use identifiers utilizing both a password combined with a personal identifier to document the positive identification of each user for the prescribing and administration of a drug, provided the pharmacist-in-charge has determined:

- i. adequate audit controls are in place to detect and deter drug diversion;
 - ii. adequate access controls are in place to assure the identity of the user and to assign accountability of the user for any drug transaction;
 - iii. adequate safeguards are in place to prevent and detect the unauthorized use of an individual's password and personal identifier;
 - iv. an ongoing quality assurance program is in place to ensure that Clauses i through iii of this term are being fulfilled and reviewed; and
 - v. appropriate policies and procedures are in place to address Clauses i through iv of this term;
- b. all of the above notwithstanding, however, positive identification as defined in §1119 of these rules shall always be used to document the:

- i. dispensing, compounding, or prepackaging of a drug;
- ii. removal and possession of a controlled substance to administer to a patient; and
- iii. waste of a controlled substance.

B. Drug Distribution and Control. The pharmacist-in-charge shall be responsible for the safe and efficient procurement, receipt, distribution, control, accountability, and patient administration and management of drugs.

1. Procedure Manual. The pharmacist-in-charge shall maintain defined procedures for the safe and efficient distribution of medications and pharmacy care. A current copy of the manual shall be available for board inspection upon request.

2. Inventories. The pharmacist-in-charge shall be responsible for the performance of an annual inventory of all controlled dangerous substances within his span of control, in compliance with the provisions of §2733 of these rules.

3. Records. The pharmacist-in-charge shall be responsible for maintaining the following records:

- a. a record of all drugs procured, the quantity received, and the name, address and wholesale distributor license number of the person from whom the drugs were procured;
- b. all drug orders and records relating to the practice of pharmacy:

i. Records of drugs dispensed shall include, but are not limited to:

- (a). the name, strength, and quantity of drugs dispensed;
- (b). the date of dispensing;
- (c). the name of the inpatient to whom, or for whose use, the drug was dispensed; and
- (d). positive identification of all pharmacists involved in the dispensing;

ii. all other records relating to the practice of pharmacy other than dispensing shall include, but are not limited to:

- (a). the name of the inpatient to whom, or for whose benefit, the activity was performed;
- (b). the nature of the pharmacy practice activity performed;
- (c). the results of the activity, if applicable; and
- (d). positive identification of all pharmacists involved in the activity; identifying the function performed by each pharmacist;

iii. records of drugs dispensed to patients for use outside the facility shall be maintained in compliance with §1123 of these rules;

c. a record of all drugs compounded or prepackaged for use only within that facility, which shall include at least the following:

- i. name of drug, strength, quantity, and dosage form;
- ii. manufacturer's or distributor's control number (except for patient-specific sterile compounded preparations);
- iii. manufacturer's or distributor's name, if a generic drug is used;
- iv. pharmacy control number;

v. manufacturer's or distributor's expiration date (except for patient-specific sterile compounded preparations);

vi. pharmacy's expiration date or beyond-use date;

vii. identification of the licensed person responsible for the compounding or prepackaging of the drug;

d. a record of the distribution of drugs to patient care areas and other areas of the facility held for administration, which shall include at least the following:

i. the name, strength, dosage form, and amount of the drug distributed;

ii. the area receiving the drug;

iii. the date distributed;

iv. identification of the individual receiving the drug if it is a controlled dangerous substance;

v. the area of the facility receiving the controlled dangerous substance shall make a record of all such drugs administered to patients. Such records shall include at least the following:

(a). name of the patient;

(b). name, dosage form, and strength when applicable of the drug;

(c). date and time the drug was administered;

(d). quantity administered;

(e). positive identification of the personnel administering the drug;

e. a log that shall be maintained of all changes made to a drug record in an electronic drug recordkeeping system after a drug transaction has been made. The log shall contain at least, but is not limited, to the following:

i. date and time of change;

ii. changes made;

iii. person making the change.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 40:2255 (November 2014), effective January 1, 2015.

§1125. Security and Confidentiality

A. The holder of the pharmacy permit shall provide adequate safeguards against improper, illegal, or unauthorized manipulation or alteration of any records in the pharmacy information system.

B. A pharmacist shall provide adequate security to prevent indiscriminate or unauthorized access to confidential information. If confidential health information is not transmitted directly between a pharmacist and a practitioner, but is transmitted through a data communications device, the confidential health information may not be accessed, maintained, or altered by the operator of the data communications device. Confidential information is privileged and may be released only subject to federal privacy laws and regulations, and subject to applicable Louisiana statutes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 23:1312, (October 1997), amended LR 29:2091 (October 2003), effective January 1, 2004, amended LR 40:2256 (November 2014), effective January 1, 2015.

§1127. Register

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 23:1312 (October 1997), amended LR 29:2091 (October 2003), effective January 1, 2004, repealed LR 40:2256 (November 2014), effective January 1, 2015.

§1129. Confidentiality

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 29:2091 (October 2003), effective January 1, 2004, repealed LR 40:2256 (November 2014), effective January 1, 2015.

Chapter 12. Automated Medication Systems

§1213. Records

A. Records and/or electronic data kept by the system shall meet the following requirements:

1. ...

2. in the event controlled substances are stored in the system, the records shall include the positive identification (as defined in §1119 of the board's rules) of the personnel retrieving and administering the controlled substance to the patient;

3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.A.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 26:1271 (June 2000), effective July 1, 2000, amended LR 40:2256 (November 2014), effective January 1, 2015.

Chapter 15. Hospital Pharmacy

§1503. Definitions

Dispensing of a Drug Pursuant to a Hospital Prescription—the professional review by a pharmacist required to place a specific drug in final association with the name of a particular hospital patient pursuant to the lawful order of a prescriber. In the case of an automated medication system meeting the requirements of Chapter 12 of these rules, the final association with the name of a particular hospital patient will be deemed to have occurred when the pharmacist has given the final approval to the patient specific order in the system.

Electronic Drug Record Keeping System—a system of storing drug records electronically and capturing the positive identification of the person responsible for a specific drug transaction including, but not limited to, the prescribing, administering, or dispensing of a drug.

* * *

Hospital Patient—a person receiving health care services within a hospital facility.

* * *

Hospital Prescription—a written, electronic or oral order for a drug for use in treating a hospital patient.

Password—a private identification that is created by a user to obtain access to an electronic drug record keeping system.

Personal Identifier—a unique user name or number for identifying and tracking a specific user's access to an

electronic drug record keeping system such as Social Security number, user identification number, or employee number.

Positive Identification—

1. has the same meaning as defined in §1119 of these rules, except that a specific hospital having a closed electronic drug record keeping system may be permitted to use identifiers utilizing both a password combined with a personal identifier to document the *positive identification* of each user for the prescribing and administration of a drug, provided the pharmacist-in-charge has determined:

- a. adequate audit controls are in place to detect and deter drug diversion;
- b. adequate access controls are in place to assure the identity of the user and to assign accountability of the user for any drug transaction;
- c. adequate safeguards are in place to prevent and detect the unauthorized use of an individual's password and personal identifier;
- d. an ongoing quality assurance program is in place to ensure that all three provisions cited above in this definition are being fulfilled and reviewed; and
- e. appropriate policies and procedures are in place to address all four provisions cited above in this definition;

2. all of the above notwithstanding, however, *positive identification* as defined in §1119 of these rules shall always be used to document the:

- a. dispensing, compounding, or prepackaging of a drug;
- b. removal and possession of a controlled substance to administer to a patient; and
- c. waste of a controlled substance.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 14:708 (October 1988), effective January 1, 1989, amended LR 29:2093 (October 2003), effective January 1, 2004, LR 33:1132 (June 2007), LR 39:1282 (May 2013), LR 40:2256 (November 2014), effective January 1, 2015.

§1509. Drug Distribution and Control

A. The hospital pharmacist-in-charge shall be responsible for the safe and efficient procurement, receipt, distribution, control, accountability, and patient administration and management of drugs. The staff of the hospital pharmacy shall cooperate with the pharmacist-in-charge in meeting drug control requirements in ordering, administering, and accounting for pharmaceuticals.

1. - 2.b....

3. Records. The pharmacist-in-charge shall be responsible for maintaining the following records:

- a. a record of all drugs procured, the quantity received, and the name, address and wholesale distributor license number of the person from whom the drugs were procured;
- b. all drug orders and records relating to the practice of pharmacy:
 - i. records of drugs dispensed shall include, but are not limited to:
 - (a). the name, strength, and quantity of drugs dispensed;
 - (b). the date of dispensing;

- (c). the name of the hospital patient to whom, or for whose use, the drug was dispensed; and

- (d). positive identification of all pharmacists involved in the dispensing;

- ii. all other records relating to the practice of pharmacy other than dispensing shall include, but are not limited to:

- (a). the name of the hospital patient to whom, or for whose benefit, the activity was performed;

- (b). the nature of the pharmacy practice activity performed;

- (c). the results of the activity, if applicable; and

- (d). positive identification of all pharmacists involved in the activity; identifying the function performed by each pharmacist;

- iii. records of drugs dispensed to patients for use outside the hospital shall be maintained in compliance with §1123 of these rules;

- c. a record of all drugs compounded or prepackaged for use only within that hospital, which shall include at least the following:

- i. name of drug, strength, quantity, and dosage form;

- ii. manufacturer's or distributor's control number (except for patient-specific sterile compounded preparations);

- iii. manufacturer's or distributor's name, if a generic drug is used;

- iv. pharmacy control number;

- v. manufacturer's or distributor's expiration date (except for patient-specific sterile compounded preparations);

- vi. pharmacy's expiration date or beyond-use date;

- vii. identification of the licensed person responsible for the compounding or prepackaging of the drug;

- d. a record of the distribution of drugs to patient care areas and other areas of the hospital held for administration, which shall include at least the following:

- i. the name, strength, dosage form, and amount of the drug distributed;

- ii. the area receiving the drug;

- iii. the date distributed;

- iv. identification of the individual receiving the drug if it is a controlled dangerous substance;

- v. the area of the hospital receiving the controlled dangerous substance shall make a record of all such drugs administered to patients. Such records shall include at least the following:

- (a). name of the patient;

- (b). name, dosage form, and strength when applicable of the drug;

- (c). date and time the drug was administered;

- (d). quantity administered;

- (e). positive identification of the personnel administering the drug;

- e. a log that shall be maintained of all changes made to a drug record in an electronic drug recordkeeping system after a drug transaction has been made. The log shall contain at least, but is not limited, to the following:

- i. date and time of change;

- ii. changes made;

iii. person making the change.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1182.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Pharmacy, LR 29:2093 (October 2003), effective January 1, 2004, amended LR 40:2257 (November 2014), effective January 1, 2015.

Malcolm J. Broussard
Executive Director

1411#016

RULE

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

Fees (LAC 46:LXXXV.501 and 505)

The Louisiana Board of Veterinary Medicine has amended LAC 46:LXXXV.501 and 505 in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953 et seq., and the Louisiana Veterinary Practice Act, R.S. 37:1518(A)(9). The board is vested with the authority to regulate the practice of veterinary medicine to insure the health, welfare, and protection of the animals and the public. The board is financially autonomous from state funds and due to the increase in the costs of discharging its lawful obligations, the board must at this time minimally increase certain annual renewal licensing fees, including application, state board examination, and original license which are one-time costs associated with initial licensure, all within the caps established by the legislature in the Veterinary Practice Act. It has been approximately 10 years since a fee increase has occurred in this profession. The rules regarding annual license renewal fees shall become effective with the license renewal period of the 2015-2016 (October 1, 2015-September 30, 2016) and annually thereafter; and the rules regarding application, state board examination, original license, and late renewal fees shall become effective upon promulgation.

Title 46

**PROFESSIONAL AND OCCUPATIONAL
STANDARDS**

Part LXXXV. Veterinarian

Chapter 5. Fees

§501. Fees

A. The board hereby adopts and establishes the following fees.

Licenses	
Annual renewal-active license	\$250
Annual renewal-inactive license	\$125
Annual renewal-faculty license	\$100
Duplicate license	\$ 25
Original license fee	\$250
Temporary license	\$100
Exams	
Clinical Competency Test (CCT)	\$190
National Board Exam (NAVLE)	\$215
State board exam	\$200
Exam and/or License Application	
Application fee	\$100

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Veterinary Medicine, LR 8:65 (February 1982), amended by Department of Health and Hospitals, Board of Veterinary Medicine, LR 18:380 (April 1992), LR 19:1326 (October 1993), LR 23:963 (August 1997), LR 25:2408 (December 1999), LR 30:796 (April 2004), LR 40:2258 (November 2014).

§505. License Renewal Late Fee

A. Any license renewed after the published expiration date stated in R.S. 37:1424 shall be subject to an additional late charge of \$150 as a late fee for each applicable expired year.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Veterinary Medicine, LR 10:208 (March 1984), amended by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 19:1429 (November 1993), LR 20:1114 (October 1994), LR 25:2408 (December 1999), LR 40:2258 (November 2014).

Wendy D. Parrish
Executive Director

1411#034

RULE

**Department of Health and Hospitals
Bureau of Health Services Financing**

**Coordinated Care Network
LACHIP Affordable Plan Benefits Administration
(LAC 50:I.3103)**

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:I.3103 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part I. Administration

Subpart 3. Medicaid Coordinated Care

Chapter 31. Coordinated Care Network

§3103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in coordinated care networks:

1. - 1.d. ...

e. uninsured women who are eligible through the Louisiana Children's Health Insurance Program (LaCHIP) prenatal option;

f. children under the age of 19 enrolled in the LaCHIP Affordable Care Plan (phase 5); and

A.2. - C. ...

D. Participation Exclusion

1. The following Medicaid and/or CHIP recipients are excluded from participation in a CCN and cannot voluntarily enroll in a CCN. Individuals who:

a. - g. ...

h. - h.i. Reserved.

E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1573 (June 2011), amended LR 40:310 (February 2014), LR 40:1096 (June 2014), LR 40:2258 (November 2014).

Kathy H. Kliebert
Secretary

1411#086

RULE

**Department of Health and Hospitals
Bureau of Health Services Financing**

**Disproportionate Share Hospital Payments
Public-Private Partnerships
(LAC 50:V.Chapter 29)**

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:V.Chapter 29 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

**Subpart 3. Disproportionate Share Hospital Payments
Chapter 29. Public-Private Partnerships**

§2901. Qualifying Criteria

A. Free-Standing Psychiatric Hospitals. Effective for dates of service on or after January 1, 2013, a free-standing psychiatric hospital may qualify for this category by being:

1. a Medicaid enrolled non-state privately owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility; or

2. a Medicaid enrolled non-state publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of inpatient Medicaid and uninsured hospital services by:

a. assuming the management and operation of services at a facility where such services were previously provided by a state owned and operated facility; or

b. providing services that were previously delivered and terminated or reduced by a state owned and operated facility.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2259 (November 2014).

§2903. Reimbursement Methodology

A. Qualifying hospitals shall be paid a per diem rate of \$581.11 per day for each uninsured patient. Qualifying hospitals must submit costs and patient specific data in a format specified by the department.

B. Cost and lengths of stay will be reviewed for reasonableness before payments are made. Payments shall be made on a monthly basis.

C. Aggregate DSH payments for hospitals that receive payment from this category, and any other DSH category, shall not exceed the hospital's specific DSH limit. If payments calculated under this methodology would cause a hospital's aggregate DSH payment to exceed the limit, the payment from this category shall be capped at the hospital's specific DSH limit.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2259 (November 2014).

Kathy H. Kliebert
Secretary

1411#087

RULE

**Department of Health and Hospitals
Bureau of Health Services Financing**

**Early and Periodic Screening, Diagnosis and Treatment
Personal Care Services
Removal of Parental Availability
(LAC 50:XV.7305)**

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:XV.7305 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 5. Early and Periodic Screening, Diagnosis, and Treatment

Chapter 73. Personal Care Services

§7305. Recipient Qualifications

A. - A.3. ...

4. Early and periodic screening, diagnosis, and treatment personal care services must be prescribed by the recipient's attending physician initially and every 180 days thereafter (or rolling 6 months), and when changes in the plan of care occur. The plan of care shall be acceptable for submission to BHSF only after the physician signs and dates the completed form. The physician's signature must be an original signature and not a rubber stamp.

5. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:177 (February 2003), amended LR

30:253 (February 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2259 (November 2014).

Kathy H. Kliebert
Secretary

1411#088

RULE

**Department of Health and Hospitals
Bureau of Health Services Financing**

Medicaid Eligibility
Former Foster Care Adolescents
(LAC 50:III.2308)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:III.2308 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part III. Eligibility

Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2308. Former Foster Care Adolescents

A. Pursuant to the Patient Protection and Affordable Care Act of 2010 (collectively referred to as the Affordable Care Act), the Department of Health and Hospitals hereby implements a Medicaid eligibility group, effective December 31, 2013, to provide health care coverage to youth who are transitioning out of foster care to self-sufficiency upon reaching age 18 or at a higher age selected by the department. This eligibility group will be called former foster care adolescents.

B. Eligibility Requirements. Youth who age out of foster care and meet all of the following requirements may receive Medicaid health care coverage under this new eligibility group.

1. The youth must be from age 18 up to age 26.
2. The youth must have been in foster care and in state custody, either in Louisiana or another state, and receiving Medicaid upon turning age 18 or upon aging out of foster care at a higher age selected by the department.
3. The youth must live in Louisiana.

C. Income, resources and insurance status are not considered when determining eligibility.

D. Individuals determined eligible in this group shall receive coverage of medically necessary health care services provided under the Medicaid state plan.

1. The assistance unit shall consist of the youth only.

E. Eligibility for the program will continue until the youth reaches age 26 unless the youth:

1. moves out of state;
2. requests closure of the case;
3. is incarcerated; or
4. dies.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2260 (November 2014).

Kathy H. Kliebert
Secretary

1411#089

RULE

**Department of Health and Hospitals
Bureau of Health Services Financing**

Medicaid Eligibility
Income Disregards for Children
(LAC 50:III.10305)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:III.10305 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part III. Eligibility

Subpart 5. Financial Eligibility

Chapter 103. Income

§10305. Income Disregards

A. - B.5. ...

C. Effective December 31, 2013, the income of children ages 6 to 19 from 100 percent up to 142 percent of the federal poverty level shall be disregarded.

D. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1629 (August 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1898 (September 2009), LR 40:2260 (November 2014).

Kathy H. Kliebert
Secretary

1411#090

RULE

**Department of Health and Hospitals
Bureau of Health Services Financing**

Medicaid Eligibility
Income Disregards for Pregnant Minors
(LAC 50:III.10305)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:III.10305 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part III. Eligibility
Subpart 5. Financial Eligibility

Chapter 103. Income

§10305. Income Disregards

- A. - B.5. ...
C. ...

D. Effective December 31, 2013, the income of parents or siblings of pregnant unmarried minors (PUMs) or pregnant minor unmarried mothers (MUMs) will not be included when determining Medicaid eligibility for a PUM or pregnant MUM.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1629 (August 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1898 (September 2009), LR 40:2261 (November 2014).

Kathy H. Kliebert
Secretary

1411#091

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Outpatient Hospital Services
Removal of Emergency Room Visit Limits
(LAC 50:V.5117)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended the August 20, 1983 Rule governing outpatient hospital services covered in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 5. Outpatient Hospital Services

Chapter 51. General Provisions

§5117. Service Limits

A. Outpatient hospital services shall be limited to the following:

1. rehabilitation services-number of visits in accordance with a rehabilitation plan prior authorized by the department or its designee;

2. clinic services-physician services provided in a clinic in an outpatient hospital setting shall be considered physician services, not outpatient services, and shall be included in the limit of 12 physician visits per year per recipient; and

3. all other outpatient services, including therapeutic and diagnostic radiology services, shall have no limit imposed other than the medical necessity for the services.

B. There shall be no limits placed on emergency room visits.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of Family Security, LR 9:551 (August 1983), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2261 (November 2014).

Kathy H. Kliebert
Secretary

1411#092

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Professional Services Program
Family Planning Services
Long-Acting Reversible Contraceptives Reimbursements
(LAC 50:IX.15145)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:IX.15145 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part IX. Professional Services Program

Subpart 15. Reimbursement

Chapter 151. Reimbursement Methodology

Subchapter E. Family Planning Services

§15145. Long-Acting Reversible Contraceptives

A. The reimbursement rates for acquiring long-acting reversible contraceptives shall be adjusted to accommodate annual changes in acquisition cost. Physicians and professional services practitioners shall be reimbursed for the contraceptive according to the fee on file at the time of insertion.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:2261 (November 2014).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Kathy H. Kliebert
Secretary

1411#093

RULE

Department of Health and Hospitals Radiologic Technology Board of Examiners

Radiologic Technologists
(LAC 46:LXVI.Chapters 1, 3, 7, 9, 11, 12, and 13)

The Louisiana State Radiologic Technology Board of Examiners, pursuant to the authority of R.S. 37:3207 and in accordance with the provisions of the Louisiana Administrative Procedures Act, R.S. 49:950 et seq., has amended its rules governing general provisions, LAC 46:LXVI. The Rule changes codify requirements enacted into law pursuant to Act 250 of the 2014 Regular Session of the Louisiana Legislature. The Rule change updates relevant occupational lists, makes technical changes to the meetings and structure of the board, updates the initial and renewal licensure procedures, and establishes a new licensure fee schedule.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part LXVI. Radiologic Technologists

Chapter 1. Implementation of the Medical Radiation Health and Safety Act

§101. Authority

A. The Louisiana Medical Radiation Health and Safety Act, R.S. 37:3200 through R.S. 37:3221, provides that, in order to safeguard life and health by preventing excessive and improper exposure to ionizing radiation, any person practicing or offering to practice as a radiologic technologist in this state shall submit evidence that (s)he is qualified to do so and shall be allowed to practice as a radiologic technologist. The Act creates a board of examiners with regulatory authority, dictates the board's composition and qualifications, methods of appointment of office of the board members. The duties of the board are specified in the act and these duties provide for the implementation of the Medical Radiation Health and Safety Act through the adoption of rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:868 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 40:2262 (November 2014).

§103. Applicability

A. All persons using radioactive materials or equipment emitting or detecting ionizing radiation on humans for diagnostic or therapeutic purposes shall be responsible for compliance in accordance with the provisions of this Chapter (refers to R.S. 37:3200-3221) and the provisions of these rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technologists Board of Examiners, LR 11:868 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 14:542 (August 1988), LR 40:2262 (November 2014).

Chapter 3. The Board of Examiners

§305. Meetings of the Board

A. As required by R.S. 37:3205(B), the board shall meet at least every three months and at such other times as may be necessary. The quarterly meetings of the board shall be held in January, April, July and October. The annual meeting shall be in July.

B. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3205 and R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:868 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 40:2262 (November 2014).

Chapter 7. Actions before the Board

§705. Informal Proceeding/Consent Order

A. - D. ...

E. If, at any point during investigation or during informal/formal proceedings as described herein, the board finds that public health, safety, or welfare imperatively requires emergency actions, the board is hereby authorized to immediately suspend the license of the licensee during the course of the proceedings. If the board decides to institute a formal hearing, the hearing shall be promptly instituted and conducted at the board's next scheduled hearing date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:869 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 19:1433 (November 1993), LR 29:182 (February 2003), LR 40:2262 (November 2014).

§707. Conduct of a Formal Hearing

A. - A.3.e. ...

4. The chairperson shall appoint a hearing panel, consisting of one or more board members and totaling less than a quorum whose primary role shall be to hear evidence and arguments and to submit written findings, conclusions and recommendations to the board.

a. ...

b. At the hearing, the charge shall be prosecuted by the board's personnel who conducted the investigation, who may be assisted by board attorney, and who will present evidence that disciplinary action should be taken against the licensee.

A.4.c. - B.1.f. ...

2. Subpoenas. The board is empowered by statute to issue subpoenas when requested in writing by any party to the proceedings.

B.2.a. - C.1.b.ii. ...

c. Repealed.

2. - 6. ...

7. After the hearing is conducted, the hearing officer/panel shall issue a report to the board containing the officer/panel's findings of fact, conclusions of the law, and recommendations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(6).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:870 (September 1985), amended by the

Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 19:1434 (November 1993), LR 40:2262 (November 2014).

§709. The Final Decision of the Board

A. ...

B. Having considered the report of the hearing officer/panel and having reviewed the record of the proceedings, the board may affirm, adopt, modify, or reject the findings and recommendations of the hearing officer/panel or it may determine findings and recommendations of its own.

C. The board's decision must be accompanied by a statement of the reasons for the decision and must dispose individually of each issue of fact or law necessary from the hearing officer.

D. The vote of the board must be recorded and made a part of the decision. The decision of a majority of a quorum shall be adopted as the final decision of the board. A member of the board who serves as a hearing officer or on a hearing panel, shall not participate in the board's final decision with respect to the subject matter of such panel, nor shall said member be considered in determining a quorum for a vote on the final decision of the board.

E. The board may assess the licensee with the costs of the hearing.

F. The final decision shall be delivered to each party by registered or certified mail, return receipt requested.

G. The final decision shall be delivered within 30 days of the close of the hearing.

H. The final decision shall become effective 11 days after the receipt of notification of all parties, provided that there is no appeal. Publication shall be withheld until that date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:871 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 40:2263 (November 2014).

Chapter 9. General Provisions

§901. Definitions

A. ...

* * *

Ionizing Radiation—commonly known as x-rays or gamma rays, they remove electrons from the atoms of matter lying in their path (e.g., ionization).

* * *

Radiologic Technologist—any person who is a radiographer, radiation therapy technologist, nuclear medicine technologist, fusion technologist, licensed under this Chapter who under the direction and supervision of a licensed practitioner applies radiation to humans upon prescription of a licensed practitioner.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:872 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 23:71 (January 1997), LR 38:97 (January 2012), LR 40:2263 (November 2014).

Chapter 11. Licensure

§1101. Scope of License

A. There are four categories of licenses for radiologic technology as defined in R.S. 37:3200 by their area of specialization. The categories are radiographer, radiation therapy technologist, nuclear medicine technologist, and fusion technologist. A radiologic technologist shall be restricted to the use of ionizing radiation by the category that is defined on his license.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1300, R.S. 37:3207 and R.S. 37:3213.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:872 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 40:2263 (November 2014).

§1105. Qualifications of Applicants for Licensure

A. - A.1. ...

2. is of good moral character;

3. is not in violation of any of the provisions of this Chapter and the rules and regulations adopted hereunder;

4. has successfully completed a four-year course of study in a secondary school (high school) approved by the state Board of Elementary and Secondary Education, passed an approved equivalency test, or has graduated from a secondary school outside Louisiana having comparable approval;

5. has successfully completed a course of study in radiography, radiation therapy technology, nuclear medicine technology, or fusion technologist as approved by the board in accordance with standards promulgated by the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3208 and R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:873 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 40:2263 (November 2014).

§1109. Licensure by Examination

A. Pursuant to R.S. 37:3207 and 3209, an application for licensure shall be required to pass the written examination of the American Registry of Radiologic Technologists (ARRT), Nuclear Medicine Technology Certification Board (NMTCB), or American Society of Clinical Pathology (ASCP).

1. ...

B. The board establishes as the passing criterion on the ARRT, NMTCB, ASCP written examination the passing score as established by the credentialing agency.

C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207, R.S. 37:3208 and R.S. 37:3209.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:873 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 29:183 (February 2003), LR 40:2263 (November 2014).

§1111. Application for Initial Licensure for Temporary Work Permit by Examination

A. Requests for application for initial licensure and for temporary work permit by examination forms shall be requested and submitted to the state board.

B. Pursuant to R.S. 37:3210(C), upon payment a temporary 90-day work permit shall be issued one time only and for the time listed on the temporary work permit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207 and R.S. 37:3209.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:873 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 29:183 (February 2003), LR 40:2263 (November 2014).

§1113. Follow-Up to Application Submission

A. - B.1. ...

B.2. - C.3. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:873 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 40:2264 (November 2014).

§1115. Modifications to Submitted Information

A. Address or Name Changes. If a licensure/temporary work permit applicant must change the mailing address which was entered on the application form, the licensee must inform the board in writing. Changes in the licensee name are to be handled in the same manner, but must be accompanied by documentary evidence of the change (e.g., copy of marriage certificate, legal name change form, etc.).

B. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:873 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 29:183 (February 2003), LR 40:2264 (November 2014).

§1117. Re-Examination

A. An applicant who fails to pass the examination within the issued 90-day time frame of the temporary work permit shall become ineligible for an extension of that temporary work permit. Board will hold original application for licensure up to one year with no additional fee.

1. - 3. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:874 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 40:2264 (November 2014).

§1121. Renewal of License

A. ...

B. Notification for renewal of license shall be mailed prior to expiration by the board to each person holding a license issued under these rules and regulations. Such notification shall be mailed to the most recent address as reflected in the official records of the board.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3215 and R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:874 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 40:2264 (November 2014).

§1125. Reinstatement of License

A. ...

1. An application for reinstatement from a radiologic technologist who has not ceased practice in accordance with provisions of R.S. 37:3200-3221 shall be made upon a form supplied by the board accompanied by two letters of character recommendation from physicians of the former licensee's place of employment, together with the applicable renewal fee plus a penalty.

a. - c. Repealed.

2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3216 and R.S. 37:3207.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:874 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 40:2264 (November 2014).

§1129. Fusion Technology Temporary Permit

A. - A.3. ...

4. satisfies the applicable fees prescribed in these rules and the Radiologic Technology Practice Act.

B. - B.2. ...

C. A temporary permit issued under this Section which has expired may be renewed or reissued by the board for one or more successive 12-month periods, not to exceed 3 years, provided that prior to the expiration of the initial temporary permit:

1. - 3. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 38:98 (January 2012), amended LR 40:2264 (November 2014).

Chapter 12. Continuing Education Requirements

§1201. Definitions

* * *

Approved Academic Course—a formal course of study offered by an accredited post-secondary educational institution in the biological sciences, physical sciences, radiologic sciences, health and medical sciences, social sciences, communication (verbal and written), mathematics, computers, management or education methodology. Activities meeting the definition of an *approved academic course* will be awarded credit at the rate of 16 CE credits for each academic semester credit and 12 CE credits for each academic quarter credit. An official transcript showing a grade of "C" or better is required to receive CE credit for an academic course. Official transcript must come from a recognized United States Department of Education (USDE) or Council for Higher Education Accreditation (CHEA) institution authorized to grant degrees by the U.S. Congress, state government, or a recognized sovereign Indian tribe.

Approved Continuing Education Activity—an educational activity which has received approval through a recognized continuing education evaluation/mechanism.

1. - 3. ...

* * *

CPR—advanced *CPR* certification (ACLS, PALS, or instructor, or instructor trainer *CPR* certification) will automatically be awarded six credits per biennium.

1. Repealed.

Category A and A+ Credit—educational activity which is planned, organized, and administered to enhance the knowledge and skills of the licensed individual and provides services to patients, the public, or medical profession.

Category B Credit—Repealed.

Continuing Education (CE)—educational activities which serve to improve and expand the knowledge and skills underlying professional performance that a radiologic technologist uses to provide services for patients, the public or the medical profession. A contact hour credit is awarded for each 50 to 60 minute educational activity. Activities longer than one hour will be assigned whole or partial CE credit based on the 50-minute hour. Educational activities of 30 to 49 minutes of duration will be awarded 1/2 a credit. An activity that lasts less than 30 minutes will receive no credit.

Documentation—proof of participation in a particular educational activity. *Documentation* must include: dates of attendance, hand written dates are not accepted; title and content of the activity; number of contact hours for the activity; name of sponsor; signature of the instructor or an authorized representative of the sponsor issuing the documentation; and a reference number, if the activity has been approved by a recognized continuing education evaluation mechanism (RCEEM). Board reserves the right to verify all continuing education documents.

Independent Study—an educational activity offered by an accredited post-secondary educational institution or a comparable sponsor wherein the participant independently completes the objectives and submits the required assignments for evaluation. *Independent study* may be delivered through various formats such as directed readings, videotapes, audiotapes, computer-assisted instruction and/or learning methods.

Recognized Continuing Education Evaluation Mechanism (RCEEM)—a mechanism for evaluating the content, quality, and integrity of an educational activity. The evaluation must include review of educational objectives, content selection, faculty qualifications, and educational methods and materials.

Sponsor—an organization responsible for the content, quality and integrity of the educational activity, which plans, organizes, supports, endorses, subsidizes and/or administers educational activities. *Sponsors* may be, but are not limited to, state, national, regional and district professional societies, academic institutions, health care agencies, health care facilities, federal or state government agencies. *Sponsors* must apply and receive approval from a RCEEM in order to offer credit for activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 21:178 (February 1995), amended LR 23:71 (January 1997), LR 40:2264 (November 2014).

§1203. Renewal of License

A. ...

B. After June 1, 2013, every person licensed under the provision of this Chapter shall maintain certification and

document on-going compliance through the ARRT, NMTCB, or ASCP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 21:180 (February 1995), amended LR 40:2265 (November 2014).

§1205. Continuing Education Requirements

A. Twenty-four hours of continuing education credits must be earned per licensing term to meet the continuing education requirements. Credits earned in excess of 24 per licensing term may not be carried over into the next licensing term. The continuing education requirement is independent of the number of licenses held by an individual (i.e., a radiologic technologist certified in both radiography and radiation therapy technology needs only 24 credits).

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 21:180 (February 1995), amended LR 23:73 (January 1997), LR 40:2265 (November 2014).

§1207. Licensing Term Schedule

A. Since the licensing term is defined as that period from June 1 of the renewal or issuance of license year, to the second May 31 to occur after that date, the continuing education credits must be earned in the two years prior to the second occurrence of May 31.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 21:180 (February 1995), amended LR 23:73 (January 1997), LR 40:2265 (November 2014).

§1209. Renewal of License by Examination

A. ...

B. Subsequent renewal of license will require documentation of 24 hours of active participation in continuing education activities for the following licensing term and every two years thereafter, unless another Board approved examination is passed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 21:180 (February 1995), amended LR 23:73 (January 1997), LR 40:2265 (November 2014).

§1211. Biannual Application for License Renewal

A. Notification for the renewal of the license will be mailed to each radiologic technologist whose license to practice radiologic technology will expire that May 31 with the license fee due.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 21:180 (February 1995), amended LR 23:73 (January 1997), LR 40:2265 (November 2014).

§1215. Applicants for Renewal Who Fail to Meet CE Requirements

A. A radiologic technologist who applies for renewal of license, but who fails to meet the renewal requirements within the previous licensing term, will automatically be transferred to a probational status. Individuals who are listed

as having a probational status, due to failure to meet these renewal requirements, status will be published on website by the Louisiana State Radiologic Technology Board of Examiners and will be reported in response to any inquiries regarding the radiologic technologist's status with the Louisiana State Radiologic Technology Board of Examiners.

B. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 21:181 (February 1995), amended LR 40:2265 (November 2014).

§1217. Fee and Expenses

A. The rules of this Chapter prescribe the fees and costs applicable to the licensing of radiologic technologists.

B. For processing applications for licensure, the following fees shall be payable to the board:

1. initial two year license—\$100;
2. duplicate license—\$25;
3. biennial renewal of license, 2 years—\$100;
4. issuance of 90 day temporary working permit—\$10;
5. delinquency fee in addition to the renewal fee for a license placed on probation using a postmark date:
 - a. all or part of June, July, August—\$50;
 - b. all or part of September—\$75;
 - c. all or part of October—\$100;
 - d. all or part of November—\$150;
 - e. all or part of December—\$200;
6. reinstatement fee, in addition to delinquency fee and renewal fee of a license which has expired—\$25 per month;
7. reinstatement of a license that has been revoked or suspended—\$300.

C. The following miscellaneous expenses, fees and charges shall be payable to the board:

1. actual cost plus \$25 processing fee for any check, money order, cashier's check, or other instrument of payment that is dishonored by the financial institution against which it is drawn;
2. actual costs associated with electronic or credit card payments and transactions;
3. photocopies of documents—\$0.25 per page;
4. actual cost for creation and provision of electronic information data or service;
5. official list of all licensed radiologic technologists—\$300;
6. processing and handling a request for the board's endorsement of licensure status to another state for the purpose of reciprocity licensure—\$25;
7. postage, mailing, shipping, handling or other costs in excess of the applicable minimum first class postage;
8. issuance of a subpoena or subpoena duces tecum in addition to the witness fees required by R.S. 49:956—\$15;
9. actual costs of the board related to any administrative hearing, judicial review, or any investigation of charges instituted by the board, unless charges are subsequently dismissed or not proven.

D. Payment to the board of any fees under this Chapter is nonrefundable.

E. Notwithstanding the foregoing, the board may, by majority vote reduce the amount of and/or waive the collection of any such fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 21:181 (February 1995), amended LR 40:2266 (November 2014).

Chapter 13. Minimum Standards for the Accreditation of Education Programs

§1301. Minimum Standards for the Accreditation of Education Programs

A. Pursuant to R.S. 37:3207(3), the board adopts as its standards for education programs and colleges that are programmatic or regionally recognized by the Council for Higher Education Accreditation (CHEA).

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3207(B)(2).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Radiologic Technology Board of Examiners, LR 11:874 (September 1985), amended by the Department of Health and Hospitals, Radiologic Technology Board of Examiners, LR 23:74 (January 1997), LR 40:2266 (November 2014).

Kenneth Jones
Executive Director

1411#014

RULE

Department of Natural Resources Office of Conservation

Fees (LAC 43:XIX.Chapter 7)

Pursuant to power delegated under the laws of the state of Louisiana, and particularly title 30 of the *Louisiana Revised Statutes* of 1950, as amended, the Office of Conservation amends LAC 43:XIX.701, 703, and 707 (Statewide Order No. 29-R) in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. The action adopts Statewide Order No. 29-R-14/15 (LAC 43:XIX, Subpart 2, Chapter 7), which establishes the annual Office of Conservation fee schedule for the collection of application, production, and regulatory fees, and will replace the existing Statewide Order No. 29-R-13/14.

Title 43

NATURAL RESOURCES

Part XIX. Office of Conservation—General Operations Subpart 2. Statewide Order No. 29-R

Chapter 7. Fees §701. Definitions

* * *

BOE—annual barrels oil equivalent. Gas production is converted to *BOE* by dividing annual MCF by a factor of 29.0.

Capable Gas—natural and casing head gas not classified as incapable gas well gas or incapable oil well gas by the Department of Revenue, as of December 31, 2013.

Capable Oil—crude oil and condensate not classified as incapable oil or stripper oil by the Department of Revenue, as of December 31, 2013.

* * *

Production Well—any well which has been permitted by and is subject to the jurisdiction of the Office of Conservation, excluding wells in the permitted and drilling in progress status, class II injection wells, liquid storage cavity wells, commercial salt water disposal wells, class V injection wells, wells which have been plugged and abandoned, wells which have reverted to landowner for use as a fresh water well (Statewide Order No. 29-B, LAC 43:XIX.137.G or successor regulations), multiply completed wells reverted to a single completion, and stripper oil wells or incapable oil wells or incapable gas wells certified by the Severance Tax Section of the Department of Revenue, as of December 31, 2013.

Regulatory Fee—an amount payable annually to the Office of Conservation, in a form and schedule prescribed by the Office of Conservation, on class II wells, class III wells, storage wells, type A facilities, and type B facilities in an amount not to exceed \$875,000 for fiscal year 2000-2001 and thereafter. No fee shall be imposed on a class II well of an operator who is also an operator of a stripper crude oil well or incapable gas well certified pursuant to R.S. 47.633 by the Severance Tax Section of the Department of Revenue as of December 31, 2013, and located in the same field as such class II well. Operators of record, excluding operators of wells and including, but not limited to, operators of gasoline/cycling plants, refineries, oil/gas transporters, and/or certain other activities subject to the jurisdiction of the Office of Conservation are required to pay an annual registration fee of \$105. Such payment is due within the time frame prescribed by the Office of Conservation.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:21 et seq.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Conservation, LR 14:542 (August 1988), amended LR 15:551 (July 1989), LR 21:1249 (November 1995), LR 24:458 (March 1998), LR 24:2127 (November 1998), LR 25:1873 (October 1999), LR 26:2302 (October 2000), LR 27:1919 (November 2001), LR 28:2366 (November 2002), LR 29:2499 (November 2003), LR 31:2950 (November 2005), LR 32:2087 (November 2006), LR 33:2461 (November 2007), LR 34:2404 (November 2008), LR 35:2463 (November 2009), LR 36:2567 (November 2010), LR 37:3271 (November 2011), LR 38:2930 (November 2012), LR 39:3099 (November 2013), LR 40:2266 (November 2014).

§703. Fee Schedule for Fiscal Year 2014-2015

A. ...

* * *

B. Regulatory Fees

1. Operators of each permitted type A facility are required to pay an annual regulatory fee of \$6,496 per facility.

2. Operators of each permitted type B facility are required to pay an annual Regulatory Fee of \$3,248 per facility.

3. Operators of record of permitted non-commercial class II injection/disposal wells are required to pay \$651 per well.

4. Operators of record of permitted class III and Storage wells are required to pay \$651 per well.

C. Class I Well Fees. Operators of permitted class I wells are required to pay \$11,940 per well.

D. Production Fees. Operators of record of capable oil wells and capable gas wells are required to pay according to the following annual production fee tiers.

Tier	Annual Production (Barrel Oil Equivalent)	Fee (\$ per Well)
Tier 1	0	17
Tier 2	1 - 5,000	94
Tier 3	5,001 - 15,000	267
Tier 4	15,001 - 30,000	443
Tier 5	30,001 - 60,000	700
Tier 6	60,001 - 110,000	974
Tier 7	110,001 - 9,999,999	1,202

E. - F.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:21 et seq., R.S. 30:560 and 706.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Conservation, LR 14:543 (August 1988), amended LR 15:552 (July 1989), LR 21:1250 (November 1995), LR 24:458 (March 1998), LR 24:2128 (November 1998), LR 25:1874 (October 1999), LR 26:2304 (October 2000), LR 27:1920 (November 2001), LR 28:2368 (November 2002), LR 29:350 (March 2003), LR 29:2501 (November 2003), LR 30:2494 (November 2004), LR 31:2950 (November 2005), LR 32:2088 (November 2006), LR 33:2461 (November 2007), LR 34:2405 (November 2008), LR 35:2463 (November 2009), LR 36:2569 (November 2010), LR 37:3273 (November 2011), LR 38:2931 (November 2012), LR 39:3099 (November 2013), LR 40:2267 (November 2014).

§705. Failure to Comply

A. Operators of operations and activities defined in §701 are required to timely comply with this order. Failure to comply by the due date of any required fee payment will subject the operator to civil penalties provided in Title 30 of the *Louisiana Revised Statutes* of 1950, including but not limited to R.S. 30:18.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:21 et seq.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Conservation, LR 14:544 (August 1988), amended LR 15:552 (July 1989), LR 21:1251 (November 1995), LR 24:459 (March 1998), LR 24:2128 (November 1998), LR 25:1874 (October 1999), LR 26:2304 (October 2000), LR 27:1921 (November 2001), LR 28:2368 (November 2002), LR 29:2501 (November 2003), LR 34:2406 (November 2008), LR 36:2569 (November 2010), LR 37:3274 (November 2011), LR 38:2931 (November 2012), LR 39:3100 (November 2013), LR 40:2267 (November 2014).

§707. Severability and Effective Date

A. The fees set forth in §703 are hereby adopted as individual and independent rules comprising this body of rules designated as Statewide Order No. 29-R-14/15 and if any such individual fee is held to be unacceptable, pursuant to R.S. 49:968(H)(2), or held to be invalid by a court of law, then such unacceptability or invalidity shall not affect the other provisions of this order which can be given effect without the unacceptable or invalid provisions, and to that end the provisions of this order are severable.

B. This order (Statewide Order No. 29-R-14/15) supersedes Statewide Order No. 29-R-13/14 and any amendments thereof.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:21 et seq.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Conservation, LR 14:544 (August 1988), amended LR 15:552 (July 1989), LR 21:1251 (November 1995), LR 24:459 (March 1998), LR 24:2128 (November 1998), LR 25:1874 (October 1999), LR 26:2305 (October 2000), LR 27:1921 (November 2001), LR 28:2368 (November 2002), LR 29:2502 (November 2003), LR 30:2494 (November 2004), LR 31:2950 (November 2005), LR 32:2088 (November 2006), LR 33:2462 (November 2007), LR 34:2406 (November 2008), LR 35:2464 (November 2009), LR 36:2570 (November 2010), LR 37:3274 (November 2011), LR 38:2931 (November 2012), LR 39:3100 (November 2013), LR 40:2267 (November 2014).

James H. Welsh
Commissioner

1411#037

RULE

Department of Public Safety and Corrections Corrections Services

Home Incarceration/Electronic Monitoring Pilot Program (LAC 22:I.401)

The Department of Public Safety and Corrections, Corrections Services, in accordance with R.S. 36:404, hereby repeals LAC 22:I.401, Home Incarceration/Electronic Monitoring Pilot Program in its entirety. Act 2 of the 2014 Regular Session of the Louisiana Legislature repealed R.S. 15:571.35, relative to pilot programs for alternative methods of incarceration and electronic monitoring.

Title 22

CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT Part I. Corrections

Chapter 4. Division of Probation and Parole

§401. Home Incarceration/Electronic Monitoring Pilot Program

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 15:823.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of Correction Services, LR 28:1026 (May 2002), repealed by the Department of Public Safety and Corrections, Correction Services, LR 40:2268 (November 2014).

James M. LeBlanc
Secretary

1411#039

RULE

Department of Public Safety and Corrections Corrections Services

Restoration of Good Time (LAC 22:I.319)

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950), the Department of Public Safety and Corrections, Corrections Services, amends the contents of Section 319, Restoration of Good Time.

Title 22

CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT

Part I. Corrections

Chapter 3. Adult Services

§319. Restoration of Good Time

A. Purpose—to state the secretary's policy regarding the restoration of previously forfeited good time for disciplinary violations for offenders who have demonstrated satisfactory progress in faithfully observing the disciplinary rules and procedures for adult offenders.

B. Applicability—deputy secretary, chief of operations, regional wardens, wardens, the sheriff or administrator of local jail facilities and the director of the office of information services. Each unit head is responsible for ensuring that appropriate unit written policy and procedures are in place to comply with the provisions of this regulation.

C. Policy. It is the secretary's policy to strengthen the department's commitment to an offender's successful reentry efforts by implementing positive rewards for offenders who have demonstrated improved institutional behavior.

D. Definitions

ARDC Supervisor/Manager—a member of the records section staff, whether employed at a state correctional facility or in the office of adult services at headquarters.

Major Rule Violation—an offense identified as a schedule B offense.

Minor Rule Violation—an offense identified as a schedule A offense.

Unit Head—the head of an operational unit, specifically, the warden or sheriff or administrator of a local jail facility or transitional work program.

E. General Procedures

1. In accordance with Act No. 87 of the 2014 Regular Session, offenders who have previously forfeited good time as a result of disciplinary action and have not been found guilty of a major rule violation for a consecutive 24-month period and have not been found guilty of a minor rule violation for a consecutive 6-month period may be eligible for restoration of previously forfeited good time. Restoration of previously forfeited good time shall not exceed 540 days during an offender's instant term of incarceration.

2. Forfeiture of good time resulting from any schedule A or schedule B rule violation may be restored in accordance with the provisions of this regulation, with the exception of rule #8, escape or attempt to escape, or any rule violation

that was a result of battery of an employee, visitor, guest or their families. All rule #1 and #21 offenses shall be carefully reviewed for consideration of restoration of good time.

3. For offenders released on parole or good time parole supervision and returned to custody as a parole violator, the availability of forfeited good time is limited to the amount earned during the instant term of incarceration. Time spent in custody prior to release on parole or good time parole supervision shall not apply toward the 24-consecutive-month period required for the review of major rule violations or the 6-consecutive-month period required for the review of minor rule violations.

4. Even though an offender may receive approval for restoration of goodtime, the department shall retain authority to void or adjust the amount of the restoration at any time during the offender's incarceration if a review of the record reveals the restoration calculation was erroneous.

5. Under no circumstances shall an offender's restoration of previously forfeited good time under the provisions of this regulation cause him to be considered overdue for release at the time of approval.

6. If an offender's request for restoration of good time is denied or good time is partially restored, the offender may reapply for reconsideration in six months from the date of the original application.

7. The decision regarding restoration of good time is final and shall not be appealed through the administrative remedy procedure.

F. Review and Outcome Process

1. State Correctional Facilities

a. Offenders housed in state correctional facilities who have not been found guilty of a major rule violation for a consecutive 24-month period, except as noted in Paragraph E.2, and have not been found guilty of a minor rule violation for a consecutive 6-month period shall complete an application for restoration of good time and submit the application to the institution's records office.

b. The ARDC supervisor/manager or designee shall review the offender's application and disciplinary record to verify the offender's eligibility for restoration of forfeited good time. (If the offender is ineligible for restoration of forfeited good time, the ARDC supervisor/manager shall indicate the reason for ineligibility on the application form and return a copy to the offender. The original application shall be filed in the offender's master record.) If the offender is eligible for restoration of good time, the number of days to be restored shall include consideration of participation or failure to participate in rehabilitative programs. If the offender is eligible for restoration of forfeited good time, the ARDC supervisor/manager shall indicate the number of days eligible for restoration on the application for restoration of good time. Upon completion, the ARDC supervisor/manager shall forward the offender's application to the warden or designee for consideration.

c. The warden or designee shall review the offender's application and verification of eligibility and shall approve or disapprove the recommendation. If approved, the ARDC supervisor/manager or designee shall restore the amount of good time approved by the warden. Only that amount which was actually forfeited can be restored. A copy of the approved application, as well as the revised master

prison record shall be sent to the offender. The originals shall be filed in the offender's master record.

d. If denied, the ARDC supervisor/manager or designee shall provide a written reason on the application for restoration of good time and provide a copy to the offender (including the justification for denial). The original application shall be filed in the offender's master record.

2. Local Jail Facilities

a. The office of adult services shall ensure that an Application for Restoration of Good Time is provided by the basic jail guidelines team leaders to the sheriff or administrator of each local jail facility within their region.

b. Offenders housed in local jail facilities who meet the eligibility requirements stated in Subparagraph F.1.a shall complete an application for restoration of good time and submit it to the sheriff or administrator, who shall forward all completed applications to the chief of operations at headquarters.

c. The chief of operations shall designate OAS staff to review the offender's application and disciplinary record to verify the offender's eligibility for restoration of forfeited good time. (If the offender is ineligible for restoration of forfeited good time, the reviewing staff member shall indicate the reason for ineligibility on the application form and return a copy to the sheriff or administrator of the local jail facility who shall notify the offender. The original application shall be filed in the offender's master record). If the offender is eligible for restoration of good time, the number of days to be restored shall include consideration of participation or failure to participate in rehabilitative programs (if available at the local jail facility). If the offender is eligible for restoration of forfeited good time, the reviewing staff member shall indicate the number of days eligible for restoration on the application for restoration of good time. Upon completion, the reviewing staff member shall forward the offender's application to the chief of operations or designee for consideration.

d. The chief of operations or designee shall review the offender's application and verification of eligibility and shall approve or disapprove the recommendation. If approved, an OAS ARDC supervisor/manager or designee shall restore the amount of good time approved by the chief of operations. Only that amount which was actually forfeited can be restored. A copy of the approved application, as well as the revised master prison record shall be returned to the sheriff or administrator of the local jail facility who shall notify the offender. The originals shall be filed in the offender's master record.

e. If denied, an OAS ARDC supervisor/manager or designee shall provide a written reason on the application for restoration of good time and return the application (including the justification for denial) to the sheriff or administrator of the local jail facility who shall notify the offender. The original application shall be filed in the offender's master record.

3. In addition to the current offender management system procedures in place regarding the maintenance of the amount of good time forfeited per offender, the Office of Information Services shall also track the restoration of good time pursuant to this regulation. The amount of good time restored shall be displayed on the offender management system master prison record screen.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:953.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Corrections Services LR 36:533 (March 2010), amended LR 40:2268 (November 2014).

James M. Le Blanc
Secretary

1411#038

RULE

Department of Public Safety and Corrections Gaming Control Board

Collection and Deduction—Landbased Casino (LAC 42:III.4732)

The Louisiana Gaming Control Board hereby gives notice that pursuant to R.S. 27:15 and R.S. 27:24 it adopted LAC 42:III.4732.

Title 42

LOUISIANA GAMING

Part III. Gaming Control Board

Chapter 47. Landbased Casino Gaming

§4732. Collection and Deduction from Gross Revenue

A. The casino operator or casino manager, after extending credit and prior to taking a deduction for uncollected credit instruments, shall:

1. furnish to the division documentation showing that it has attempted to collect the full amount of the debt at least once every 30 days while the debt was treated as collectible by requesting payment in a letter sent to the debtor's known address, or in personal or telephone conversations with the debtor, or by presenting the credit instrument to the debtor's bank for collection, or otherwise demonstrate to the satisfaction of the division that it has made good faith attempts to collect the full amount of the debt; and

2. furnish the credit instrument within 30 days of the division's request, unless the casino operator or casino manager has independent, written, and reliable verification that the credit instrument:

a. is in the possession of a court, governmental agency, or financial institution;

b. has been returned to the debtor upon the casino operator's or casino manager's good faith belief that it had entered into a valid and enforceable settlement; or

c. has been stolen and the casino operator or casino manager has made a written report of the theft to an appropriate law enforcement agency, other than the division, having jurisdiction to investigate the theft.

B. The division may waive the requirements of Paragraph 2 of Subsection A of this Section if the credit instrument cannot be produced because of circumstances beyond the casino operator's or casino manager's control. Such waiver shall be solely within the division's discretion.

C. If the casino operator, or casino manager has returned a credit instrument upon partial payment, consolidation, or redemption of the debt, it shall issue a new substituted credit instrument in place of the original and shall furnish the substituted credit instrument to the division in lieu of the original credit instrument as provided in Paragraph 2 of Subsection A of this Section.

D. Any report of theft made pursuant to Subparagraph c of Paragraph 2 of Subsection A of this Section shall be made within 30 days of the casino operator's or casino manager's discovery of the theft and shall include general information about the alleged crime, including, without limitation, the amount of financial loss sustained, the date of the alleged crime, and the names of employees, agents, or representatives of the casino operator or casino manager who may be contacted for further information. The casino operator or casino manager shall furnish to the division a copy of the theft report within 30 days of its creation.

E. If the casino operator or casino manager believes that a credit or substituted credit instrument has been subject to a forgery, then the casino operator or casino manager shall within 30 days of the discovery of the forgery:

1. submit a written report of the forgery to an appropriate law enforcement agency having jurisdiction to investigate the crime, which report shall include the amount of financial loss sustained, the date of the alleged forgery, and the names of employees, agents, or representatives of the casino operator or casino manager who may be contacted for further information. The casino operator or casino manager shall furnish a copy of forgery report made pursuant to this paragraph to the division within 30 days of their creation;

2. retain all documents evidencing or relevant to the forgery and shall create and retain detailed records of compliance with Subsection E of this Section and furnish them to the division within 30 days of its request.

F. Unless ordered by a bankruptcy court or approved by the division, the casino operator or casino manager shall not settle a debt for less than its full amount unless:

1. such settlement is designed to:

a. induce the debtor to make a partial payment;

b. compromise a genuine dispute between the debtor and the casino operator or casino manager regarding the existence or amount of the debt;

c. obtain the debtor's business and to induce timely payment of the credit instrument; and

2. the percentage of the discount off the face value of the credit instrument is reasonable as compared to the prevailing practice in the gaming industry at the time the credit instrument was issued and the casino operator or casino manager documents or otherwise keeps detailed records of the settlement.

G. The casino operator or casino manager shall ensure that:

1. the settlement is in writing and is with and executed by the debtor to whom credit was initially extended or his successors and assigns;

2. the individuals executing the settlement agreement on behalf of the parties have been duly authorized in writing to settle the debt and to execute any and all documents necessary to effectuate such settlement;

3. the terms of the settlement are set forth in a single written agreement prepared within 30 days of any oral agreement; and

4. the written settlement agreement includes:

a. the names of all parties to the agreement, including, without limitation, the names of the creditor and debtor;

b. the original amount of the debt;

- c. the rate of interest, if any, on the debt;
 - d. the amount of the settlement stated in both numbers and words;
 - e. the date of the agreement;
 - f. the basis or reason for the settlement; and
 - g. the signatures of the parties;
5. the parties' signatures are duly acknowledged before a notary public unless the settlement is an authentic act executed before a notary public.

H. If the division determines that it is necessary to independently verify the existence or the amount of a settlement, the casino operator or casino manager shall fully cooperate with and use its best efforts to assist the division with its efforts to verify the settlement and its terms and circumstances with the debtor to whom the credit was initially extended, its successors and assigns, and any third party whom the division believes may have information or documentation relative to the settlement.

I. The settlement or write-off of an uncollectible account shall be authorized and approved by a credit committee composed of key employees of the casino operator or casino manager. No individual who was involved in the original issuance of a credit or who was involved in any attempts at collection or in settlement talks concerning the credit shall be a member of the credit committee authorizing and approving the settlement or write-off of such credit. A majority of the committee may approve a settlement or write-off of an uncollectable debt as a group but no individual member acting alone may do so. The committee's approval of a settlement or write-off shall be in writing and signed by each member voting to approve the settlement or write-off.

J. The casino operator or casino manager shall provide to the division all records relevant to the debt, including, but not limited to, the debtor's credit and collection file, upon request.

K. The division may approve or disapprove any settlement or write-off of uncollectable debt consistent with these regulations and the division shall notify the casino operator or casino manager in writing of its approval or disapproval.

L. In the case of a dispute, the casino operator or casino manager may request review of the division's determination by the hearing officer of the board whose decision may be appealed to the board in accordance with the Act and these regulations. Such request for review shall be made within 10 days of receipt of the division's determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Gaming Control Board, LR 40:2270 (November 2014).

Ronnie Jones
Chairman

1411#047

RULE

**Department of Public Safety and Corrections
Gaming Control Board**

Disallowed Deductions—Landbased Casino Gaming
(LAC 42:III.4733)

The Louisiana Gaming Control Board hereby gives notice that pursuant to R.S. 27:15 and R.S. 27:24 it has amended LAC 42:III.4733.C.

Title 42

LOUISIANA GAMING

Part III. Gaming Control Board

Chapter 47. Landbased Casino Gaming

§4733. Disallowed Deductions

A. - B. ...

C. The casino operator or casino manager shall not knowingly compromise any credit collection amount with any person that has an outstanding debt with any affiliate or subsidiary of the casino operator or casino manager without the approval of the division.

AUTHORITY NOTE: Promulgated in accordance with R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Gaming Control Board, LR 38:1692 (July 2012), amended LR 40:2271 (November 2014).

Ronnie Jones
Chairman

1411#048

RULE

**Department of Public Safety and Corrections
Gaming Control Board**

Electronic Gaming Devices (LAC 42:III.4212)

The Louisiana Gaming Control Board hereby gives notice that pursuant to R.S. 27:15 and R.S. 27:24 it has amended LAC 42:III.4212.A.3.

Title 42

LOUISIANA GAMING

Part III. GAMING CONTROL BOARD

Chapter 42. Electronic Gaming Devices

§4212. Marking, Registration, and Distribution of Gaming Devices

A. - A.2. ...

3. a per device registration fee is paid by company check, money order, or certified check made payable to: State of Louisiana, Department of Public Safety and Corrections. The per device registration fee is required for all gaming devices destined for use in Louisiana by riverboat licensees or the casino operator. This fee is not required on devices which are currently registered with the board or division and display a valid registration certificate. The amount of the device registration fee is \$100 per device for riverboat licensees and \$10 per device for the casino operator; and

A.4. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 27:15 and 24.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Gaming Control Board, LR 38:1681 (July 2012), amended LR 40:2271 (November 2014).

Ronnie Jones
Chairman

1411#049

RULE

Department of Treasury Board of Trustees of the Teachers' Retirement System of Louisiana

Optional Retirement Plan (LAC 58:III.Chapter 15)

In accordance with R.S. 49:950 et seq., of the Administrative Procedure Act, and through the authority granted in R.S. 11:826, the Board of Trustees of the Teachers' Retirement System of Louisiana has repealed LAC 58:III.1501, Marketing Guidelines, and has adopted LAC 58:III.1501 through 1531 in order to provide within the optional retirement plan document certain federal tax provisions governing qualified governmental retirement plans.

Title 58 RETIREMENT

Part III. Teachers' Retirement System of Louisiana Chapter 15. Optional Retirement Plan (ORP)

§1501. Definitions

A. Terms not otherwise defined in this Chapter shall have the meaning given by the *Internal Revenue Code*.

B. Whenever used in the plan, each of the following terms has the meaning stated below.

Account—the total of the individual sub-account(s) maintained on behalf of each participant, beneficiary, or alternate payee under the investment option(s) held pursuant to the plan. The following sub-accounts shall be maintained by the ORP providers: an employer *account* to which employer contributions shall be credited; and an employee *account* to which employee contributions shall be credited. The ORP provider shall maintain such other accounts as determined by the ORP provider and the plan administrator.

Alternate Payee—a person who is an *alternate payee* under an order directed to the plan that the plan administrator or ORP provider has determined to be a domestic relations order.

Applicable Form—a form prescribed by the plan administrator or an ORP provider.

Applicable Law—the law of the state of Louisiana or, where required, federal law, including the *Internal Revenue Code*.

Beneficiary—the eligible recipient of an annuity or other benefit provided by the plan. A *beneficiary* shall be a natural person or the succession of a natural person.

Board of Trustees—the board provided for by retirement system law to administer the plan.

Contributions—*contributions* under the provisions of this plan, including employee *contributions* and employer *contributions*.

Distributee—any participant or beneficiary who receives, or but for his/her instruction to the plan administrator or ORP provider is entitled to receive, a distribution. A *distributee* includes an alternate payee to whom the plan administrator or ORP provider is directed to make a payment under a domestic relations order.

Distribution—as appropriate in the context, any kind of *distribution* or the particular kind of *distribution* provided by the plan.

Distribution Commencement Date—the first date on which a distribution (or any payment under a distribution) is paid or becomes payable.

Domestic Relations Order or *DRO*—a *domestic relations order* directed to the plan that creates or recognizes the existence of the right of an alternate payee to receive all or a portion of any benefit payable to a participant under the plan and that further meets all requirements for a *domestic relations order* as applied to a governmental plan.

DRO Distribution—a distribution to an alternate payee required or permitted following a DRO.

Earnable Compensation—the compensation earned by an employee during the full normal working time as a teacher as defined in R.S. 11:701. *Earnable compensation* shall include any differential wage payment as defined by 26 U.S.C. §3401(h)(2) that is made by an employer to any individual performing qualified military service. *Earnable compensation* shall not include per diem, post allowances, payment in kind, hazardous duty pay, or any other allowance for expense authorized and incurred as an incident to employment, nor payments in lieu of unused sick or annual leave, nor retroactive salary increases unless such an increase was granted by legislative act or by a city or parish system wide salary increase, nor payment for discontinuation of contractual services, unless the payment is made on a monthly basis. If an employee is granted an official leave and he or she makes contributions for the period of leave, *earnable compensation* shall not include compensation paid for other employment which would not have been possible without the leave. The board of trustees shall determine whether or not any other payments are to be classified as *earnable compensation*.

Effective Date—July 1, 1990, which is the *effective date* of the plan. The implementation of the plan for academic and administrative employees of public institutions of higher education occurred on July 1, 1990. The implementation of the plan for employees of constitutionally established higher education boards occurred on July 1, 1998.

Eligible Employee—has the meaning provided in R.S. 11:921 and 11:928.

Employee Contribution—contributions required from the participant under R.S. 11:927.

Employer—any *employer* of an employee who makes irrevocable election to be in the plan which includes employees of the Board of Regents, Board of Supervisors of the University of Louisiana System, Board of Supervisors of Louisiana State University and Agricultural and Mechanical College, and Board of Supervisors of Southern University and Agricultural and Mechanical College, or their successors, any other constitutionally established board which manages institutions of higher education, public institutions of higher education, or any other TRSL-covered

employer with an employee required to continue participation in the ORP as provided in R.S. 11:928.

Employer Contributions—contributions made by the employer under R.S. 11:927.

Enabling Statute—R.S. 11:921 et seq.

Internal Revenue Code or *IRC*—the *Internal Revenue Code* of 1986, as amended, and including any regulations and rulings (or other guidance of general applicability) under the *IRC*, as applicable to a governmental plan as defined by *IRC* §414(d).

Investment Option—any investment option offered by the ORP provider.

ORP Provider—a company designated by the Board of Trustees of the Teachers' Retirement System of Louisiana under R.S. 11:924.

Participant—the eligible employee who has irrevocably elected to participate in the plan.

Payout Option—any of the annuity options or other options for payment that is provided in R.S. 11:929. A *payout option* must satisfy all applicable provisions of the plan.

Personal Representative—the person duly appointed by an order of the court (or of a registrar or administrator under the court's supervision) having jurisdiction over the estate of the participant that grants the person the authority to receive the property of the deceased participant and to act as the *personal representative* of the participant's probate estate.

Plan or *ORP*—the Louisiana optional retirement *plan* provided by R.S. 11:921 et seq., and applicable regulations.

Plan Administrator—consistent with R.S. 11:923 and R.S. 11:924, the Teachers' Retirement System of Louisiana Board of Trustees or any successor.

Plan Sponsor—the state of Louisiana.

Regular Retirement Plan—the defined benefit pension plan administered by the Teachers' Retirement System of Louisiana.

Retirement System Law—those provisions of title 11 of the *Revised Statutes* of Louisiana that apply generally to the management or administration of this plan or the regular retirement plan of the Teachers' Retirement System of Louisiana.

Rollover Distribution—any eligible *rollover distribution* that is to be paid directly into an eligible retirement plan as a rollover under *IRC* §§401(a)(31) and 402.

R.S.—*Louisiana Revised Statutes*.

SEC—the Securities and Exchange Commission, an agency of the government of the United States of America, established by §4(a) of the federal Securities Exchange Act of 1934.

Severance from Employment—the date the participant terminates employment with an employer with no obligation for future services to be performed for an employer in the plan by the participant.

Spouse—except for the purposes of *IRC* §§401(a)(9) and 401(a)(31), the individual that is the participant's *spouse* under applicable law.

State—the *state* of Louisiana unless the context clearly indicates otherwise.

TRSL—Teachers' Retirement System of Louisiana.

Trust—the legal entity and the legal relationship created by state law. Consistent with *IRC* §401(a)(2), the *trust* must be solely for the purposes of the plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2272 (November 2014).

§1503. Plan Year

A. The plan year for the plan shall be the fiscal year commencing July 1 through June 30. The limitation year is the calendar year.

B. The plan administrator and ORP provider shall be entitled to rely on the assumption that a participant's taxable year is the calendar year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2273 (November 2014).

§1505. Establishment of Plan

A. The plan sponsor and plan administrator intend that the plan conform to the *Internal Revenue Code* of 1986 requirements for favorable federal tax treatment under *IRC* §401(a) and is a governmental plan within the meaning of *IRC* §414(d), with employee contributions picked up under an arrangement consistent with *IRC* §414(h)(2). Therefore, the plan administrator will construe and interpret the plan to state provisions that conform to the requirements of *IRC* §401, as applicable to a governmental plan under *IRC* §414(d). When the *Internal Revenue Code* is amended through subsequent legislation, or interpreted through revenue rulings, the plan administrator will construe and interpret the plan as stating provisions consistent with such amendment of relevant law.

B. To the extent required for this plan to qualify under *IRC* §401(a), the provisions of this plan shall be construed, consistent with treasury reg. §1.401-1(b)(1)(i), to provide:

1. a definite pre-determined formula for allocating contributions and a definite pre-determined formula for allocating investment earnings (and losses) among accounts;
2. periodic valuation of plan assets (including investment options) and trust assets at least once each year;
3. periodic valuation of accounts at least once each year; and
4. distribution of plan accounts after severance from employment or the occurrence of some event.

C. This Chapter states the provisions of an optional retirement plan for the classes of employees covered by R.S. 11:921 et seq. The purpose of the optional retirement plan is set out by R.S. 11:922. The provisions of R.S. 11:921 et seq., are incorporated as if fully set out in this *Louisiana Administrative Code*.

D. The plan is established and maintained with the intent that the plan conforms to the applicable requirements of the retirement system law. The provisions of the plan shall be interpreted whenever possible to state provisions that conform to the applicable requirements of the enabling statute. When the enabling statute is amended or interpreted through subsequent legislation or regulations or an attorney general opinion, the plan should be construed as stating provisions consistent with such amendment or interpretation of the applicable law. In the event of a conflict between the *Louisiana Administrative Code* and the enabling statute, the enabling statute will supersede.

E. Subject only to the Constitution of Louisiana, the Louisiana legislature has the right to amend the plan at any time. To the extent consistent with the retirement system law, the plan administrator has the right to amend the plan to implement applicable federal and state law at any time. Any amendment of the plan and trust shall not be effective to the extent that the amendment has the effect of causing any plan assets to be diverted to or inure to the benefit of the plan administrator, ORP provider, or any employer, or to be used for any purpose other than providing benefits to participants and beneficiaries and defraying reasonable expenses of administering the plan and trust.

F. The plan is established for the exclusive benefit of participants and their beneficiaries. Consistent with IRC §401(a)(2), no amount held under the plan will ever inure to the benefit of the plan sponsor, any employer, the plan administrator, the ORP provider or any successor of any of them, and all plan investments and amounts will be held for the exclusive purpose of providing benefits to the plan's participants and their beneficiaries. Notwithstanding anything in the plan to the contrary, plan assets shall not be used for or diverted to purposes other than for the exclusive benefit of participants, beneficiaries, and alternate payees before the satisfaction of all liabilities to participants, beneficiaries, and alternate payees, except that payment of taxes and administration expenses may be made from the plan assets as provided by the plan or permitted by applicable law.

G. Plan contributions are invested, at the direction of each participant, in one or more funding vehicles provided by ORP providers to participants under the plan. Required participant plan contributions are designated picked up so as not to be included in participants' gross income for federal income tax purposes as provided by IRC §414(h)(2).

H. At no time shall the plan assets be used for, or diverted to, any person other than for the exclusive benefit of the employees and their beneficiaries and defraying reasonable expenses of administering the plan, except that contributions made by the employer may be returned to the employer if the contribution was made due to a mistake of fact.

I. The plan, and all acts and decisions taken under it, is binding and conclusive, for all purposes, upon every participant, beneficiary, alternate payee, any person claiming through a participant or beneficiary or alternate payee, all other interested persons, and upon the personal representatives, executors, administrators, heirs, successors and assigns of any and all such persons. The plan shall not affect contracts or other dealings with a person who is not an interested person, unless a written agreement executed by that person expressly so provides.

J. For purposes of the IRC, the plan is a defined contribution money purchase retirement plan under IRC §401(a).

K. The plan is an individual account plan which provides for an individual account for each participant and for benefits based solely upon the amount of contributions, investment gains and losses, fees, and expenses allocated to the participant's account.

L. The *United States Code* provisions created by title I of the Employee Retirement Income Security Act of 1974 ("ERISA") do not apply to this plan.

M. The plan is a governmental plan within the meaning of 29 USC 1002(32) and IRC §414(d).

N. The Teachers' Retirement System of Louisiana as the plan administrator provides for the administration and maintenance of the ORP pursuant to R.S. 11:921 et seq. The plan administrator may delegate duties to ORP providers to the extent permitted by applicable law.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2273 (November 2014).

§1507. Eligibility and Election to Participate

A. Academic and administrative employees of public institutions of higher education and employees of the Board of Regents, Board of Supervisors for the University of Louisiana System, Board of Supervisors of Louisiana State University and Agricultural and Mechanical College, and Board of Supervisors of Southern University and Agricultural and Mechanical College, or their successors, and any other constitutionally established board which manages institutions of higher education who are current employees in the regular retirement plan of the TRSL may make an irrevocable election to participate in the ORP within 180 days after the implementation date of the ORP at their employer institution or board.

B. Academic and administrative employees of public institutions of higher education and employees of the Board of Regents, Board of Supervisors for the University of Louisiana System, Board of Supervisors of Louisiana State University and Agricultural and Mechanical College, and Board of Supervisors of Southern University and Agricultural and Mechanical College, or their successors, and any other constitutionally established board which manages institutions of higher education who are initially employed on or after the implementation date at their employer institution or board may make an irrevocable election to participate in the ORP within 60 days after their employment date.

C. Any academic or administrative employee of a public institution of higher education or employee of the Board of Regents, Board of Supervisors for the University of Louisiana System, Board of Supervisors of Louisiana State University and Agricultural and Mechanical College, or Board of Supervisors of Southern University and Agricultural and Mechanical College, or their successors, and any other constitutionally established board which manages institutions of higher education who is a part-time, seasonal, or temporary employee as defined in 26 CFR 31:3121(b)(7)-2, or in any successor regulation shall be eligible to participate in the ORP upon election by such employee.

D. Notwithstanding the provisions of Subsections A and B of this Section, any academic or administrative employee of a public institution of higher education and any employee of the Board of Regents, Board of Supervisors for the University of Louisiana System, Board of Supervisors of Louisiana State University and Agricultural and Mechanical College, and Board of Supervisors of Southern University and Agricultural and Mechanical College, or their successors, and any other constitutionally established board which manages institutions of higher education who is an active contributing member in the regular retirement plan of

the TRSL and who has less than five years of creditable service in the TRSL, may make an irrevocable election to participate in the ORP and transfer his accumulated employee contributions to the ORP under the provisions of R.S. 11:926(A). This election can only be made by a member prior to attainment of five years of creditable service in the TRSL.

E. Elections must be made in writing and filed with the appropriate officer of the employer institution or board, who shall forward a copy of the completed election to the TRSL.

F. The election of employees making an election to participate in ORP as provided in Subsection A of this Section will be effective as of the date they are filed. Elections of eligible employees hired on or after the implementation date of the optional retirement plan at their institution or board as provided in Subsection B of this Section will be effective as of the date of their employment. If an eligible employee fails to make the election provided for in this Section, he shall become a member of the regular retirement plan of the TRSL in accordance with R.S. 11:721.

G. Any person electing to participate in the ORP shall always be ineligible for membership in the regular retirement plan of the TRSL even if he is employed in a position covered by the TRSL, as prescribed by R.S. 11:928.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2274 (November 2014).

§1509. Employer Contributions

A. Each participant shall contribute a mandatory monthly employee contribution percentage into the plan, as provided by law. Each employer shall pick-up employee contributions for all earnable compensation paid after the effective date. The employee contributions so picked up shall be treated as employer contributions pursuant to IRC §414(h)(2). The employer shall remit the picked up contributions to the TRSL for direct transfer to the ORP provider, instead of paying such amounts to the participants, and such contributions shall be paid from the same funds that are used in paying salaries to participants. Such contributions, although designated as employee contributions, shall be paid by the employer in lieu of contributions by participants. Participants may not elect to receive such contributions directly instead of having them paid by the employer to the plan. Employer contributions so picked up shall be treated for all purposes of the plan and state law, other than federal tax law, in the same manner as employee contributions made without a pick-up. See PLR 8633052.

B. The entirety of each participant's contribution, less any monthly fee established by the board of trustees to cover the cost of administration and maintenance of the plan, will be remitted to the ORP provider for application to the participant's account.

C. If a participant first became eligible for membership in the TRSL, or the plan, on or after July 1, 1996, the employee contributions remitted by the TRSL to any ORP provider shall not be based on compensation in excess of the annual limit of IRC §401(a)(17) as amended and revised pursuant to IRC §401(a)(17)(B).

D. A participant who attains his or her eligibility for a distribution and continues to be an employee will continue to make employee contributions, and will continue to

participate under the plan until his or her severance from employment or the occurrence of some other event. Further, a participant's and spouse's right to his/her account is non-forfeitable as of his/her eligibility for a distribution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2275 (November 2014).

§1511. Employer Contributions

A. Each employer shall contribute a mandatory monthly employer contribution percentage into the plan, as provided by law. Upon receipt of the employer contribution, the TRSL will promptly forward the amount established in compliance with law to the ORP provider. Such amount paid over to the ORP provider shall be credited to the participant's account. The TRSL shall retain the balance of the employer contribution for application to the unfunded accrued liability of the TRSL.

B. If a participant first became eligible for membership in the Teachers' Retirement System of Louisiana, or the ORP, on or after July 1, 1996, the employer contributions remitted by the Teachers' Retirement System of Louisiana to any ORP provider shall not be based on compensation in excess of the annual limit of IRC §401(a)(17) as amended and revised pursuant to IRC §401(a)(17)(B).

C. A participant who attains his eligibility for a distribution and continues to be an employee will continue to receive employer contributions, and will continue to participate under the plan until his or her severance from employment or the occurrence of some other event. Further, a participant's and spouse's right to his/her account is non-forfeitable as of his/her eligibility for a distribution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2275 (November 2014).

§1513. Distributions

A. Retirement benefits shall be payable to plan participants or their beneficiaries by the ORP providers. Subject to the provisions of the contract, retirement benefits shall be paid in the form of a lifetime income, unless the participant or beneficiary requests a trustee-to-trustee single-sum cash rollover payment between qualified plans, or payment made directly to an individual retirement account, but death benefits may be paid in the form of a single-sum cash payment paid directly to the beneficiary or estate, whichever is applicable.

B. The ORP provider shall offer ORP participants the following single-sum cash payments:

1. direct transfers by and between OPR providers;
2. death benefits.
3. an initial benefit payable upon retirement, provided such benefit is approved by the ORP provider. The initial benefit shall not exceed an amount equal to the participant's monthly benefit, payable as a single-life annuity with no guarantees, times 36.

C. Minimum Distribution

1. For purposes of this Section, the following definitions shall apply.

Designated Beneficiary—the individual who is designated as the beneficiary under the plan and is the

designated beneficiary under IRC §401(a)(9) and treasury regulations section 1.401(a)(9)-1, Q&A-4.

Required Beginning Date—the April 1 of the calendar year following the later of:

- i. the calendar year in which the participant attains age 70 1/2 ; or
- ii. the calendar year in which the participant retires.

(a). The participant, alternate payee, or beneficiary may elect on the applicable form whether to recalculate life expectancy (or any element of it) to the fullest extent permitted by IRC §401(a)(9)(D). If the participant, alternate payee, or beneficiary does not timely make this election, the participant, alternate payee, or beneficiary is deemed to have elected the "default" method specified by the applicable investment option(s), or to the extent that no method is so specified, that no recalculation shall apply with respect to any individual's life expectancy.

2. The requirements of this Section will take precedence over any inconsistent provisions of the plan. All distributions required under this Section will be determined and made in accordance with IRC §401(a)(9) and the treasury regulations under IRC §401(a)(9). Distributions to a participant and his/her beneficiaries shall only be made in accordance with the incidental death benefit requirements of IRC §401(a)(9)(G) and the treasury regulations thereunder.

3. The participant's entire interest will be distributed, or begin to be distributed, to the participant no later than the participant's required beginning date. If the participant dies before distributions begin, the participant's entire interest will be distributed, or begin to be distributed, no later than as follows.

a. If the participant's surviving spouse is the participant's sole designated beneficiary, then distributions to the surviving spouse will begin by December 31 of the calendar year immediately following the calendar year in which the participant died, or by December 31 of the calendar year in which the participant would have attained age 70 1/2, if later.

b. If the participant's surviving spouse is not the participant's sole designated beneficiary, then distributions to the designated beneficiary will begin by December 31 of the calendar year immediately following the calendar year in which the participant died.

c. If there is no designated beneficiary as of September 30 of the year following the year of the participant's death, the participant's entire interest will be distributed by December 31 of the calendar year containing the fifth anniversary of the participant's death.

d. If the participant's surviving spouse is the participant's sole designated beneficiary and the surviving spouse dies after the participant but before distributions to the surviving spouse begin, this Subparagraph, rather than Subparagraph 3.a, will apply as if the surviving spouse were the participant.

4. For purposes of this Section, unless Subparagraph 3.a applies, distributions are considered to begin on the participant's required beginning date. If Subparagraph 3.a applies, distributions are considered to begin on the date distributions are required to begin to the surviving spouse under Subparagraph 3.a. If distributions under an annuity purchased from an insurance company irrevocably

commence to the participant before the participant's required beginning date (or to the participant's surviving spouse) before the date distributions are required to begin to the surviving spouse under Subparagraph 3.a, the date distributions are considered to begin is the date distributions actually commence.

5. If the participant's interest is distributed in the form of an annuity purchased from an insurance company, distributions thereunder will be made in accordance with the requirements of IRC §401(a)(9) and the treasury regulations thereunder.

6. If a distribution is required to begin to a beneficiary and the beneficiary has not filed a claim by the date that is 90 days before the date required by IRC §401(a)(9) (or if the ORP provider has denied a claim and an acceptable claim has not been filed before the applicable date), the ORP provider shall direct payment (or, if provided by the investment option, the ORP provider may without instruction make payment) according to the automatic payout option provided by the applicable investment option(s), or, to the extent not so provided, as a lump sum distribution.

7. If a participant has not furnished evidence of his or her spouse's date of birth, the ORP provider will use the employee's age in determining the minimum distribution period according to treasury reg. §1.401(a)(9)-5/Q&A-4(a) without regard to treasury reg. §1.401(a)(9)-5/Q&A-4(b).

D. Required Minimum Distribution Waiver of 2009

1. Notwithstanding any other provisions of this Section, a participant or beneficiary who would have been required to receive required minimum distributions for 2009 but for the enactment of IRC §401(a)(9)(H) ("2009 RMDs"), and who would have satisfied that requirement by receiving distributions that are: equal to the 2009 RMDs; or one or more payments in a series of substantially equal distributions (that include the 2009 RMDs) made at least annually and expected to last for the life (or life expectancy) of the participant's designated beneficiary, or for a period of at least 10 years ("extended 2009 RMDs"), will not receive those 2009 distributions unless the participant or beneficiary elects to receive such distribution. Participants and beneficiaries described in the preceding sentence will be given the opportunity to elect to receive the distributions described in the preceding sentence. However, those participants and beneficiaries who receive required minimum distributions through the automatic payment system will continue to receive 2009 RMDs unless he or she elects not to receive the 2009 RMDs.

2. Notwithstanding any other provisions of the plan, and solely for purposes of applying the rollover provisions of the plan, 2009 RMDs [amounts that would have been required minimum distributions for 2009 but for the enactment of IRC §401(a)(9)(H)] and extended 2009 RMDs (one or more payments in a series of substantially equal distributions (that include the 2009 RMDs) made at least annually and expected to last for the life (or life expectancy) of the participant's designated beneficiary, or for a period of at least 10 years), will be treated as eligible rollover distributions.

E. Claim for Distribution

1. Any distribution shall be paid only upon a claim made on the applicable form, and submission of additional

information requested by the ORP provider, including but not limited to:

- a. if the distribution is made, appropriate evidence that the participant has a severance from employment;
- b. if the distribution is an eligible rollover distribution, the distributee's instruction as to whether the distribution (or a portion of the distribution) is to be paid directly to an eligible retirement plan, and if any amount is to be paid directly to an eligible retirement plan, the name and address of the trustee or administrator of that eligible retirement plan together with any other information that the plan administrator, ORP provider, or the eligible retirement plan administrator reasonably requests pursuant to treas. reg. §1.401(a)(31)-1;
- c. if the distribution is made on account of the participant's death, appropriate evidence of the participant's death;
- d. whenever required by the ORP provider, the date-of-birth of any distributee as relevant to the distribution;
- e. if the account consists of more than one investment option, the order in which any investment options are to be charged or redeemed to pay the distribution; and
- f. any other evidence or information that the ORP provider finds is relevant to administer a provision of the plan in the participant's or beneficiary's and the distributee's circumstances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2275 (November 2014).

§1515. Rollover Distribution

A. For purposes of this Section, the following definitions shall apply.

Direct Rollover—a payment by the plan to the eligible retirement plan specified by the distributee.

Distributee—includes a participant or former participant. It also includes the participant's or former participant's surviving spouse and the employee's or former employee's spouse or former spouse who is the alternate payee under a domestic relations order. It also includes the participant's or former participant's nonspouse beneficiary who is a designated beneficiary as defined by IRC §401(a)(9)(E). Effective January 1, 2007, and notwithstanding anything in the plan to the contrary that otherwise would limit a *distributee's* election under this Section, and to the extent allowed under the applicable provisions of the IRC and the treasury regulations, a *distributee* who is a designated beneficiary, but not a surviving spouse, spouse or former spouse alternate payee may elect, at the time and in the manner prescribed by the plan administrator, to have all or any part of the account that qualifies as an eligible rollover distribution paid in a direct trustee-to-trustee transfer to an eligible retirement plan that is an individual retirement plan described in Clause (i) or (ii) of the IRC §402(c)(8)(B). If such a transfer is made:

- a. the transfer shall be treated as an eligible rollover distribution;
- b. the individual retirement plan shall be treated as an inherited individual retirement account or individual retirement annuity (within the meaning of IRC §408(d)(3)(C)); and

c. IRC §401(a)(9)(B) (other than clause (iv) thereof) shall apply to such individual retirement plans.

Eligible Retirement Plan—any program defined in IRC §§401(a)(31) and 402(c)(8)(B), that accepts the distributee's eligible rollover distribution, and any of the following:

- a. an individual retirement account under IRC §408(a);
- b. an individual retirement annuity under IRC §408(b);
- c. a qualified trust as described in IRC §401(a), provided that such trust accepts the employee's eligible rollover distribution;
- d. an annuity plan as described in IRC §403(a);
- e. an eligible deferred compensation plan described in IRC §457(b) which is maintained by an eligible governmental employer under IRC §457(e)(1)(A) (provided the plan contains provisions to account separately for amounts transferred into such plan);
- f. an annuity contract under IRC §403(b); or
- g. a Roth IRA as described under IRC §408A.

Eligible Rollover Distribution—

a. the distribution of all or any portion of the balance to the credit of an employee from a qualified plan, except that an *eligible rollover distribution* does not include:

- i. any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the distributee or the joint lives (or joint life expectancies) of the participant and the participant's designated beneficiary, or for a specified period of 10 years or more;
- ii. any distribution to the extent such distribution is required under IRC §401(a)(9); or
- iii. the portion of any distribution that is not includible in gross income, provided that any portion of any distribution that is not includible in gross income may be an *eligible rollover distribution* for purposes of a rollover to either:

(a). a traditional individual retirement account or individual retirement annuity under IRC §§408(a) or 408(b); or

(b). a qualified trust which is part of a plan which is a defined contribution plan or a defined benefit under IRC §§401(a) or 403(a) or to an annuity contract described in IRC §403(b), and such trust or annuity contract separately accounts for amounts so transferred, including separate accounting for the portion of such distribution that is includible in gross income and the portion of such distribution that is not includible.

b. a qualified rollover contribution to a Roth IRA within the meaning of IRC §408A.

B. Consistent with IRC §401(a)(31), for any distribution that is an eligible rollover distribution, the distributee may elect, at the time and in the manner prescribed by the ORP provider, to instruct the ORP provider to have any portion of an eligible rollover distribution paid directly to an eligible retirement plan specified by the distributee. The ORP provider shall provide written information to the distributee regarding eligible rollover distributions no more than 180 days prior to payment of the eligible rollover distribution, to the extent required by IRC §402(f).

C. A current employee in the TRSL who elects participation in the plan shall have the right to have his or

her accumulated employee contributions transferred to the plan to purchase benefits thereunder in accordance with R.S. 11:926. A current vested employee in the TRSL or an employee with sufficient years of service credit but who is not old enough to receive a benefit and who elects participation in the plan will have the same rights and privileges accorded by R.S. 11:726.

D. The ORP provider may (but is not required to) commence the distribution less than 30 days after giving an eligible rollover distribution notice only if the following requirements are met. To the extent required by IRC §402(f) and treasury reg. §1.402(c)-2, the ORP provider must inform the distributee in an eligible rollover distribution notice or otherwise that the distributee has a right to a period of at least 30 days after receiving the eligible rollover distribution notice to consider the decision of whether to elect a distribution and any available payout option, and the distributee after receiving the eligible rollover distribution notice must affirmatively elect a distribution.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2277 (November 2014).

§1517. Benefit Limitation

A. Annual additions with respect to a member shall not exceed the lesser of \$40,000 (as adjusted pursuant to IRC §415(d) or 100 percent of the member's compensation.

1. For purposes of this Section, the following definition shall apply.

Annual Additions—the sum (for any year) of employer contributions to a defined contribution plan, member contributions, and forfeitures credited to a member's individual account. Member contributions are determined without regard to rollover contributions and to picked-up employee contributions that are paid to a defined benefit plan.

2. For purposes of applying IRC §415(c) and for no other purpose, the definition of compensation where applicable will be compensation actually paid or made available during a limitation year, except as noted below and as permitted by treasury regulation §1.415(c)-2, or successor regulation; provided, however, that member contributions picked up under IRC §414(h) shall not be treated as compensation.

3. Compensation will be defined as wages within the meaning of IRC §3401(a) and all other payments of compensation to an employee by an employer for which the employer is required to furnish the employee a written statement under IRC §§6041(d), 6051(a)(3) and 6052 and will be determined without regard to any rules under IRC §3401(a) that limit the remuneration included in wages based on the nature or location of the employment or the services performed [such as the exception for agricultural labor in IRC §3401(a)(2)].

a. However, for limitation years beginning after December 31, 1997, compensation will also include amounts that would otherwise be included in compensation but for an election under IRC §§125(a), 402(e)(3), 402(h)(1)(B), 402(k), or 457(b).

b. For limitation years beginning after December 31, 2000, compensation shall also include any elective amounts that are not includible in the gross income of the member by reason of IRC §132(f)(4).

B. For limitation years beginning on and after January 1, 2009, compensation for the limitation year shall also include compensation paid by the later of two and one-half months after a member's severance from employment or the end of the limitation year that includes the date of the member's severance from employment if the payment is regular compensation for services during the member's regular working hours, or compensation for services outside the member's regular working hours (such as overtime or shift differential), commissions, bonuses or other similar payments, and, absent a severance from employment, the payments would have been paid to the member while the member continued in employment with the employer.

C. Any payments not described in Subsection B of this Section are not considered compensation if paid after severance from employment, even if they are paid within two and one-half months following severance from employment, except for payments to the individual who does not currently perform services for the employer by reason of qualified military service [within the meaning of IRC §414(u)(1)] to the extent these payments do not exceed the amounts the individual would have received if the individual had continued to perform services for the employer rather than entering qualified military service.

D. An employee who is in qualified military service [within the meaning of IRC §414(u)(1)] shall be treated as receiving compensation from the employer during such period of qualified military service equal to:

1. the compensation the employee would have received during such period if the employee were not in qualified military service, determined based on the rate of pay the employee would have received from the employer but for the absence during the period of qualified military service; or

2. if the compensation the employee would have received during such period was not reasonably certain, the employee's average compensation from the employer during the twelve month period immediately preceding the qualified military service (or, if shorter, the period of employment immediately preceding the qualified military service).

E. Back pay, within the meaning of treasury regulation §1.415(c)-2(g)(8), shall be treated as compensation for the limitation year to which the back pay relates to the extent the back pay represents wages and compensation that would otherwise be included under this definition.

F. If the annual additions for any member for a plan year exceed the limitation under IRC §415(c), the excess annual addition will be corrected as permitted under the employee plans compliance resolution system (or similar IRS correction program).

G. For limitation years beginning on or after January 1, 2009, a member's compensation for purposes of this Paragraph shall not exceed the annual limit under IRC §401(a)(17).

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2278 (November 2014).

§1519. Annual Compensation Limitation

A. In addition to other applicable limits stated by the plan and notwithstanding any other provision of the plan to the contrary, the amount of earnable compensation determined for the purposes of the contributions to the plan shall not exceed the limit prescribed by IRC §401(a)(17) as adjusted each year according to IRC §401(a)(17)(B).

B. For purposes of this Section, the following definition shall apply.

Annual Compensation—earnable compensation during the plan year or such other consecutive 12-month period over which compensation is otherwise determined under the plan (the determination period). The cost-of-living-adjustment in effect for a calendar year applies to annual compensation for the determination period that begins with or within such calendar year.

C. If the plan year or applicable period for determining *annual compensation* contains fewer than 12 calendar months, then this compensation limit is the amount equal to the annual IRC §401(a)(17) limit for the applicable calendar year during which the compensation period begins multiplied by the ratio that is obtained by dividing the number of full months in the period by 12.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2279 (November 2014).

§1521. Fiduciary Responsibility

A. Any person electing to participate in the plan shall agree to the provisions of the plan in accordance with R.S. 11:929.

B. The ORP providers may not engage in any prohibited transactions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2279 (November 2014).

§1523. Plan Assets

A. Except as provided in Subsection B of this Section, plan assets shall be held by the ORP providers in an individual or group annuity contract, or custodial account which meets the requirements of IRC §401(f) in order to be treated as a qualified trust.

B. A separate trust is hereby established under state law for the purpose of segregating fees to be used for the payment of reasonable plan expenses. This trust shall be administered by the board of trustees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2279 (November 2014).

§1525. Vesting

A. A participant's interest in his/her account shall immediately become and shall at all times remain fully vested and non-forfeitable.

B. The plan shall be construed consistently with IRC §§401(a)(4) and 401(a)(7) as in effect on September 1, 1974.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2279 (November 2014).

§1527. Governing Law

A. The plan, and actions under or relating to the plan, and the statute of limitations for such actions shall be governed by and enforced by the laws of the state of Louisiana and shall be construed, to the extent that any construction beyond the written plan is necessary, according to the laws of the state of Louisiana or the *Internal Revenue Code* or other federal law, where applicable.

B. If, under any application filed by or on behalf of the plan, the IRS determines that the plan as amended and restated does not qualify under IRC §401(a), and the determination is not contested, or if contested, is finally upheld (or otherwise finally determined), the plan administrator may retroactively amend the plan to the earliest date permitted by treasury regulations to the fullest extent that the plan administrator considers necessary to obtain an IRS determination that the plan qualifies under IRC §401(a). Such actions may be taken without further authorization or consent from the plan sponsor, provided amendments are not contrary to state law.

C. If any contribution (or any portion of a contribution) is made by the employer by a good faith mistake of fact, upon receipt in good order of a proper request, the plan administrator or the ORP provider shall return the amount of the mistaken contribution(s), except as limited below, to the employer in accordance with rev. rul. 91-4. The amount of any contribution returned may not exceed the difference between the amount actually contributed and the amount which would have been contributed had there been no mistake of fact and may not include the earnings attributable to such contribution. The amount of the contributions returned must be reduced by any losses attributable to the contribution, and no participant may have his benefit payable hereunder reduced by the return of the contribution to less than such benefit would have been had the returned contribution never been made. The amount of the erroneous contributions will be corrected and returned no later than 30 days after notification of the error if such correction and return can be completed within one year of the erroneous contributions.

D. In any event, any correction under this section shall be made in accordance with the Internal Revenue Service employee plans compliance resolution system (or similar IRS correction program).

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2279 (November 2014).

§1529. USERRA

A. Notwithstanding any provisions of this plan to the contrary, contributions, benefits, and service credits with respect to qualified military service shall be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and the Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART"), IRC §401(a)(37), and IRC §414(u).

B. For purposes of this Section, the following definition shall apply.

Qualified Military Service (as defined by in chapter 43, title 38, *United States Code*)—the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from a position of employment for the purposes of an examination to determine the fitness of the person to perform any such duty, and a period for which a person is absent from employment for the purposes of performing funeral honors duty as authorized by 10 U.S.C. §12503 or 32 U.S.C. §115 if such individual is entitled to reemployment rights under USERRA with respect to such service.

Uniformed Service—the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of Public Health Service, and any other category of persons designated by the President of the U.S. in the time of war or national emergency.

C. An eligible employee whose employment is interrupted by qualified military service under IRC §414(u) or who is on a leave of absence for qualified military service under IRC §414(u) shall be entitled to receive any employer contributions that he failed to receive under the plan as a result of his military service, provided he returns to employment with the employer upon receiving an honorable discharge from military service and there is no intervening employment outside of the employment with the employer.

D. Effective January 1, 2009, an eligible employee whose employment is interrupted by qualified military service or who is on a leave of absence for qualified military service and who receives a differential wage payment within the meaning of IRC §414(u)(12)(D) from the employer will be treated as an eligible employee of the employer and the differential wage payment will be treated as compensation for purposes of applying the limits on annual additions under IRC §415(c).

E. Effective January 1, 2007, death benefits payable under the plan shall be paid in accordance with IRC §401(a)(37), which provides that in the case of an eligible employee who dies while performing qualified military service (as defined in IRC §414(u)), the survivors of the eligible employee are entitled to any additional benefits (other than benefit accruals relating to the period of qualified military service) provided under the plan had the eligible employee resumed and then terminated employment with the employer on account of death.

F. Notwithstanding anything in the plan to the contrary, a participant who is a reservist or national guardsman (as defined in 37 U.S.C. §101(24), and who was ordered or called to active duty, after September 11, 2001, for a period in excess of 179 days or for an indefinite period may request, during the period beginning on the date of the order or call to duty and ending at the close of the active duty period, a distribution of all or part of his or her account attributable to salary deferral contributions. The distribution shall be paid to the participant as promptly as practicable after the plan administrator or ORP provider receives the

participant's request. If the participant's interest in the plan is invested in more than one of the separate investment options maintained under the plan, a withdrawal of less than the complete balance of the interest shall be withdrawn pro rata from each applicable investment option.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2279 (November 2014).

§1531. ORP Providers

A. In the selection of ORP provider(s) as required by law, the board of trustees will, at a minimum, consider the following criteria in the selection process:

1. portability of the contracts offered or to be offered by the company, based on the number of states in which the designated company provides contracts under similar plans;
2. efficacy of the contracts in the recruitment and retention of employees for the various state public institutions of higher education and higher education boards;
3. nature and extent of the rights and benefits to be provided by the contracts for participating employees and their beneficiaries;
4. relation of the rights and benefits to the amount of the contributions to be made pursuant to the provisions of the Plan;
5. suitability of the rights and benefits to the needs and interests of participating employees and employers; and
6. ability of the designated company or companies to provide the rights and benefits under such contracts.

B. The TRSL will enter into a contract with each ORP provider. Effective July 1, 2015, each ORP provider contract shall include the "operational guide for ORP providers" developed by the TRSL.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:921-929.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 40:2280 (November 2014).

Maureen H. Westgard
Director

1411#035

RULE

Department of Treasury Deferred Compensation Commission

Public Employees Deferred Compensation Plan
(LAC 32:VII.101, 505, and 721)

The Louisiana Deferred Compensation Commission ("LDCC"), in accordance with R.S. §49:950 et seq., of the Louisiana Administrative Procedure Act, amends rules necessary to allow participants of the Louisiana Public Employees Deferred Compensation Plan to have the option to designate their elective deferrals as Roth contributions in accordance with IRC 457. This Rule applies to deferrals made on or after January 1, 2015. The Louisiana Deferred Compensation Commission also amends Chapter 7 relative to transfers into the plan.

**Title 32
EMPLOYEE BENEFITS**

**Part VII. Public Employee Deferred Compensation
Subpart 1. Deferred Compensation Plan**

Chapter 1. Administration

§101. Definitions

* * *

Designated Roth Account—a separate account maintained by the plan in accordance with IRC §402A and the regulations thereunder for accepting designated Roth contributions. A designated Roth contribution is an elective deferral that would otherwise be excludable from gross income but that has been designated by the participant who elects the deferral as not being so excludable, or an existing account which is converted to a *designated Roth account* in compliance with the *Internal Revenue Code*.

* * *

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1962 (October 1998), amended LR 28:1494 (June 2002), LR 32:118 (January 2006), LR 37:1617 (June 2011), LR 40:2281 (November 2014).

Chapter 5. Investments

§505. Participant Accounts

A. - B. ...

C. Beginning on January 1, 2011, the commission may maintain or cause to be maintained (for individual participants) designated Roth accounts.

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1967 (October 1998), amended LR 28:1497 (June 2002), LR 40:2281 (November 2014).

Chapter 7. Distributions

§721. Transfers and Rollovers

A. Transfers Into the Plan. At the direction of the employer, the administrator may permit a class of participants who are participants in another eligible governmental plan under code §457(b) to transfer assets to the plan. Such a transfer is permitted only if the other plan provides for the direct transfer of each participant's interest therein to the plan. The administrator may require in its sole discretion that the transfer be in cash. The administrator may require such documentation from the other plan as it deems necessary to effectuate the transfer in accordance with code §457(e)(10) and treasury regulation §1.457-10(b) and to confirm that the other plan is an eligible governmental plan as defined in treasury regulation §1.457-2(f). The amount so transferred shall be credited to the participant's account balance and shall be held, accounted for, administered and otherwise treated in the same manner as an annual deferral by the participant under the plan, except that the transferred amount shall not be considered an annual deferral under the plan in determining the maximum deferral under article III.

B. - D.2. ...

AUTHORITY NOTE: Promulgated in accordance with IRC §457 and R.S. 42:1301-1308.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Deferred Compensation Commission, LR 24:1969

(October 1998), amended LR 28:1499 (June 2002), LR 37:1621 (June 2011), LR 40:2281 (November 2014).

Emery Bares
Chairman

1411#015

RULE

**Department of Wildlife and Fisheries
Office of Fisheries**

Reef Fish—Harvest (LAC 76:VII.335)

The Department of Wildlife and Fisheries has amended LAC 76:VII.335, modifying existing reef fish harvest regulations. Changes remove closed seasons and bag limits on rock and red hind. Authority for amendment of this Rule is included in the Administrative Procedure Act, R.S. 49:950 et seq., and through the authority granted in R.S. 56:6(25)(a), 56:320.2, 56:326.1, and 56:326.3 to the Department of Wildlife and Fisheries.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic Life

Chapter 3. Saltwater Sport and Commercial Fishery

§335. Reef Fish—Harvest Regulations

A. Recreational bag limits regarding the harvest of reef fish: triggerfishes, amberjacks, grunts, wrasses, snappers, groupers, sea basses, tilefishes, and porgies, within and without Louisiana's territorial waters.

Species	Recreational Bag Limits
1. Red Snapper	2 fish per person per day
2. Queen, mutton, blackfin, cubera, gray, silk, yellowtail snappers, and wenchman	10 fish per person per day (in aggregate)
3. Vermilion snapper, lane snapper, gray triggerfish, almaco jack, goldface tilefish, tilefish, and blueline tilefish	20 per person per day (in aggregate) with not more than 2 gray triggerfish and not more than 10 vermilion snapper per person included in the bag limit.
4. Speckled hind, black grouper, red grouper, snowy grouper, yellowedge grouper, yellowfin grouper, yellowmouth grouper, warsaw grouper, gag grouper, scamp	4 fish per person per day (in aggregate) with not more than 1 speckled hind and 1 warsaw grouper per vessel and with not more than 4 red grouper per person and not more than 2 gag grouper per person included in the bag limit
5. Greater amberjack	1 fish per person per day
6. Banded rudderfish and lesser amberjack	5 fish per person per day (in aggregate)
7. Hogfish	5 fish per person per day
8. No person shall possess goliath grouper or Nassau grouper whether taken from within or without Louisiana territorial waters per LAC 76:VII.337.	

B. - B.5. ...

6. For-hire vessels operated by a legally licensed Louisiana guide having a valid recreational offshore landing permit in possession and fishing the waters of the state during an open season can harvest and possess a recreational limit of reef fish.

C. - D.8. ...

* * *

E. Recreational and commercial minimum and maximum size limits, unless otherwise noted.

Species	Minimum Size Limits
1. Red snapper	16 inches total length (Recreational) 13 inches total length (Commercial)
2. Gray, yellowtail, and cubera snapper	12 inches total length
3. Lane snapper	8 inches total length
4. Mutton snapper	16 inches total length
5. Vermilion snapper	10 inches total length
6. Red grouper	20 inches total length (Recreational) 18 inches total length (Commercial)
7. Yellowfin grouper	20 inches total length
8. Gag grouper	22 inches total length
9. Black grouper	22 inches total length (Recreational) 24 inches total length (Commercial)
10. Scamp	16 inches total length
11. Greater amberjack	30 inches fork length (Recreational) 36 inches fork length (Commercial)
12. Hogfish	12 inches fork length
13. Banded rudderfish and lesser amberjack	14 inches fork length (minimum size) 22 inches fork length (maximum size)
14. Gray triggerfish	14 inches fork length

F. - G1. ...

* * *

2. Seasons for the recreational harvest of reef fish species or groups listed below shall be closed during the periods listed below.

Species or Group	Closed Season
a. Gag	January 1-June 30 of each year
b. Black, red, yellowfin, and yellowmouth groupers, and scamp	February 1-March 31 of each year in waters seaward of the 20 fathom boundary
c. Red Snapper	October 1 through the Friday before Palm Sunday of the following year. The open season shall be for weekends only. A <i>weekend</i> is defined as Friday, Saturday and Sunday, with the exception of Memorial Day and Labor Day, when Monday would be classified as a weekend as well.
d. Greater Amberjack	June 1-July 31 of each year.
e. Gray Triggerfish	June 1-July 31 of each year.

G3. - J. ...

AUTHORITY NOTE: Promulgated in accordance with R.S.56:6(25)(a), R.S. 56:320.2(C), R.S. 56:326.1 and R.S. 56:326.3.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 16:539 (June 1990), amended LR 19:1442 (November 1993), LR 20:797 (July 1994), LR 21:1267 (November 1995), LR 22:860 (September 1996), LR 24:1138, 1139 (June 1998), LR 24:1972 (October 1998), LR 26:793 (April 2000), LR 26:1505 (July 2000), LR 26:2833 (December 2000), LR 31:3166 (December 2005), LR

33:1156 (June 2007), repromulgated LR 33:1397 (July 2007), amended LR 34:2209 (October 2008), LR 34:2682 (December 2008), LR 36:1791 (August 2010), LR 38:2383 (September 2012), LR 39:330 (February 2013), LR 40:95 (January 2014), repromulgated LR 40:1116 (June 2014), LR 40:2281 (November 2014).

Billy Broussard
Chairman

1411#029

RULE

**Department of Wildlife and Fisheries
Wildlife and Fisheries Commission**

Aerial Feral Hog Control Permits (LAC 76:V.135)

The Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission has amended rules and regulations governing the taking of feral hogs using a helicopter.

Title 76

WILDLIFE AND FISHERIES

Part V. Wild Quadrupeds and Wild Birds

Chapter 1. Wild Quadrupeds

§135. Aerial Feral Hog Control Permits

A. Purpose

1. The purpose of this Section is to establish regulations concerning the use of aircraft to aid in the control of feral hogs. The regulations provide and establish general rules regarding permit requirements, reporting requirements, landowner authorization, and safety training.

B. Definitions

Aerial Hog Control Permit—a permit issued by LDWF to locate, pursue, take, harass, or kill feral hogs by using an aircraft.

Applicant—An individual, partnership, or corporation who files an application for an aerial hog control permit.

Department or LDWF—the Louisiana Department of Wildlife and Fisheries.

Gunner—an individual who uses a firearm to shoot or attempt to shoot feral hogs pursuant to an aerial hog control permit.

Landowner's Authorization—signed consent from the landowner or the landowner's agent.

Observer—any person other than the pilot or gunner who is on board an aircraft while feral hog control measures are being taken pursuant to an aerial hog control permit.

Permittee—any individual who has obtained a valid aerial hog control permit.

Pilot—an individual who pilots an aircraft to locate, pursue, take, harass, or kill feral hogs pursuant to an aerial hog control permit.

Possess—in its different tenses, the act of having in possession or control, keeping, detaining, restraining, holding as owner, or as agent, bailee, or custodian for another.

Qualified Landowner or Landowner's Authorized Agent—a person who contracts to be a gunner or observer and who has not:

a. been convicted of a class II or greater wildlife violation in Louisiana, or the equivalent in another state within the past five years;

b. been convicted of a felony in Louisiana or another state; or

c. been convicted of a violation of 16 U.S.C. §§3371-3378 (the Lacey Act).

Take—in its different tenses, the attempt or act of hooking, pursuing, netting, capturing, snaring, trapping, shooting, hunting, wounding, or killing by any means or device.

C. Permits

1. An aerial feral hog control (AFHC) permit authorizes the permittee to utilize a helicopter to locate, pursue, take, harass, or kill feral hogs.

2. It shall be unlawful for any person to use a helicopter to locate, pursue, take, harass, or kill feral hogs without an AFHC permit.

3. Possession of an AFHC permit does not exempt the permit holder from other local, state, or federal rules, laws, or permit requirements.

4. Permits are not transferrable.

D. Permit Requirements

1. Application for an aerial feral hog control (AFHC) permit shall be made on an official application form provided by the department. AFHC permits will be valid for the calendar year in which issued and will expire on December 31 of each year.

2. A permit may be issued in the name of an individual, partnership, or corporation for named pilots to locate, pursue, take, harass, or kill feral hogs by the use of an aircraft.

3. Application for a permit shall include:

a. name, address, and phone number of applicant;

b. if applicant is an individual, the birth date, federal aviation administration (FAA) certificate number, and driver's license number of the applicant;

c. name, address, driver's license number, FAA license number, and date of birth for each individual pilot; and

d. make, model, color, and registration number of each aircraft to be used.

4. Anyone who has been convicted of a class II or greater wildlife violation in Louisiana, or the equivalent in another state within the past five years, has been convicted of a felony in Louisiana or another state, or been convicted of a violation of 16 U.S.C. §§3371-3378 (the Lacey Act) shall not be eligible for an AFHC permit.

5. The application must contain a signed waiver statement holding the Department of Wildlife and Fisheries and its employees harmless for liability as a result of issuing an AFHC permit. AFHC permits will only be issued to those applicants who are willing to accept full responsibility and liability for any damages or injuries that occur during or as a result of activities related to the AFHC permit.

E. Landowner's Authorization

1. Prior to participation in permitted activities, a permit holder must submit to LDWF a landowner's authorization form (LOA) for each contiguous and non-contiguous piece of property on which feral hog control activities will be performed.

2. A landowner's authorization form will be made on an official application form provided by the department and shall include:

a. the name, mailing address, driver's license number, and phone number of the landowner;

b. the name, mailing address, driver's license number, and phone number of the authorized landowner's agent, if applicable;

c. the name and permit number of the permittee;

d. a description and specific location of the property, including acreage; and

e. justification for why feral hogs should be controlled by use of a helicopter.

3. A landowner's authorization for feral hog control will be valid for the duration of the permit, unless:

a. that permit expires without renewal or is revoked;

b. the landowner's authorization specifies a time limit; or

c. the landowner requests in writing to LDWF and the permittee that authorization be withdrawn.

4. A single LOA form may be submitted by a group of landowners or by an association on behalf of such landowners. In the case of a group submission, the landowner's authorization form must have an attached list of participating landowner names, phone numbers, mailing addresses, physical addresses of the properties, and acreages for each participating landowner. The justification for control will be for the entirety of the properties listed on the form.

5. Property outlined in an LOA must exceed 1000 acres to be eligible for feral hog control activities under an AFHC permit.

6. If a LOA is approved by LDWF, a unique control number will be issued to identify the property and LOA in permit activities.

7. AFHC permit activities may not commence on a property until a LOA control number has been assigned by LDWF and received by the permittee.

F. Landowner's Authorization to Appoint Subagents

1. A permittee may contract with a qualified landowner or landowner's authorized agent to act as a gunner or observer in the location, pursuit, taking, harassing or killing of feral hogs from a helicopter, provided that the permittee possesses a valid, properly obtained LOA describing the activity.

2. A landowner with a valid LOA number can allow an AFHC permit holder to appoint subagents to act as gunners or observers during permit activities, provided that the landowner or the landowner's authorized agent has completed a landowner's authorization to appoint subagents (LAAS) form. Such forms shall be made on an official application form provided by the department and shall include:

a. the name, mailing address, and phone number of the landowner;

b. the name, mailing address, and phone number of the authorized landowner's agent, if applicable;

c. the name and permit number of the permittee;

d. LOA number;

e. physical address of the property referenced by the LOA number;

f. signatures and dates of agreement to the terms by the landowner or landowner's authorized agent and the permittee; and

g. time limit for the LAAS, if desired.

3. LAAS forms will be valid for the duration of the permit, unless:

a. that permit expires without renewal or is revoked;

b. if the LAAS specifies a time limit; or

c. if a landowner requests in writing to the permittee that authorization be withdrawn.

4. AFHC permit holders will be responsible for completion of LAAS forms, and will maintain completed LAAS forms in perpetuity.

5. LAAS forms will be made available for inspection upon demand by LDWF personnel.

F. General Rules

1. A holder of an AFHC permit is authorized to engage in feral hog control by the use of an aircraft only on land described in the landowner's authorization (LOA).

2. The AFHC permit shall be carried in the aircraft when performing feral hog control activities using an aircraft.

3. The permit is only valid for the taking of feral hogs from a helicopter. Taking any wildlife or animals other than feral hogs is strictly prohibited.

4. A pilot of an aircraft used for feral hog control must maintain a daily flight log and report as detailed below. The daily flight log must be up-to-date and made available for inspection upon demand of LDWF employees.

5. A pilot of an aircraft must possess and maintain a valid pilot's license as required by the FAA.

6. All pilots and permittees must comply with FAA regulations for the specific type of aircraft listed in the permit.

7. The permit holder may only use an aircraft to take feral hogs that are causing verifiable damage to land, structures, crops, water, or livestock, domestic animals, or human life.

8. An AFHC permit holder may only take feral hogs that are located on property outlined in the LOA. It is prohibited to fire shots over property not included in the LOA. It is prohibited to fire upon, haze, harass, or track any animals, including feral hogs, located on property not listed in the LOA.

9. Any activities performed under this permit must occur during daylight hours, from one half hour before official sunrise to one half hour after official sunset.

10. An AFHC permit is not to be used for sport hunting.

11. All observers and gunners must successfully complete a four hour safety training held by the permittee prior to participating in AFHC permit activities. Safety training must include aspects of:

a. aircraft safety procedures;

b. target and non-target animal identification;

c. firearm safety;

d. emergency procedures.

12. Attendance at a safety training course will allow a gunner or observer to participate in AFHC permit activities for 90 days after successfully completing the class.

13. Permittee must report violations of these regulations by pilots, observers, gunners, or ground personnel during AFHC activities to LDWF within 24 hours of occurrence of the violation.

14. Any unreported violation of AFHC regulations by a pilot, gunner, or observer may result in immediate and permanent loss of this permit and possible criminal prosecution.

G. Reporting and Renewal Requirements

1. A report of activities completed under this permit shall be required within 30 days of the end of each calendar quarter. Additionally, a report of activities completed under this permit shall be required when submitting a request for permit renewal or upon termination of the permit. This report shall be completed on official forms provided for this purpose by LDWF, and consist of daily flight log sheets, showing:

a. name, permit number, and signature of permit holder;

b. number of feral hogs managed under the permit;

c. landowner's authorization control number issued by LDWF;

d. dates of flight;

e. time of day an authorized flight begins and is completed;

f. type of management taken by use of aircraft;

g. name, pilot's license number, and signature of pilot;

h. name and address of gunner(s) and observer(s);

i. date that safety training was successfully completed by observer(s) and gunner(s).

2. Application for renewal of an AFHC permit must be submitted to LDWF no later than 45 days prior to expiration of the permit and AFHC permits will not be renewed until all renewal requirements are received.

3. If no flights were taken during the calendar quarter, a negative daily flight log and report must be submitted to LDWF.

H. Penalties for Violation. Unless another penalty is provided by law, violation of these regulations will be a class two violation as defined in title 56 of the *Louisiana Revised Statutes*. In addition, upon conviction for violation of these regulations, the AFHC permit associated with the permittee may be revoked.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:112(B).

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 40:2282 (November 2014).

Billy Broussard
Chairman

1411#031

RULE

**Department of Wildlife and Fisheries
Wildlife and Fisheries Commission**

**Crappie Regulations—Daily Take
on Bayou D’Arbonne Lake
(LAC 76:VII.197)**

The Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission has modified the daily take of crappie on Bayou D’Arbonne Lake per Act 334 of the 2013 Louisiana Legislature which repealed Subsection B of Section 197. The daily take will be 50 fish per person and the possession limit will be as established in statute.

Title 76

WILDLIFE AND FISHERIES

Part VII. Fish and Other Aquatic life

**Chapter 1. Freshwater Sports and Commercial
Fishing**

§197. Crappie Regulations—Daily Take

A. Poverty Point Reservoir (Richland Parish)

1. Daily Limit—25 fish per person:

a. on water possession—same as daily limit per person.

B. - B.1.a. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:325 and Act 389 of the 2014 Regular Legislative Session.

HISTORICAL NOTE: Promulgated in accordance with Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 30:2339 (October 2004), amended LR 38:2941 (November 2012), amended LR 39:1833 (July 2013), LR 40:2285 (November 2014).

Billy Broussard
Chairman

1411#030

Notices of Intent

NOTICE OF INTENT

Department of Children and Family Services Economic Stability Section

Access to Child Care for Homeless Families (LAC 67:III.Chapter 51)

In accordance with the provisions of the Administrative Procedure Act R.S. 49:953(A), the Department of Children and Family Services (DCFS) proposes to amend LAC 67:III, Subpart 12, Child Care Assistance Program, Chapter 51, Child Care Assistance Program, Subchapter A, Administration, Conditions of Eligibility, and Funding, Section 5102, Definitions and Section 5103, Conditions of Eligibility, and Subchapter B, Child Care Providers, Section 5109, Payment. Adoption is pursuant to the authority granted to the department by the child care and development fund (CCDF) in 45 CFR 98.11.

Section 5102 is being amended to include definitions relative to homeless families. Section 5103 is being amended to conform to the requirements of the Improving Access to Child Care for Homeless Louisiana Families Act, R.S. 46:1443 et seq. Section 5109 is being amended to authorize payments to child care providers on behalf of homeless families.

Title 67

SOCIAL SERVICES

Part III. Economic Stability

Subpart 12. Child Care Assistance Program

Chapter 51. Child Care Assistance Program

Subchapter A. Administration, Conditions of Eligibility, and Funding

§5102. Definitions

* * *

Homeless—lacking a fixed, regular, and adequate nighttime residence. The term “homeless” shall encompass children and youths experiencing the particular conditions and situations provided for in subtitle B of title VII of the McKinney-Vento Education for Homeless Children and Youth Act, 42 U.S.C. 11434a(2).

* * *

Seeking Employment—register for work with Louisiana Workforce Commission (LWC) by creating a helping individuals reach employment (HiRE) account and by maintaining an active work registration within their HiRE account.

* * *

Transitional Living Program—any residential program or facility providing housing to homeless people, including but not limited to: emergency shelters; runaway and homeless youth residential programs or facilities; programs for parenting youth; programs for individuals who are fleeing domestic violence, dating violence, sexual assault, or stalking; transitional housing programs; and prisoner reentry programs.

AUTHORITY NOTE: Promulgated in accordance with 45 CFR Parts 98 and 99, P.L. 104-193, 7 CFR Part 273, ACF Guidance: ACYF-IM-CC-05-03, P.L. 110-246.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 26:2826 (December 2000), amended LR 27:1932 (November 2001), LR 28:1490 (June 2002), LR 29:43 (January 2003), LR 29:189 (February 2003), LR 30:1484 (July 2004), LR 31:2262 (September 2005), LR 32:1464 (August 2006), LR 36:845 (April 2010), LR 36:1278 (June 2010), amended by the Department of Children and Family Services, Economic Stability and Self-Sufficiency Section, LR 36:2535 (November 2010), amended by the Department of Children and Family Services, Economic Stability Section, LR 41:

§5103. Conditions of Eligibility

A. - A.1. ...

B. Low-income families not receiving FITAP cash assistance, including former FITAP recipients who are given priority consideration, must meet the following eligibility criteria.

1. - 3. ...

4. Effective September 1, 2002, unless disabled as established by receipt of Social Security Administration disability benefits, supplemental security income, Veterans' Administration disability benefits for a disability of at least 70 percent, or unless disabled and unable to care for his/her child(ren) as verified by a doctor's statement or by worker determination, the TEMP must be:

a. effective June 1, 2011, employed for a minimum average of 30 hours per week and all countable employment hours must be paid at least at the federal minimum hourly wage; or

b. attending a job training or educational program for a minimum average of, effective June 1, 2011, 30 hours per week (attendance at a job training or educational program must be verified, including the expected date of completion); or

c. engaged in some combination of employment which is paid at least at the federal minimum hourly wage, or job training, or education as defined in Subparagraph B.4.b of this Section that averages, effective June 1, 2011, at least 30 hours per week;

d. Exception: a household in which all of the members described in Paragraph B.4 of this Section meet the disability criteria is not eligible for child care assistance unless one of those members meets, effective June 1, 2011 the required minimum average of 30 activity hours per week.

e. Exception: The employment and training activity requirements may be waived for a period of 180 days from the effective date of certification for homeless parents or persons acting as parents who demonstrate that they are seeking employment or participating in a transitional living program as defined in Section 5102. There is a six-month lifetime maximum for this exception.

5. - 7.c. ...

C. The family requesting child care services must provide the information and verification necessary for determining eligibility and benefit amount, and meet

appropriate eligibility requirements established by the state. However, the verification of a child's age and/or immunizations may be waived for a period of 90 days from the effective date of certification for a household in which all of the members meet the homeless definition described in Section 5102, as long as all other eligibility factors described in Section 5103 Subsection B Paragraphs 1-3 and 5-7 are met.

D. Cases eligible for payment may be assigned a certification period of up to twelve months. However, cases based on §5103.B.4.e that have waived the 30 hours per week employment and training requirement for a homeless family shall be assigned a certification period of six months.

E. Effective October 1, 2004, all children receiving services must be age-appropriately immunized according to the schedule of immunizations as promulgated by the Louisiana Office of Public Health, or be in the process of receiving all age-appropriate immunizations. No person is required to comply with this provision if that person or his/her parent or guardian submits a written statement from a physician stating that the immunization procedure is contraindicated for medical reasons, or if the person or his/her parent or guardian objects to the procedure on religious grounds. However, the verification of a child's age and/or immunizations may be waived for a period of 90 days from the effective date of certification for a household in which all of the members meet the homeless definition described in Section 5102, as long as all other eligibility factors described in Section 5103, Subsection B, Paragraphs 1-3 and 5-7 are met.

F. CCAP households must participate in the system designated by the agency for capturing time and attendance. This process may include finger imaging for the head of household and their household designees. The agency will determine the maximum number of household designees allowed on a CCAP case. Finger imaging is a requirement to participate in CCAP if the provider chosen by the client utilizes this as the mechanism for capturing time and attendance. Exceptions may be granted by the Executive Director of Economic Stability or his or her designee on a case by case basis.

G. ...

AUTHORITY NOTE: Promulgated in accordance with 45 CFR Parts 98 and 99, P.L.104-193, Act 58 2003 Reg. Session, ACF Guidance: ACYF-IM-CC-05-03.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 24:356 (February 1998), amended LR 25:2444 (December 1999), LR 26:2827 (December 2000), LR 27:1932 (November 2001), LR 28:1490 (June 2002), LR 29:43 (January 2003), LR 29:1106 (July 2003), LR 29:1833 (September 2003), LR 30:496 (March 2004), LR 30:1487 (July 2004), LR 31:101 (January 2005), LR 31:2263 (September 2005), LR 32:1464 (August 2006), LR 33:506 (March 2007), LR 34:692 (April 2008), LR 36:845 (April 2010), LR 36:1278 (June 2010), repromulgated LR 36:1767 (August 2010), amended by the Department of Children and Family Services, Division of Programs, LR 37:1374 (May 2011), amended by the Department of Children and Family Services, Division of Programs, Economic Stability Section, LR 38:3103 (December 2012), amended by the Department of Children and Family Services, Economic Stability Section, LR 41:

Subchapter B. Child Care Providers

§5109. Payments

A. ...

B. Determination of Payments

1. Payments to providers on behalf of non-FITAP recipients with the exception of homeless families who are exempt from employment and training requirements as defined in §5103.B.4.e will be a percentage of the lesser of:

- a. the provider's actual charge multiplied by authorized service days or authorized service hours; or
- b. the state maximum rate for authorized services effective January 1, 2007, and with the addition of rates for class M centers effective October 30, 2009, as indicated below.

Provider Type	Regular Care	Regular Care for Infants/Toddlers (under age 3)	Special Needs Care Incentive	Special Needs Care Incentive for Infants/Toddlers (under age 3)
Class A	\$17.50	\$18.50	\$21.65	\$22.65
Class E	\$15.00	\$16.00	\$18.50	\$19.50
Class R	\$15.00	\$16.00	\$18.50	\$19.50
Class U	\$14.50	\$15.50	\$17.90	\$18.90
Class M	\$17.50	\$18.50	\$21.65	\$22.65

2. Payments to providers on behalf of FITAP recipients and homeless families who are exempt from employment and training requirements as defined in §5103.B.4.e will be the lesser of:

- a. the provider's actual charge multiplied by authorized service days or authorized service hours; or
- b. the state maximum rate for authorized services effective January 1, 2007, as indicated below.

Provider Type	Regular Care	Regular Care for Infants/Toddlers (under age 3)	Special Needs Care Incentive	Special Needs Care Incentive for Infants/Toddlers (under age 3)
Class A	\$17.50	\$18.50	\$21.65	\$22.65
Class E	\$15.00	\$16.00	\$18.50	\$19.50
Class R	\$15.00	\$16.00	\$18.50	\$19.50
Class U	\$14.50	\$15.50	\$17.90	\$18.90
Class M	\$17.50	\$18.50	\$21.65	\$22.65

B.3. - F. ...

AUTHORITY NOTE: Promulgated in accordance with 45 CFR Parts 98 and 99, and P.L. 104-193, ACF Guidance: ACYF-IM-CC-05-03.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 24:357 (February 1998), amended LR 25:2445 (December 1999), LR 26:2828 (December 2000), LR 27:1933 (November 2001), LR 28:1491 (June 2002), LR 29:1834 (September 2003), LR 30:1485 (July 2004), repromulgated LR 30:2078 (September 2004), amended LR 31:2265 (September 2005), LR 32:1465 (August 2006), LR 32:2097 (November 2006), LR 33:507 (March 2007), LR 34:692 (April 2008), LR 36:555 (March 2010), LR 36:847 (April 2010), LR 36:1278 (June 2010), amended by the Department of Children and Family Services, Economic Stability Section, LR 37:3491 (December 2011), amended by the Department of Children and Family Services, Division of Programs, Economic Stability

Family Impact Statement

1. What effect will this Rule have on the stability of the family? This Rule will have no adverse effect on the family's stability.

2. What effect will this have on the authority and rights of persons regarding the education and supervision of their children? This Rule will have no effect on the authority and rights of persons regarding the education and supervision of their children.

3. What effect will this have on the functioning of the family? This Rule will have no negative effect on the functioning of the family.

4. What effect will this have on family earnings and family budget? This Rule will have no negative effect on family earnings or family budget.

5. What effect will this have on the behavior and personal responsibility of children? This Rule will have no effect on the behavior and personal responsibility of children.

6. Is the family or local government able to perform the function as contained in this proposed Rule? No, these functions are department functions.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Impact Statement

The proposed Rule will have no adverse impact on small businesses as defined in the Regulatory Flexibility Act.

Provider Impact Statement

The proposed rulemaking is not anticipated to have any impact on providers of services funded by the state as described in HCR 170 of the 2014 Regular Legislative Session.

Public Comments

All interested persons may submit written comments through, December 30, 2014, to Lisa Andry, Acting Deputy Assistant Secretary of Programs, Department of Children and Family Services, P.O. Box 94065, Baton Rouge, LA, 70804.

Public Hearing

A public hearing on the proposed Rule will be held on December 30, 2014 at the Department of Children and Family Services, Iberville Building, 627 North Fourth Street, Seminar Room 1-127, Baton Rouge, LA beginning at 9 a.m. All interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at said hearing. Individuals with disabilities who require special services should contact the Bureau of Appeals at least seven working days in advance of the hearing. For assistance, call (225) 342-4120 (voice and TDD).

Suzu Sonnier
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Access to Child Care for Homeless Families

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

The Department of Children and Family Services (DCFS) proposes to amend LAC 67:III, Subpart 12 Child Care Assistance Program (CCAP), Chapter 51 Child Care Assistance Program, Subchapter A Administration, Conditions of Eligibility, and Funding, Section 5102—Definitions and Section 5103—Conditions of Eligibility, as well as Subchapter B Child Care Providers, Section 5109—Payments. The proposed rule includes definitions relative to homelessness, temporarily waives certain eligibility requirements for families experiencing homelessness so they may receive child care assistance as required by the Improving Access to Child Care for Homeless Louisiana Families Act (Act 787 of 2014), and authorizes payments to child care providers on behalf of homeless families.

It is anticipated that the implementation of this amendment will result in an estimated programmatic cost in Child Care and Development Block Grant (CCDF) federal funds of \$586,880 for FY 15, \$1,795,853 for FY 16, and \$1,831,770 for FY 17. There will be no increase in the expenditure of state general funds for programmatic costs. Based on a report from the Institute for Children, Poverty, & Homeless, The American Almanac of Family Homelessness 2013, there are an estimated 469 homeless families in Louisiana. The average child care assistance payment is \$233.63 per month (excluding co-payments) based on March 2014 program statistics. The Department estimates an average of 1.34 children per family. Thus, an estimated 628 children of homeless families would receive child care assistance under the proposed rule (469 homeless families x 1.34 average child per family) at a monthly cost of \$146,720 (628 x \$233.63). In FY 15, total costs are estimated at \$586,880 (\$146,720 x 4 months). Historical information indicates that provider costs for child care increase 2% annually. Therefore, for FY 16 child care assistance for homeless families would increase to \$1,795,853 in FY 16 (2% increase on \$1,760,640 = \$146,720 x 12 months) and \$1,831,770 in FY 17. The only other cost associated with this rule is the cost of publishing rulemaking which is estimated to be approximately \$1,917 (Federal) in State Fiscal Year 2014-2015.

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

Implementation of this proposed rule will have no effect on revenue collections of State or local governmental units.

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

The proposed rule change will reduce barriers for families experiencing homelessness to access child care by temporarily waiving certain eligibility requirements.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule will not have an impact on competition and employment for low-income families.

Lisa Andry
Deputy Assistant Secretary
1411#056

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Children and Family Services Economic Stability Section

Supplemental Nutritional Assistance Program (SNAP) (LAC 67:III.1942)

In accordance with the provisions of the Administrative Procedure Act R.S. 49:953 (A), the Department of Children and Family Services (DCFS) proposes to adopt LAC 67:III, Subpart 3 Supplemental Nutritional Assistance Program (SNAP), Chapter 19, Certification of Eligible Households, Subchapter G, Work Requirements, Section 1942, Workforce Training and Education Pilot Initiative.

Section 1942 adopts provisions necessary to establish a pilot initiative in Tangipahoa parish for the purpose of enhancing workforce readiness and improving employment opportunities for SNAP recipients who are unemployed or underemployed able-bodied adults without dependents (ABAWDs).

Pursuant to the authority granted to the department by the Food and Nutrition Services (FNS), the department considers these amendments necessary to comply with Act 622 of the 2014 Regular Session of the Louisiana Legislature.

Title 67 SOCIAL SERVICES

Part III. Economic Stability

Subpart 3. Supplemental Nutritional Assistance Program (SNAP)

Chapter 19. Certification of Eligible Households Subchapter G. Work Requirements

§1942. Workforce Training and Education Pilot Initiative

A. The department shall administer a workforce training and education pilot initiative within SNAP for the purpose of enhancing workforce readiness and improving employment opportunities for SNAP recipients who are unemployed or underemployed able-bodied adults without dependents (ABAWDs). Individuals to be served by the pilot initiative shall include, exclusively, all ABAWDs residing in Tangipahoa parish who are not exempt by provisions of this Section.

B. Individuals are ineligible to continue to receive SNAP benefits if, during any 36-month period after February 2015, they received SNAP benefits for at least three months (consecutive or otherwise) while that individual did not either:

1. work an average of 20 hours per week;
2. participate in and comply with a Job Training Partnership Act Program, Trade Adjustment Act Program, or Employment and Training Program (other than a job search or job search training program) for 20 hours or more per week; or
3. participate in and comply with a workfare program.

C. An individual is exempt from this requirement if the individual is:

1. under age 18, or 50 years of age or older;
2. medically certified as physically or mentally unfit for employment;

3. a parent of a household member under age 18, even if the household member who is under age 18 does not receive SNAP benefits;

4. residing in a household where a household member is under age 18, even if the household member who is under age 18 does not receive SNAP benefits;

5. pregnant;

6. meeting one or more of the following criteria relative to educational advancement:

a. in the previous six months, the individual enrolled in an accredited postsecondary educational institution that grants associate or baccalaureate degrees;

b. in the previous six months, the individual enrolled in a program designed to lead to a high school diploma;

c. in the previous six months, the individual enrolled in a general education development test preparation course;

d. in the previous six months, the individual earned a high school diploma or a general education development certificate;

7. satisfactorily participating or satisfactorily participated in LaJET (a SNAP employment and training program) in the previous six months; or

8. otherwise exempt from work registration requirements.

D. Regaining Eligibility for Assistance

1. Individuals denied eligibility under the pilot initiative rule can regain eligibility if during a 30-day period the individual:

a. works 80 hours or more;

b. participates in and complies with a Job Training and Partnership Act Program, Trade Adjustment Assistance Act Program, or Employment and Training Program (other than a job search or job search training program) for 80 hours or more;

c. participates in and complies with a workfare program (under Section 20 of the Food and Nutrition Act of 2008 or a comparable state or local program) for 80 hours or more.

2. An individual who regained eligibility and who is no longer fulfilling the work requirement is eligible for three consecutive countable months one time in any 36-month period, starting on the date the individual first notifies the agency that he or she is no longer fulfilling the work requirement, unless the individual has:

a. met one or more of the following criteria relative to educational advancement:

i. in the previous six months, the individual enrolled in an accredited postsecondary educational institution that grants associate or baccalaureate degrees;

ii. in the previous six months, the individual enrolled in a program designed to lead to a high school diploma;

iii. in the previous six months, the individual enrolled in a general education development test preparation course;

iv. in the previous six months, the individual earned a high school diploma or a general education development certificate;

b. satisfactorily participated in LaJET (a SNAP employment and training program) in the previous six months; or

c. otherwise been exempted from work registration requirements.

AUTHORITY NOTE: Promulgated in accordance with P.L. 104-193, P.L. 110-246, and Act 622 of the 2014 Regular Session of the Louisiana Legislature.

HISTORICAL NOTE: Promulgated by the Department of Children and Family Services, Economic Stability Section, LR 40:

Family Impact Statement

1. What effect will this Rule have on the stability of the family? This Rule will have no effect on the family's stability.

2. What effect will this have on the authority and rights of persons regarding the education and supervision of their children? This Rule will have no effect on the authority and rights of persons regarding the education and supervision of their children.

3. What effect will this have on the functioning of the family? This Rule will have no effect on the functioning of the family.

4. What effect will this have on family earnings and family budget? This Rule will have no effect on family earnings or family budget.

5. What effect will this have on the behavior and personal responsibility of children? This Rule will have no effect on the behavior and personal responsibility of children.

6. Is the family or local government able to perform the function as contained in this proposed Rule? No, these functions are department functions.

Poverty Impact Statement

The proposed rulemaking may have an impact on poverty as described in R.S. 49:973 if individuals become employed. The poverty rate may decrease.

Small Business Impact Statement

The proposed Rule will have no adverse impact on small businesses as defined in the Regulatory Flexibility Act.

Provider Impact Statement

The proposed rulemaking is not anticipated to have any impact on providers of services funded by the state as described in HCR 170 of the 2014 Regular Legislative Session.

Public Comments

All interested persons may submit written comments through, December 29, 2014, to Lisa Andry, Acting Deputy Assistant Secretary of Programs, Department of Children and Family Services, P.O. Box 94065, Baton Rouge, LA, 70804.

Public Hearing

A public hearing on the proposed Rule will be held on December 29, 2014 at the Department of Children and Family Services, Iberville Building, 627 North Fourth Street, Seminar Room 1-127, Baton Rouge, LA beginning at 9 a.m. All interested persons will be afforded an opportunity to submit data, views, or arguments, orally or in writing, at said hearing. Individuals with disabilities who require special

services should contact the Bureau of Appeals at least seven working days in advance of the hearing. For assistance, call (225) 342-4120 (Voice and TDD).

Suzy Sonnier
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Supplemental Nutritional Assistance Program (SNAP)

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

This rule proposes to adopt Louisiana Administrative Code (LAC), Title 67, Part III, Subpart 3 Supplemental Nutritional Assistance Program (SNAP), Chapter 19 Certification of Eligible Households, Subchapter G Work Requirements, Section 1942—Workforce Training and Education Pilot Initiative. The proposed rule adopts provisions enabling the secretary of the Department of Children and Family Services (DCFS) to establish a pilot initiative in Tangipahoa parish for the purpose of enhancing workforce readiness and improving employment opportunities for SNAP recipients in that parish who are unemployed or underemployed able-bodied adults without dependents (ABAWDs). The proposed rule requires SNAP recipients identified as ABAWDs (unless exempt) to either work an average of 20 hours per week or participate/comply with certain programs that enhance workforce readiness and improve employment for 20 hours per week.

There is no anticipated direct material effect on state expenditures in DCFS as a result of this proposed rule. The proposed rule requires SNAP recipients identified as ABAWDs to meet certain employment and training requirements in order to be exempt from the 6-month time limit. This rule does not require additional staff or resources to meet the administrative requirements of the pilot initiative in Tangipahoa. While DCFS receives reimbursement from the federal government for administering the SNAP program, the federal government pays 100% of SNAP benefits.

The only cost associated with this proposed rule is the cost of publishing rulemaking. It is anticipated that \$1,278 (\$639 State General Fund and \$639 Federal Funds) will be expended in SFY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

Implementation of this proposed rule will have no direct effect on revenue collections of State or local governmental units.

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

This proposed rule may enhance workforce readiness and improve employment opportunities for SNAP recipients identified as unemployed or underemployed ABAWDs.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule will not have an impact on competition and employment for low-income families.

Lisa Andry
Deputy Assistant Secretary
1411#055

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Economic Development Office of Business Development

Quality Jobs Program (LAC 13:I.1107)

The Department of Economic Development, Office of Business Development, as authorized by and pursuant to the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., proposes to amend and reenact Section 1107 of the Quality Jobs Program in LAC 13:I.Chapter 11. The proposed regulation changes the time period an applicant has to file for their renewal contract from within 60 days of the expiration of the initial contract to within 1 year of the expiration of the initial contract.

Title 13

ECONOMIC DEVELOPMENT

Part I. Financial Incentive Programs

Chapter 11. Quality Jobs Program

§1107. Application Fees, Timely Filing

A. The applicant shall submit an advance notification on the prescribed form before locating the establishment or the creation of any new direct jobs in the state. All financial incentive programs for a given project shall be filed at the same time, on the same advance notification form. An advance notification fee of \$100, for each program applied for, shall be submitted with the advance notification form. An advance notification filing shall be considered by the department to be a public record under *Louisiana Revised Statutes*, title 44, chapter 1, Louisiana public records law, and subject to disclosure to the public.

B. An application for the Quality Jobs Program must be filed with the Office of Business Development, Business Incentives Services, P.O. Box 94185, Baton Rouge, LA 70804-9185, on the prescribed forms within 18 months after the first new direct job is hired; however, no more than 24 months after the department has received the advance notification and fee. Failure to file an application within the prescribed timeframe will result in the expiration of the advance notification. An extension to the advance notification of no more than 6 months may be granted if the applicant requests, in writing, the extension prior to the expiration of the advance notification.

C. An application fee shall be submitted with the application based on the following:

1. 0.2 percent (.002) times the estimated total incentive rebates (see application fee worksheet to calculate);

2. the minimum application fee is \$200 and the maximum application fee is \$5,000 for a single project;

3. an additional application fee will be due if a project's employment or investment scope is or has increased, unless the maximum has been paid.

D. For initial contracts expiring on or after June 30, 2013, an application to renew a contract shall be filed within 18 months of the initial contract expiring. A fee of \$50 must be filed with the renewal contract.

E. The Office of Business Development reserves the right to return the advance notification, application, or annual certification to the applicant if the estimated exemption or the fee submitted is incorrect. The document

may be resubmitted with the correct fee. The document will not be considered officially received and accepted until the appropriate fee is submitted. Processing fees for advance notifications, applications, or annual certification that have been accepted for eligible projects shall not be refundable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 51:2451-2462 et seq.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Office of Commerce and Industry, Financial Incentives Division, LR 22:963 (October 1996), amended by the Department of Economic Development, Office of Business Development, Business Resources Division, LR 29:2308 (November 2003), amended by the Office of Business Development, LR 37:2591 (September 2011), LR 41:

Family Impact Statement

The proposed Rule changes should have no impact on family formation, stability or autonomy, as described in R.S. 49:972.

Poverty Impact Statement

The proposed rulemaking should have no impact on poverty as described in R.S. 49:973.

Small Business Statement

It is anticipated that the proposed Rule will not have a significant adverse impact on small businesses as defined in the Regulatory Flexibility Act. The agency, consistent with health, safety, environmental and economic factors has considered and, where possible, utilized regulatory methods in drafting the proposed Rule to accomplish the objectives of applicable statutes while minimizing any anticipated adverse impact on small businesses.

Provider Impact Statement

The proposed rulemaking should have no provider impact as described in HCR 170 of 2014.

Public Comments

Interested persons may submit written comments to Danielle Clapinski, Louisiana Department of Economic Development, P.O. Box 94185, Baton Rouge, LA 70804-9185; or physically delivered to Capitol Annex Building, Office of the Secretary, Second Floor, 1051 North Third Street, Baton Rouge, LA, 70802. Comments may also be sent by fax to (225) 342-9448, or by email to danielle.clapinski@la.gov. All comments must be received no later than 5 p.m. on December 29, 2014.

Public Hearing

A public hearing to receive comments on the Notice of Intent will be held on December 30, 2014 at 10 a.m. at the Department of Economic Development, 1051 North Third Street, Baton Rouge, LA 70802.

Steven Grissom
Deputy Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Quality Jobs Program

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

There will be no incremental costs or savings to state or local governmental units due to the implementation of these rules. The Department of Economic Development intends to administer the program with existing personnel.

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

This rule change allows participating businesses a longer period of time in which to request renewal of their Quality Jobs contracts. To date, LED is aware of only twelve companies who have initial Quality Jobs contracts that have expired on or after June 30, 2013 (new deadline in rule change) and have not renewed within the 60-day requirement under current rule. LED anticipates that only seven of these twelve companies will actually renew their contracts per the rule change. LED estimates that credits/rebates from these seven companies will decrease state governmental revenues by approximately \$3,375,000 million per year. Most of this decrease is due to one company that had average annual payroll rebates of \$1,625,000 per year. However, due to ramp up, this company is predicted to have approximately \$3 million per year in annual rebates over the second five year period of the contract. Some companies in the future whose contracts would have lapsed under current rules will be able to renew contracts at later dates due to the rule change, further decreasing state governmental revenues. However, there is no way to estimate revenue impacts from these delayed contract renewals in the future.

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

The income of businesses participating in the program will increase by the amount of benefits received.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Companies who renew their contract will continue to receive benefits under this program and will gain competitively over companies that do not receive the program's benefits. While employment may increase in participating businesses, employment may be lessened in other competing businesses that do not participate in the program.

Steven Grissom
Deputy Secretary
1411#050

Greg Albrecht
Chief Economist
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 131—Alternative Education Schools/Programs Standards (LAC 28:CXLIX.Chapter 21)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 131—Alternative Education Schools/Programs Standard* §2101. Program Requirements, §2103. Reporting Requirements, §2105. Requirements for Educational Management Organizations, and §2107. Definitions. These revisions are required by Act 530 of the 2014 Regular Legislative Session. The proposed revisions provide regulations for district agreements with educational management organizations to provide dropout recovery programs.

**Title 28
EDUCATION**

Part CXLIX. Bulletin 131—Alternative Education Schools/Programs Standards

Chapter 21. Dropout Prevention and Recovery Programs

§2101. Program Requirements

A. Each school district and charter school that provides instruction to high school students may offer a dropout recovery program for eligible students.

B. BESE's prescribed standards and testing requirements shall apply to dropout recovery programs.

C. The dropout recovery program shall do the following:

1. make available appropriate and sufficient supports for students, including tutoring, career counseling, and college counseling;
2. comply with federal and state laws and BESE policies governing students with disabilities; and
3. meet state requirements for high school graduation.

D. Each eligible student enrolled in a dropout recovery program shall have an individual graduation plan developed by the student and the student's academic coach and meeting all BESE requirements for individual graduation plans. The plan shall also include the following elements:

1. the start date and anticipated end date of the plan;
2. courses to be completed by the student during the academic year;
3. whether courses will be taken sequentially or concurrently;
4. state exams to be taken, as necessary;
5. expectations for satisfactory monthly progress; and
6. expectations for contact with the student's assigned academic coach.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:100.5, R.S. 17:221.4, and R.S. 17:221.6.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§2103. Reporting Requirements

A. A student enrolled in a dropout recovery program shall be included in the student enrollment count for the school or school system offering the program. Each school and school system shall report the following information to the LDE on a monthly basis:

1. newly enrolled students in the dropout recovery program who have an individual graduation plan on file on or before the first school day of the month;
2. students who met the expectations for satisfactory monthly progress for the month;
3. students who did not meet the expectations for satisfactory monthly progress for the month but did meet the expectations one of the two previous months; and
4. students who met expectations for program reentry in the revised individual graduation plan in the previous month.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:100.5, R.S. 17:221.4, and R.S. 17:221.6.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§2105. Requirements for Educational Management Organizations

A. School districts and charter schools may contract with an educational management organization to provide a dropout recovery program. If contracting with an educational management organization, the school district or charter school shall ensure that all of the following requirements are met:

1. the educational management organization is accredited by a regional accrediting body;
2. teachers provided by the educational management organization hold a current teaching license from any state, and teachers of core subjects are highly qualified in the subjects to which they are assigned; and
3. the educational management organization has provided one or more dropout recovery programs for at least two years prior to providing a program pursuant to this Section.

B. Entities that are contracted to provide dropout recovery programs may conduct outreach to encourage students who are not enrolled in a school district or charter school in this state to return to school.

1. These entities shall not conduct advertising or marketing campaigns directed at students who are currently enrolled in a school district or charter school or undertake any other activity that encourages students who are enrolled to stop attending school in order to qualify for a dropout recovery program.

C. All contracts entered into by an LEA for the provision of student dropout recovery programs shall include requirements for the protection of all personally identifiable student information that shall comply with all applicable state and federal laws and BESE regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:100.5, R.S. 17:221.4, and R.S. 17:221.6.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§2107. Definitions

Academic Coach—an adult who assists students in selecting courses needed to meet graduation requirements, monitors students pace and progress through the program, and conducts regular pace and progress interventions.

Eligible Student—a student who is not enrolled in a school district or charter school and who has been withdrawn from a school district or charter school for at least 30 days, unless a school administrator determines that the student is unable to participate in other district programs.

Satisfactory Monthly Progress—an amount of progress that is measurable on a monthly basis and that, if continued for a full 12 months, would result in the same amount of academic credit being awarded to the student as would be awarded to a student in a traditional education program who completes a full school year. Satisfactory monthly progress may include a lesser required amount of progress for the first two months that a student participates in the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:100.5, R.S. 17:221.4, and R.S. 17:221.6.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Family Impact Statement

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

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

Poverty Impact Statement

In accordance with Section 973 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this Section, the word *poverty* means living at or below one hundred percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.
2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.
3. Will the proposed Rule affect employment and workforce development? No.
4. Will the proposed Rule affect taxes and tax credits? No.
5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., December 9, 2014, to Kimberly Tripeaux, Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Kimberly Tripeaux
Executive Director

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

**RULE TITLE: Bulletin 131—Alternative Education
Schools/Programs Standards**

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

There is an indeterminable impact to the Minimum Foundation Program formula funding as a result of this policy as the number of students enrolled in schools each year affect MFP distributions. Most school districts currently offer dropout recovery programs. Some districts operate their own program while others contract with educational management organizations. Thus, while the overall impact may not be significant, the expansion of these programs could result in the retention of students who would otherwise drop out of school or bring students who have already dropped out back into the classroom, resulting in continued or reinstated MFP funding for that student. Alternatively if there are no significant changes in the districts' programs and the number of dropout students increases, there could be potential cost savings to the MFP.

There may be indeterminable costs or savings to local school districts as a result of these policies. Local school districts expanding existing programs, or implementing new programs could have increased staffing and other resource needs to provide counseling, tutoring and the development of individual graduation plans for affected students. Alternatively, if a district chooses to contract with an educational management organization, those contract costs presumably would represent an increase in expenditures. However, those costs may be less than the amount of MFP funding recouped by the district.

The proposed revisions provide regulations for districts which choose to offer dropout recovery programs including authorizing agreements with educational management organizations to provide such programs. The policy revisions are required by Act 530 of the 2014 Regular Legislative Session.

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

This policy could potentially assist districts in retaining Minimum Foundation Program (MFP) formula funding if students do not drop out of school, or by recouping lost MFP funding if students who have previously dropped out are re-enrolled.

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

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

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)**

This policy may have an indeterminable effect on competition and employment, if the district contracts with an educational management organization to provide instruction for at risk students or recovered dropouts.

Beth Scioneaux
Deputy Superintendent
1411#057

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 135—Health and Safety
(LAC 28:CLVII.309)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 135—Health and Safety* §309. Communicable Disease Control. These revisions address the dissemination of public health information by the Louisiana Department of Education to school governing authorities as well as the local superintendent or charter school's leader authority to exclude students or employees having communicable diseases.

Title 28

EDUCATION

Part CLVII. Bulletin 135—Health and Safety

Chapter 3. Health

§309. Communicable Disease Control

A. The LDE will work cooperatively with the Louisiana Department of Health and Hospitals for the prevention, control and containment of communicable diseases in schools and shall assist in the dissemination of information relative to communicable diseases to all school governing authorities, including but not limited to information relative to imminent threats to public health or safety which may result in loss of life or disease.

B. Students are expected to be in compliance with the required immunization schedule.

1. The principal is required under R.S. 17:170 to exclude children from school attendance who are out of compliance with the immunizations required by this statute.

2. School personnel will cooperate with public health personnel in completing and coordinating all immunization data, waivers and exclusions, including the necessary Vaccine Preventable Disease Section's school ionization report forms (EPI-11, 11/84) to provide for preventable communicable disease control.

C. The local superintendent or chief charter school officer may exclude a student or staff member for not more than five days, or the amount of time required by state or local public health officials, from school or employment when reliable evidence or information from a public health officer or physician confirms him/her of having a communicable disease or infestation that is known to be spread by any form of casual contact and is considered a health threat to the school population. Such a student or staff member may be excluded unless state or local public health officers determine the condition is no longer considered contagious.

D. - I.6.a. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(10)(15); R.S. 17:170; R.S. 17:437; R.S. 17:1941; 20 USCS 1232.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 39:1035 (April 2013), amended LR 41:

Family Impact Statement

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

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

Poverty Impact Statement

In accordance with Section 973 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this Section, the word *poverty* means living at or below one hundred percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.
2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.
3. Will the proposed Rule affect employment and workforce development? No.
4. Will the proposed Rule affect taxes and tax credits? No.
5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., December 9, 2014, to Kimberly Tripeaux, Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Kimberly Tripeaux
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: **Bulletin 135—Health and Safety**

- I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENT UNITS (Summary)
There may be an indeterminable cost to local school districts if substitute teachers must be engaged for extended periods as a result of these policies.
These revisions address the dissemination of public health information by the Louisiana Department of Education to school governing authorities as well as the local superintendent or charter school's leader authority to exclude students or employees from school or employment if they have been confirmed to have a communicable disease considered a health threat to the school population.
- II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)
This policy will have no effect on revenue collections of state or local governmental units.
- III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)
There will be no estimated cost and/or economic benefit to directly affected persons or non-governmental groups.
- IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)
This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1411#058

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 138—Jump Start Program
(LAC 28:CLXIII.501 and 503)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 138—Jump Start*

Program: §501. General Provisions; and §503. Training Provider Selection Process. These revisions are required by Act 737 of the 2014 Regular Legislative Session. The proposed revisions establish rules and regulations for the process of approving training providers at which a TOPS-Tech Early Start award may be used.

Title 28

EDUCATION

Part CLXIII. Bulletin 138—Jump Start Program

Chapter 5. TOPS Tech Early Start Training Providers

§501. General Provisions

A. Pursuant to R.S. 17:3048.5, by January 31 annually, BESE shall determine approval of training program providers eligible to receive funds through TOPS Tech Early Start for the academic year that begins in the fall of that year.

B. For the 2014-2015 school year, the number of training program providers approved by BESE shall be limited to five.

C. BESE approval for training program providers shall be for a term of three years, starting from the school year the training provider is first authorized to provide training as part of the TOPS Tech Early Start program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7, R.S. 17:183.2, R.S. 17:2930 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 40:1326 (July 2014), amended LR 41:

§503. Training Provider Selection Process

A. The LDE shall annually release a request for applications to solicit applications from training program providers interested in delivering technical or applied career and technical education courses.

1. Applications shall include, but not be limited to, provider background, capabilities, and financial structure.

2. The LDE will review each draft application submitted by the draft application deadline and provide comments in time for the submitting organization to revise and resubmit their application prior to the final deadline.

B. Applicants selected by the LDE shall participate in interviews with the LDE selection committee to evaluate the quality of the instruction and ability to fulfil training obligations.

C. By January 31 annually, the LDE shall recommend training program providers for approval to BESE to begin offering courses during the academic year that begins in the fall of that year.

D. All applicants submitted to BESE for approval shall be approved by Workforce Investment Council and meet the requirements in R.S. 17:3048.5.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7, R.S. 17:183.2, R.S. 17:2930 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 40:1326 (July 2014), amended LR 41:

Family Impact Statement

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

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

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

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

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

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

6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Poverty Impact Statement

In accordance with Section 973 of Title 49 of the *Louisiana Revised Statutes*, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this Section, the word “poverty” means living at or below 100 percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.

2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.

3. Will the proposed Rule affect employment and workforce development? No.

4. Will the proposed Rule affect taxes and tax credits? No.

5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., December 9, 2014, to Kimberly

Kimberly Tripeaux
Executive Director

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Bulletin 138—Jump Start Program**

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

The proposed policies, as prescribed by Act 737 of the 2014 Regular Legislative Session, will likely increase state costs for TOPS-Tech Early Start (TTES) awards by indeterminable amounts for FY15 and thereafter. TTES providers may receive up to \$150 per three credit hour course not to exceed two such courses per semester for 11th and 12th grade students. However, there is no way to estimate how many providers will be approved and how many additional students might take TTES courses from those approved providers. While the number of approved providers is capped at five for the first year (FY15), there is no limit to the number of participating students. Further, there is no limitation on the number of approved providers for FY16 and thereafter.

The Jump Start Program aims to provide career courses and workplace experience to high school students and focuses on dual enrollment programs like TTES for completion of industry-based certificates. Using DOE public school student counts from 2/4/14 (81,935 in 11th and 12th grade) and information from Louisiana's ACT Profile Report from 2012, 90.1% of students in the state scored 15 or greater on the ACT and would be eligible to participate in TTES (73,823 potential students). If all 29,333 students scoring between 15 and 19 choose to participate in the program, the potential annual increase could be as much as \$17.6M. However if only 10% of those eligible students participated annually, TTES costs would only increase by \$1.8M.

These revisions prescribe the rules and regulations for the application and approval process for selecting training providers at which TOPS-Tech Early Start awards may be used. Act 737 of the 2014 Regular Legislative Session requires that BESE promulgate rules for this process.

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

This policy will have no effect on revenue collections of state or local governmental units.

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

There is a potential economic benefit (in the form of tuition revenues) to new and existing private providers who choose to offer instructional courses to eligible students.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)**

This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1411#059

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 741—Louisiana Handbook for School
Administrators—Emergency Planning and Attendance
(LAC 28: CXV.339 and 1103)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 741—Louisiana Handbook for School Administrators* §339. Emergency Planning and Procedures and §1103. Compulsory Attendance. These revisions broadly define emergency situations, inclusive of public health emergencies, and address the continued education of students who have been quarantined following prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, as ordered by state or local health officials.

Title 28

EDUCATION

**Part CXV. Bulletin 741—Louisiana Handbook for
School Administrators**

**Chapter 3. Operation and Administration
§339. Emergency Planning and Procedures**

A. - G. ...

H. The local superintendent or chief charter school officer may dismiss any or all schools due to emergency situations, including any actual or imminent threat to public health or safety which may result in loss of life, disease, or injury; an actual or imminent threat of natural disaster, force majeure, or catastrophe which may result in loss of life, injury or damage to property; and, when an emergency situation has been declared by the governor, the state health officer, or the governing authority of the school.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:416.16 and R.S. 17:154.1.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1262 (June 2005), amended LR 39:3258 (December 2013), LR 41:

**Chapter 11. Student Services
§1103. Compulsory Attendance**

A. - E.4. ...

F. A student who has been quarantined by order of state or local health officers following prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, and is temporarily unable to attend school, shall be provided any missed assignments, homework, or other instructional services in core academic subjects in the home, hospital environment, or temporary shelter to which he has been assigned. The principal, with assistance from the local superintendent or chief charter school officer and the LDE, shall collaborate with state and local health officers and emergency response personnel to ensure the timely delivery or transmission of such materials to the student.

G. Elementary students shall be in attendance a minimum of 60,120 minutes (equivalent to 167 six-hour

days) a school year. In order to be eligible to receive grades, high school students shall be in attendance a minimum of 30,060 minutes (equivalent to 83.5 six-hour school days), per semester or 60,120 minutes (equivalent to 167 six-hour school days) a school year for schools not operating on a semester basis.

1. Students in danger of failing due to excessive absences may be allowed to make up missed time in class sessions held outside the regular class time. The make-up sessions must be completed before the end of the current semester and all other policies must be met.

H. Each LEA shall develop and implement a system whereby the principal of a school, or his designee, shall notify the parent or legal guardian in writing upon or before a student's third unexcused absence or unexcused occurrence of being tardy, and shall hold a conference with such student's parent or legal guardian. This notification shall include information relative to the parent or legal guardian's legal responsibility to enforce the student's attendance at school and the civil penalties that may be incurred if the student is determined to be habitually absent or habitually tardy. The student's parent or legal guardian shall sign a receipt for such notification.

I. Tardy shall include but not be limited to leaving or checking out of school unexcused prior to the regularly scheduled dismissal time at the end of the school day but shall not include reporting late to class when transferring from one class to another during the school day.

J. Exceptions to the attendance regulation shall be the enumerated extenuating circumstances below that are verified by the supervisor of child welfare and attendance or the school principal/designee where indicated. These exempted absences do not apply in determining whether a student meets the minimum minutes of instruction required to receive credit:

1. extended personal physical or emotional illness as verified by a physician or nurse practitioner licensed in the state;

2. extended hospital stay in which a student is absent as verified by a physician or dentist;

3. extended recuperation from an accident in which a student is absent as verified by a physician, dentist, or nurse practitioner licensed in the state;

4. extended contagious disease within a family in which a student is absent as verified by a physician or dentist licensed in the state; or

5. quarantine due to prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, as ordered by state or local health officials; or

6. observance of special and recognized holidays of the student's own faith;

7. visitation with a parent who is a member of the United States Armed Forces or the National Guard of a state and such parent has been called to duty for or is on leave from overseas deployment to a combat zone or combat support posting. Excused absences in this situation shall not exceed five school days per school year;

8. absences verified and approved by the school principal or designee as stated below:

a. prior school system-approved travel for education;

b. death in the immediate family (not to exceed one week); or

c. natural catastrophe and/or disaster.

K. For any other extenuating circumstances, the student's parents or legal guardian must make a formal appeal in accordance with the due process procedures established by the LEA.

L. Students who are verified as meeting extenuating circumstances, and therefore eligible to receive grades, shall not receive those grades if they are unable to complete makeup work or pass the course.

M. Students participating in school-approved field trips or other instructional activities that necessitate their being away from school shall be considered to be present and shall be given the opportunity to make up work.

N. If a student is absent from school for 2 or more days within a 30-day period under a contract or employment arrangement to render artistic or creative services for compensation as set forth in the Child Performer Trust Act (R.S. 51:2131 et seq.) the employer shall employ a certified teacher, beginning on the second day of employment, to provide a minimum of three education instruction hours per day to the student pursuant to the lesson plans for the particular student as provided by the principal and teachers at the student's school. There must be a teacher to student ratio of one teacher for every 10 students.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:112, R.S. 17:221.3-4, R.S. 17:226.1, and R.S. 17:233.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1273 (June 2005), amended LR 32:546 (April 2006), LR 32:1030 (June 2006), LR 33:2351 (November 2007), LR 35:641 (April 2009), LR 35:1097 (June 2009), LR 35:1475 (August 2009), LR 36:482 (March 2010), LR 36:1224 (June 2010), LR 37:1126 (April 2011), LR 37:2132 (July 2011), LR 38:1000 (April 2012), LR 38:1225 (May 2012), LR 38:1399 (June, 2012), LR 39:2205 (August 2013), LR 41:

Family Impact Statement

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

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

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

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

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

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

6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Poverty Impact Statement

In accordance with Section 973 of Title 49 of the Louisiana Revised Statutes, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact

Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this Section, the word "poverty" means living at or below one hundred percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.

2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.

3. Will the proposed Rule affect employment and workforce development? No.

4. Will the proposed Rule affect taxes and tax credits? No.

5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., December 9, 2014, to Kimberly Tripeaux, Board of Elementary and Secondary Education, Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Kimberly Tripeaux
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Bulletin 741—Louisiana Handbook for School Administrators Emergency Planning and Attendance

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

There may be an indeterminable cost to local school districts in order to continue providing quarantined students access to instructional services as a result of these policies.

These revisions broadly define emergency situations, inclusive of public health emergencies, and address the

continued education of students who have been quarantined following prolonged exposure to or direct contact with a person diagnosed with a contagious, deadly disease, as ordered by state or local health officials.

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

This policy will have no effect on revenue collections of state or local governmental units.

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

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

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1411#060

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 1566—Pupil Progression Policies and Procedures (LAC 28:XXXIX.503 and 705)

Editor's Note: This Notice of Intent is being repromulgated in its entirety to correct citation errors. Section 703, Promotion of LAA 2 Eligible Students, was shown as being repealed. This Section was never promulgated and as such cannot be repealed. The original Notice of Intent can be viewed on pages 1753-1754 of the September 20, 2014 edition of the *Louisiana Register*.

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 1566—Pupil Progression Policies and Procedures*: §503, Regular Placement; §703, Promotion of LAA 2 Eligible Students; and §705, Supports for Students. The proposed revisions require local pupil progression plans to include promotion requirements for students with disabilities aligned to the new policies as required by Act 833 of the 2014 Regular Legislative Session and removes the promotion policy for Louisiana alternate assessment, level 2 (LAA 2) eligible students. The revisions include the elimination of the LAA 2.

Title 28

EDUCATION

Part XXXIX. Bulletin 1566—Pupil Progression Policies and Procedures

Chapter 5. Placement Policies—General Requirements

§503. Regular Placement

A. Promotion—Grades K-12

1. Promotion from one grade to another for regular students and students with disabilities shall be based on the following statewide evaluative criteria.

a. Each plan shall include the school attendance requirements.

b. Each plan shall include the course requirements for promotion by grade levels.

c. Each plan shall include promotion requirements for LEAP alternate assessments, level 1 (LAA 1) eligible students aligned to policy contained in this bulletin.

d. Each plan shall include promotion requirements for students with disabilities aligned to policies included in *Bulletin 1530—Louisiana’s IEP Handbook for Students with Exceptionalities*.

e. Each plan shall include other applicable requirements, including the high stakes policy requirements for entering students in fifth or ninth grade.

B. - E.1.b. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17.7 and R.S. 17:24.4.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 25:2171 (November 2000), amended LR 26:1433 (July 2000), LR 26:1576 (August 2000), LR 27:188 (February 2001), LR 27:1006 (July 2001), LR 27:1682 (October 2001), LR 29:123 (February 2003), LR 30:407 (March 2004), LR 31:1974 (August 2005), LR 31:3103 (December 2005), LR 33:2063 (October 2007), LR 34:2389 (November 2008), LR 36:2003 (September 2010), LR 41:

Chapter 7. High Stakes Testing Policy

§705. Supports for Students

A. Remediation

1. - 4. ...

5. Repealed.

B. - B.2.c. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 17.7 and R.S. 17:24.4.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 36:2005 (September 2010), amended LR 41:

Family Impact Statement

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

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

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

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

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

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

6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes

Poverty Impact Statement

In accordance with section 973 of title 49 of the *Louisiana Revised Statutes*, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this section, the word "poverty" means living at or below 100 percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.

2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? Yes.

3. Will the proposed Rule affect employment and workforce development? No.

4. Will the proposed Rule affect taxes and tax credits? No.

5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? No.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., October 9, 2014, to Heather Cope, Board of Elementary and Secondary Education, P.O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Heather Cope
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: *Bulletin 1566—Pupil Progression Policies and Procedures*

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

The proposed policies will have no effect on costs or savings to state or local governmental units. The proposed revisions require local pupil progression plans to include promotion requirements for students with disabilities aligned to the new policies as required by Act 833 of the 2014 Regular Legislative Session and removes the promotion policy for LAA 2 eligible students. The revisions include the elimination of the Louisiana Alternate Assessment, Level 2 (LAA 2).

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

This policy will have no effect on revenue collections of state or local governmental units.

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

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

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1411#012

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 741 (Nonpublic)—Louisiana Handbook for Nonpublic School Administrators (LAC 28:LXXIX.2109)

Editor's Note: Section 2109 is being repromulgated in its entirety to correct citation errors. The original Notice of Intent can be viewed on pages 1757-1762 of the September 20, 2014 edition of the *Louisiana Register*.

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, notice is hereby given that the Board of Elementary and Secondary Education approved for advertisement revisions to *Bulletin 741—Louisiana Handbook for School Administrators*: §2109, High School Graduation Requirements; §2305, Art; §2309, Dance; §2313, English; §2317, Foreign Languages; §2323, Mathematics; §2325, Music; §2329, Science; §2331, Social Studies; and §2337. The revisions update graduation requirements to align with Taylor Opportunity Program for Students (TOPS) core courses as stated in Act 566 of the 2014 Regular Legislative Session and Act 359 of the 2013 Regular Legislative Session and with the graduation requirements for public schools. Also, the revisions provide the option of the career diploma for nonpublic school students and the State Bilingual Seal as proposed in Act 99 of the 2014 Regular Legislative Session. Lastly, graduation requirements for students entering ninth grade prior to 2008-2009 have been deleted.

Title 28 EDUCATION

Part LXXIX. Bulletin 741 (Nonpublic)—Louisiana Handbook for Nonpublic School Administrators

Chapter 21. Curriculum and Instruction Subchapter C. Secondary Schools

§2109. High School Graduation Requirements

A. For incoming freshmen in 2009-2010 and beyond, the 24 units required for graduation shall include 16 required units and 8 elective units for the Louisiana Basic Core Curriculum, or 21 required units and 3 elective units for the Louisiana Core 4 Curriculum.

B. For incoming freshmen from 2009-2010 to 2013-2014 who are completing the Louisiana Core 4 Curriculum, the minimum course requirements shall be the following:

1. English—4 units, shall be English I, II, III, and IV;
2. mathematics—4 units, shall be:
 - a. algebra I (1 unit) or algebra I-Pt. 2;
 - b. geometry;

- c. algebra II;
- d. the remaining unit shall come from the following: financial mathematics, math essentials, advanced mathematics-pre-calculus, advanced mathematics-functions and statistics, pre-calculus, calculus, probability and statistics, discrete mathematics, AP Calculus BC, or a locally-initiated elective approved by BESE as a math substitute;

3. science—4 units, shall be:

- a. biology;
- b. chemistry;
- c. 2 units from the following courses: physical science, integrated science, physics I, physics of technology I, aerospace science, biology II, chemistry II, earth science, environmental science, physics II, physics of technology II, agriscience II, anatomy and physiology, or a locally initiated elective approved by BESE as a science substitute;

- i. students may not take both integrated science and physical science.

- ii. agriscience I is a prerequisite for agriscience II and is an elective course;

4. social studies—4 units, shall be:

- a. 1 unit of civics or AP American government, or 1/2 unit of civics or AP American Government and 1/2 unit of free enterprise;

- b. 1 unit of U.S. history;

- c. 1 unit from the following: world history, world geography, western civilization, or AP European history;

- d. 1 unit from the following: world history, world geography, western civilization, AP European history, law studies, psychology, sociology, African American studies, economics, world religions, history of religion, or religion I, II, III, or IV;

5. health and physical education—2 units;

6. foreign language—2 units, shall be 2 units from the same foreign language or two speech courses;

7. arts—1 unit, shall be one unit of art (§2305), dance (§2309), media arts (§2324), music (§2325), theatre, or fine arts survey;

NOTE: Students may satisfy this requirement by earning half credits in two different arts courses.

8. electives—3 units;

9. total—24 units.

C. For incoming freshmen in 2009-2010 through 2014-2015 who are completing the Louisiana Basic Core Curriculum, the minimum course requirements for graduation shall be the following.

1. English—4 units, shall be English I, II, III, and IV or senior applications in English.

2. Mathematics—4 units, shall be:

- a. algebra I (1 unit) or algebra I-pt. 1 and algebra I-pt. 2 (2 units);

- b. geometry;

- c. the remaining units shall come from the following:

- i. algebra II;

- ii. financial mathematics;

- iii. math essentials;

- iv. advanced mathematics-pre-calculus;

- v. advanced mathematics-functions and statistics;

- vi. pre-calculus;

- vii. calculus;

- viii. probability and statistics;
- ix. discrete mathematics; or
- x. a locally initiated elective approved by BESE

as a math substitute.

3. Science—3 units, shall be:

- a. biology;
- b. 1 unit from the following physical science cluster:

- i. physical science;
 - ii. integrated science;
 - iii. chemistry I;
 - iv. physics I;
 - v. physics of technology I;
- c. 1 unit from the following courses:

- i. aerospace science;
- ii. biology II;
- iii. chemistry II;
- iv. earth science;
- v. environmental science;
- vi. physics II;
- vii. physics of technology II;
- viii. agriscience II;
- ix. anatomy and physiology;
- x. an additional course from the physical science cluster; or
- xi. a locally initiated elective approved by BESE

as a science substitute.

(a). Students may not take both integrated science and physical science.

(b). Agriscience I is a prerequisite for agriscience II and is an elective course.

4. Social Studies—3 units, shall be:

- a. 1 unit of civics and/or AP American government, or 1/2 unit of civics or AP American government and 1/2 unit of free enterprise;
- b. 1 unit of U.S. history;
- c. 1 unit from the following: world history, world geography, western civilization, or AP European history.

5. Health and physical education—2 units.

6. Electives—8 units.

7. Total—24 units.

D. For incoming freshmen in 2014-2015 and beyond who are completing the TOPS university diploma, the minimum course requirements shall be the following:

1. English—four units:

- a. English I;
- b. English II;
- c. one of the following:
 - i. English III;
 - ii. AP English language arts and composition;
 - iii. IB literature;
 - iv. IB language and literature;
 - v. IB literature and performance;
- d. one of the following:
 - i. English IV;
 - ii. AP English literature and composition;
 - iii. IB literature;
 - iv. IB language and literature;
 - v. IB literature and performance;

2. mathematics—four units:

- a. algebra I;
- b. geometry;

c. algebra II;

NOTE: Integrated Mathematics I, II, and III may be substituted for the Algebra I, Geometry, and Algebra II sequence.

d. one of the following:

- i. algebra III;
- ii. advanced math—functions and statistics;
- iii. advanced math—pre-calculus;
- iv. pre-calculus;
- v. IB math studies (math methods);
- vi. calculus;
- vii. AP calculus AB;
- viii. IB mathematics SL;
- ix. AP calculus BC;
- x. AP statistics;
- xi. IB further mathematics HL;
- xii. IB mathematics HL;

3. science—four units:

- a. biology I;
- b. chemistry I;
- c. two units from the following:

- i. earth science;
- ii. environmental science;
- iii. physical science;
- iv. agriscience II—the elective course agriscience

I is a pre-requisite;

- v. one of:
 - (a). chemistry II;
 - (b). AP chemistry;
 - (c). IB chemistry I;
 - (d). IB chemistry II;
- vi. one of:
 - (a). AP environmental science;
 - (b). IB environmental systems;
- vii. one of:
 - (a). physics I;
 - (b). IB physics I;
- viii. one of:
 - (a). AP physics C: electricity and magnetism;
 - (b). AP physics C: mechanics;
 - (c). IB physics II;
- ix. AP physics I and AP physics II;
- x. one of:
 - (a). biology II;
 - (b). AP biology;
 - (c). IB biology I;
 - (d). IB biology II;

4. social studies—four units:

- a. one unit chosen from:
 - i. U.S. history;
 - ii. AP U.S. history;
 - iii. IB history of the Americas I;
- b. one unit chosen from:
 - i. civics with a section on free enterprise;
 - ii. government;
 - iii. AP U.S. government and politics: comparative;

or

iv. AP U.S. government and politics: United States;

c. two units chosen from:

- i. one of:
 - (a). European history;
 - (b). AP European history;

- (c). western civilization;
 - ii. one of:
 - (a). world geography;
 - (b). AP human geography;
 - (c). IB geography;
 - iii. one of:
 - (a). world history;
 - (b). AP world history;
 - (c). IB history of the Americas II;
 - iv. IB economics;
 - v. economics;
 - vi. AP macroeconomics;
 - vii. AP microeconomics;
 - viii. history of religion;
5. foreign language—two units:
- a. two units from the same language (§2317);
6. art—one unit from the following:
- a. art (§2305);
 - b. music (§2325);
 - c. dance (§2309);
 - d. theatre (§2337);
 - e. speech III and IV—one unit combined;
 - f. fine arts survey;
 - g. drafting;
7. health and physical education—2 units;
8. electives—three units;
9. total—24 units.
- E. The 23 units required for the career diploma shall include academic credits and participation in an approved training program leading to an approved industry-based credential. This diploma option is available to entering freshmen in 2014-2015 and beyond.
1. The minimum course requirements for a career diploma for incoming freshmen in 2014-2015 and beyond shall be the following:
- a. English—4 units:
 - i. English I;
 - ii. English II;
 - iii. the remaining units shall come from the following:
 - (a). technical reading and writing;
 - (b). business English;
 - (c). English III;
 - (d). English IV;
 - (e). any AP or IB English course; or
 - (f). comparable Louisiana Technical College courses offered by Jump Start regional teams as approved by BESE;
 - b. mathematics—4 units:
 - i. algebra I, applied algebra I, or algebra I-Pt. 2 (the elective course algebra I-Pt. 1 is a pre-requisite);
 - ii. the remaining units shall come from the following:
 - (a). geometry;
 - (b). financial literacy (formerly financial math);
 - (c). math essentials;
 - (d). algebra II;
 - (e). advanced math-functions and statistics;
 - (f). advanced math-pre-calculus;
 - (g). algebra III;
 - (h). pre-calculus;

(i). comparable Louisiana Technical College courses offered by Jump Start regional teams as approved by BESE;

(j). integrated mathematics I, II, and III may be substituted for algebra I, geometry, and algebra II and shall count as 3 math credits;

c. science—2 units:

- i. 1 unit of biology;
- ii. 1 unit from the following:

- (a). chemistry I;
- (b). physical science;
- (c). earth science;
- (d). agriscience II;

NOTE: Agriscience I is a prerequisite for Agriscience II and is an elective course.

- d. environmental science;
- e. any AP or IB science course;
- f. social studies—2 units:

i. 1 of the following:

- (a). U.S. history;
- (b). AP U.S. history;
- (c). IB history of the Americas I;

ii. civics; or

- (a). 1/2 unit of:
 - (i). government; or
 - (ii). AP U.S. government and politics:

comparative; or

- (iii). AP U.S. government and politics: US;

and

(b). 1/2 unit of:

- (i). economics; or
- (ii). AP macroeconomics; or
- (iii). AP microeconomics;

g. health and physical education—2 units;

h. at least nine credits in an approved Jump Start course sequence, workplace experience or credentials;

i. total—23 units.

F. State Seal of Biliteracy

1. Schools are encouraged but not required to participate in the State Seal of Biliteracy program.

a. If a school opts to participate in the state seal of Biliteracy program, its governing authority shall maintain appropriate records in order to identify students who have earned the seal and affix the seal to the transcript and diploma of each student who earns the seal.

2. The State Seal of Biliteracy certifies that a student meets all of the following criteria:

a. has completed all English language arts requirements for graduation;

b. has passed the reading and English parts of the ACT series with a score of 19 or above; and

c. has demonstrated proficiency in one or more languages other than English through one of the methods below.

i. Passing a world language advanced placement examination with a score of three or higher or a world language international baccalaureate examination with a score of four or higher.

(a). For languages in which an advanced placement test is not available, school systems may use an equivalent summative test as approved by the state superintendent of education.

ii. Successful completion of a four-year high school course of study in a world language or successful completion of seven Carnegie units or more in language or content courses in a world language immersion setting.

iii. Passing a foreign government's approved language examination and receiving a receipt of a certificate of competency from the authorizing government agency at:

(a). the European B2 level;

(b). American Council on the Teaching of Foreign Languages Advanced Low level; or

(c). equivalent measures.

3. If the primary language of a student in grades 9 through 12 is other than English, he shall do both of the following to qualify for the State Seal of Biliteracy:

a. attain the early advanced proficiency level on the English language development assessment; and

b. meet the requirements of Paragraph 2 of this Subsection.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, R.S. 17:22(6), R.S. 17:391.1-391.10, and R.S. 44:411.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 29:2351 (November 2003), amended LR 30:2776 (December 2004), LR 31:3081 (December 2005), LR 34:2099 (October 2008), LR 36:2849 (December 2010), LR 37:2142, 2144 (July 2011), repromulgated LR 37:2390 (August 2011), amended LR 37:2597 (September 2011), LR 38:769 (March 2012), LR 38:1008 (April 2012), LR 39:1444 (June 2013), LR 41:

Family Impact Statement

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

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

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

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

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

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

6. Is the family or a local government able to perform the function as contained in the proposed Rule? Yes.

Poverty Impact Statement

In accordance with section 973 of title 49 of the *Louisiana Revised Statutes*, there is hereby submitted a Poverty Impact Statement on the Rule proposed for adoption, amendment, or repeal. All Poverty Impact Statements shall be in writing and kept on file in the state agency which has adopted, amended, or repealed a Rule in accordance with the applicable provisions of the law relating to public records. For the purposes of this section, the word "poverty" means living at or below one hundred percent of the federal poverty line.

1. Will the proposed Rule affect the household income, assets, and financial security? No.

2. Will the proposed Rule affect early childhood development and preschool through postsecondary education development? No.

3. Will the proposed Rule affect employment and workforce development? No.

4. Will the proposed Rule affect taxes and tax credits? No.

5. Will the proposed Rule affect child and dependent care, housing, health care, nutrition, transportation, and utilities assistance? Yes.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., October 9, 2014, to Heather Cope, Board of Elementary and Secondary Education, P.O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Heather Cope
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: **Bulletin 741 (Nonpublic)—Louisiana Handbook for Nonpublic School Administrators**

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

The revisions update graduation requirements to align with Taylor Opportunity Program for Students (TOPS) core courses as stated in Act 566 of the 2014 Regular Legislative Session and Act 359 of the 2013 Regular Legislative Session and with the graduation requirements for public schools. Also, the revisions provide the option of the career diploma for nonpublic school students and the State Biliteracy Seal as proposed in Act 99 of the 2014 Regular Legislative Session. Lastly, graduation requirements for students entering ninth grade prior to 2008-2009 have been deleted.

There will be an indeterminable but nominal increase for the LDE related only to the design and purchase of seals for diplomas.

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

This policy will have no effect on revenue collections of state or local governmental units.

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

The proposed policy will have no effect on costs or savings to nonpublic schools.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1411#011

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Office of the Governor

Board of Examiners of Certified Shorthand Reporters

Certification of Transcript (LAC 46:XXI.1103)

In accordance with the Administrative Procedures Act, R.S. 49:950 et seq., notice is hereby given that the Louisiana Board of Examiners of Certified Shorthand Reporters proposes to adopt changes made to the court reporting procedures rules.

Title 46

PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XXI. Certified Shorthand Reporters

Chapter 11. Court Reporting Procedures

§1103. Certification of Transcript

A. Effective January 1, 2015 each certified court reporter shall attest to the accuracy of every transcript prepared by that reporter by dating, signing, and sealing a certification page containing substantially the following language.

This certification is valid only for a transcript accompanied by my original signature and original required seal on this page.

I, [reporter's name], Certified Court Reporter in and for the State of Louisiana, as the officer before whom this testimony was taken, do hereby certify that [name of person(s) to whom oath was administered], after having been duly sworn by me upon authority of R.S. 37:2554, did testify as hereinbefore set forth in the foregoing [number of] pages; that this testimony was reported by me in the [stenotype; stenomask; penwriter; electronic] reporting method, was prepared and transcribed by me or under my personal direction and supervision, and is a true and correct transcript to the best of my ability and understanding; that the transcript has been prepared in compliance with transcript format guidelines required by statute or by rules of the board, and that I am informed about the complete arrangement, financial or otherwise, with the person or entity making arrangements for deposition services; that I have acted in compliance with the prohibition on contractual relationships, as defined by Louisiana Code of Civil Procedure Article 1434 and in rules and advisory opinions of the board; that I have no actual knowledge of any prohibited employment or contractual relationship, direct or indirect, between a court reporting firm and any party litigant in this matter nor is there any such relationship between myself and a party litigant in this matter. I am not related to counsel or to the parties herein, nor am I otherwise interested in the outcome of this matter.

B. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2554 and R.S. 37:2557.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Examiners of Certified Shorthand Reporters, LR 21:21 (January 1995), amended by the Office of the Governor, Board of Examiners of Certified Shorthand Reporters, LR 37:318 (January 2011), LR38:1957 (August 2012), effective January 1, 2013, LR 41:

Family Impact Statement

The proposed Rule changes have no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the impact of the proposed Rule has been considered.

Provider Impact Statement

The proposed Notice of Intent should not have any foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments on the proposed changes until 4 p.m., December 10, 2014, to Judge Paul A. Bonin, Chair of the Louisiana Board of Examiners of Certified Shorthand Reporters, P.O. Box 1840, Walker, LA 70785-1840.

Judge Paul A. Bonin
Chair

**FISCAL AND ECONOMIC IMPACT STATEMENT
FOR ADMINISTRATIVE RULES
RULE TITLE: Certification of Transcript**

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

The proposed rule change will not result in any implementation costs (or savings) to state or local governmental units other than those one-time costs directly associated with the publication and dissemination of this rule. The proposed rule change consists of updating certification pages to ensure that all court reporters are in compliance by confirming they have no financial, contractual, or other relationship with any party litigant in the matter being reported.

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

There will be no effect on revenue collections to state or local governmental units as a result of the proposed rule change.

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

There are no estimated costs and/or economic benefits to directly affected persons or non-governmental groups associated with the proposed rule change.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated effect on competition or employment as a result of this rule change.

Judge Paul A. Bonin
Chair
1411#053

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Office of the Governor
Board of Examiners of Certified Shorthand Reporters

Code of Ethics (LAC 46:XXI.1303)

In accordance with the Administrative Procedures Act, R.S. 49:950 et seq., notice is hereby given that the Louisiana Board of Examiners of Certified Shorthand Reporters proposes to adopt rules and accompanying form as authorized under Act 839 of the 2014 Regular Legislative Session.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XXI. Certified Shorthand Reporters

Chapter 13. Code of Ethics

§1303. Employment Relationship with Court Reporting Firm

A. Application and Scope. This rule protects the integrity, independence, and impartiality of court reporters in their relationships with court reporting firms, as defined in R.S. 37:2555(G) that are doing business in Louisiana.

B. Safe Harbor. A licensed Louisiana court reporter may accept employment from a court reporting firm and shall not be considered an "employee" for purposes of Code of Civil Procedure Article 1434 upon furnishing to the board a certification, on a form approved by the board, from an authorized and knowledgeable officer of the court reporting firm that the Firm has no prohibited employment or contractual relationship, direct or indirect, under Code of Civil Procedure Article 1434 with a party litigant in the matter for which the reporter was retained to provide services. The reporter must file with the board a copy of the certification within thirty days after the date of the deposition. The reporter shall obtain and maintain, for a minimum of three years, the schedule of all charges and other disclosures, which shall be obtained by the reporter concurrently with the original certification from the court reporting firm. Upon request, the reporter shall provide to the board a copy of the schedule of all charges and other disclosures. The Louisiana court reporter shall immediately notify the board, in writing, if a safe harbor request was made upon a court reporting firm and the firm refused or failed to provide the requested certification or the schedule of all charges and other disclosures. The reporter shall include the name of the court reporting firm and the date the request was made.

C. Certification by Court Reporting Firm. Upon request by a licensed Louisiana court reporter, a court reporting firm doing business in Louisiana shall provide a certification on forms adopted by the board and executed by affidavit from an authorized and knowledgeable officer of the firm,

attesting that the firm has no prohibited employment or contractual relationship, direct or indirect, under Code of Civil Procedure Article 1434 with a party litigant in the matter for which the reporter was retained to provide services.

D. The court reporting firm and the court reporter shall immediately inform the board of any change in relationships or actual knowledge of any relationships, direct or indirect, that are at variance with representations made in the certification by the court reporting firm.

E. Certification Affidavit of Court Reporting Firm

CERTIFICATION AFFIDAVIT OF COURT REPORTING FIRM

STATE OF
PARISH OR COUNTY OF

BEFORE ME, the undersigned authority, duly qualified to take acknowledgments and administer oaths within the state and locality inscribed above, personally appeared ("Affiant"), who is representing a [state] corporation [or limited liability company or other form of business organization] that is doing business in Louisiana as a court reporting firm as defined by Acts 2014, No. 839 (hereinafter, "Court Reporting Firm"). The physical address of the entity's principal place of business is [street and suite number, if any] in [city], State of, Zip Telephone: () Email After being duly sworn, Affiant did attest as follows:

- 6. Affiant is a knowledgeable representative who is authorized to act on behalf of the Court Reporting Firm in executing this Certification Affidavit.
7. The Court Reporting Firm has engaged a Louisiana licensed court reporter to perform court reporting services in connection with the deposition(s) of [identify by name each deponent covered by this certification] to be taken in the following proceeding: vs. pending in the Court under number
8. Affiant certifies, after performing due diligence, that the Court Reporting Firm has no prohibited employment or contractual relationship, direct or indirect, under Louisiana Code of Civil Procedure Article 1434 with a party litigant in the matter for which the court reporter's services have been engaged. Affiant further acknowledges affiant's duty to provide information and will provide information promptly to the Louisiana Board of Examiners of Certified Shorthand Reporters (hereinafter, "CSR Board") regarding any change in these relationships or in Affiant's knowledge of these relationships.
9. Affiant attaches hereto the schedule of all charges and other disclosures that the court reporter must have available at the time of taking the deposition.
10. Affiant further states that Affiant is familiar with the nature of an oath and with penalties as provided by applicable state laws for falsely swearing to statements made in an instrument of this nature. Affiant further certifies that Affiant has read and understands the full facts and content of this Affidavit.

SIGNATURE OF AFFIANT:

Sworn before me this me this day of , 201

Notary Public
Print name:
My commission expires:

Each Firm Certification Affidavit must be filed with the CSR Board by the court reporter within 30 days of the date of the deposition. The filing does not need to include the schedule of charges.

I, a Louisiana Licensed Court Reporter, hereby submit this certification affidavit via _____ [facsimile/e-mail] within 30 days of the date of the depositions to which this certification applies and acknowledge my obligation to maintain the schedule for a minimum of three years. I further certify that I have received the required schedule of all charges and other disclosures from the Court Reporting Firm in connection with this certification.

Signature

Date

Printed Name

LA CCR NO.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2557(B), R.S. 37:2555(G), and R.S. 37:2556(D).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Examiners of Certified Shorthand Reporters, LR 41:

Family Impact Statement

The proposed rules have no known impact on family formation, stability, and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the impact of the proposed rules have been considered.

Provider Impact Statement

The proposed Notice of Intent should not have any foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit comments in writing through December 10, 2014, to Judge Paul A. Bonin, Louisiana Board of Examiners of Certified Shorthand Reporters, P.O. Box 1840, Walker, LA 70785-1840.

Judge Paul A. Bonin
Chair

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Code of Ethics

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

There are expected to be minimal one-time costs associated with the publication and dissemination of the rule changes for the Louisiana Board of Examiners of Certified Shorthand Reporters. Pursuant to Act 839 of 2014, the rule changes clarify language regarding the legality of relationships between court reporting firms and any litigant parties involved in the case being reported upon. In addition, the proposed rule changes provide that court reporters must maintain the schedule of all charges and other disclosures of cases they have reported for a minimum of three years.

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

There is no estimated effect on revenue collections of state or local governmental units associated with the proposed rule change.

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

The proposed rule changes may result in an insignificant increase in costs as reporters will be required to maintain the schedule of all charges and other disclosures for a minimum of three years after the case is heard.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated effect on competition and employment.

Judge Paul A. Bonin
Chair
1411#054

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Office of the Governor Board of Home Inspectors

Home Inspectors (LAC 46:XL.Chapter 1-7)

Editor's Note: This Notice of Intent is being repromulgated to correct submission errors. The original Notice of Intent maybe viewed in the September 20, 2014 edition of the *Louisiana Register* on pages 1772-1778.

The Board of Home Inspectors proposes to amend LAC 46:XL.107, 109, 115, 117, 119, 120, 123, 125, 127, 133, 135, 137, 139, 141, 303, 305, 307, 309, 311, 313, 315, 317, 319, 321, 323, 325, 329, 501, 701, 705, 711 and 713 in accordance with the provisions of the Administrative Procedures Act, R.S. 49:950 et seq., and the Louisiana home inspector licensing law, R.S. 37:1471 et seq. The text is being amended primarily as an overhaul of the rules to correct any typographical errors, render rules consistent with each other and phrase the rules more properly. Other rules are being amended non-substantively to provide consistency with other rules. In addition, Section 309, 325 and 501 are being revised to comport with Act 2014 No. 572, revising R.S. 37:1478.

Title 46 PROFESSIONAL AND OCCUPATIONAL STANDARDS

Part XL. Home Inspectors

Chapter 1. General Rules

§107. Meetings

A. All meetings shall be held in accordance with the Louisiana open meetings law. Unless otherwise designated by the board, all meetings shall be held at the board's domicile in Baton Rouge.

B. ...

C. Special meetings shall be held at least two weeks after notification is given to each board member, unless a decision or action is required by the board within two weeks of the scheduling of a special meeting. In that case, each board member shall receive at least 24-hour's notice. The public

shall be provided notice of all special meetings as soon as practicable, but no less than 24-hour's notice. Special meeting agendas are to be posted at the meeting site at least 24 hours prior to the meeting.

D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1474-1475 and R.S. 42:7.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2739 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 41:

§109. Definitions

* * *

Code—the professional and occupational standards of home inspectors promulgated in LAC 46:XL.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S.37:1473 and R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2739 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1686 (August 2004), LR 36:2858 (December 2010), LR 41:

§115. Licensing Applications; Forms; Terms; Renewals; Inactive Status

A. Initial home inspector license applications are to be made on approved forms supplied by the board. Each applicant shall complete all chapters of the application. The application shall also be notarized and accompanied by two current passport sized photographs of the applicant. The application shall contain the applicant's Social Security number, however, the number shall be deleted or blackened out from any public record.

B. - C. ...

D. Any licensee who fails to timely renew his license may thereafter obtain renewal upon filing a renewal application and upon paying the appropriate renewal and delinquent fees. The period for delinquent renewal of an expired license shall be limited to the 12-month period immediately following the expiration date of the active license. Failure to renew an expired license during such 12-month period shall require the former licensee to pass the board approved licensing examination, pay the appropriate renewal and delinquent fees, file a renewal application, and complete all continuing education requirements accruing during the period of delinquency. Failure to renew an expired license within the 36-month period immediately following the expiration date of the active license shall, in addition to the above requirements, require the licensee to retake and pass 90 hours of classroom education as set forth in the board rules and take the standards of practice and *Code of Ethics* report writing seminar offered by the board or other board approved education provider. Any home inspection performed during an expiration period is considered a violation and shall subject the licensee to disciplinary action by the board.

E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475-1477 and R.S. 37:1479.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2740 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1687 (August 2004), LR 36:2858 (December 2010), LR 37:2405 (August 2011), LR 41:

§117. Fees; Submission of Report Fees; Timeliness of Filings

A. - A.7. ...

B. Each home inspection performed by an inspector under these rules shall be subject to a \$5 state inspection fee per home inspection. This fee is to be made payable to the Louisiana State Board of Home Inspectors and is to be remitted monthly in the following manner.

1. - 3. ...

4. The board may inspect any licensee's records to insure compliance with the licensee's obligation to submit reports and remit fees. The failure of a licensee to cooperate with the board's reasonable request for said inspection shall constitute a violation of these rules.

C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475-1477 and R.S. 37:1479.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2740 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 34:1926 (September 2008), LR 36:2858 (December 2010), LR 41:

§119. Education/Training and Testing; Initial Licensure

A. Initial applicants for licensure must pass a board-approved licensing examination covering home inspection methods and techniques, the standards of practice set forth in §301 et seq., and code of ethics set forth in §501.

B. ...

C. The 130 hours of home inspection instruction and training shall consist of the following:

1. 90 hours of home inspection course work approved by the board and taught by a certified pre-licensing education provider as set forth in §120;

2. ...

3. 10 hours of instruction and training from a certified in-field trainer, which shall consist of attending 10 live home inspections at a residential structure where a fee is paid and a report is provided to a client.

C.4. - K. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475 and R.S. 37:1485-1487.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2741 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1687 (August 2004), LR 35:1519 (August 2009), LR 36:2858 (December 2010), LR 38:2529 (October 2012), LR 41:

§120. Education Providers; Qualifications

A.1. - A.5. ...

6. A *guest lecturer* is defined as an individual licensed and/or certified in a construction related field, who provides pre-license and/or continuing education instruction for an education provider.

B.1. - G.3. ...

4. All other educational providers shall provide the student with documentation, either electronically or otherwise, which clearly sets forth the title, date, location and cost of the course and the number of continuing education or field training hours that are approved by the board for the course.

H. - J.3.f. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475 and R.S. 37:1485-1487.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home inspectors, LR 30:1687 (August 2004), amended by the Office of the Governor, Board of Home Inspectors, LR 31:2011 (August 2005), LR 35:1520 (August 2009), LR 36:2859 (December 2010), LR 38:2530 (October 2012), LR 41:

§123. Home Inspection Reports; Consumer Protection

A. All home inspection reports shall comply with all requirements as set forth in the standards of practice, these rules and the home inspector licensing law.

B. - C. ...

D. Refusal to comply with this Section shall constitute cause for disciplinary action resulting in license revocation, suspension, and/or fine.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475-1477 and R.S. 37:1479-1480.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2742 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 41:

§125. Home Inspectors Record Keeping; Inspection; Production Retention

A. ...

B. Records shall be made available, upon reasonable request, to the board's representatives during normal business hours. Such request shall be made in writing on board stationery. The failure of a licensee to maintain adequate records or the failure to furnish copies of such records within 72 hours receipt of a written request by the board shall constitute a violation of this rule.

C. - D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2742 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 36:2860 (December 2010), LR 41:

§127. Insurance

A. All active, licensed home inspectors shall carry errors and omissions insurance as well as general liability insurance.

1. ...

2. Each licensee shall be notified of the required terms and conditions of coverage for the annual policy at least 30 days prior to the annual renewal date. If the required terms and conditions have not been modified from the previous year's policy, the terms and conditions for the previous year shall apply and the licensee shall not be so notified.

B. - F. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475, R.S. 37:1477 and R.S. 37:1485.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home inspectors, LR 26:2743 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1688 (August 2004), LR 41:

§133. Report of Address Changes

A. Every licensee shall report any change in office address, residence address, office phone, and residence phone to the board, in writing, within 15 days of such change. The board shall acknowledge any change, in writing, and shall update all records accordingly.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2744 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 41:

§135. Display of License

A. - B. ...

C. A license certificate shall be displayed at the licensee's place of business. If the licensee operates from home, it is to be readily accessible.

D. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2744 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 41:

§137. LSBHI Funds; Deposits and Disbursements; Board Members; Reimbursement

A. All board funds received shall be paid to the Louisiana State Board of Home Inspectors through its secretary-treasurer and deposited to the board's operating account established for that purpose. Disbursements made by board shall be signed by the chairman and the secretary-treasurer. In absence of the chairman or the secretary-treasurer, the vice chairman may sign all documents with the remaining authorized signatory.

B. All fees and moneys received by the board shall be used solely to effectuate the provisions of the law and these rules. Such use may include, but is not limited to expenditures necessary for office fixtures, equipment and supplies and all other charges necessary to conduct the business of the board.

C. No board member shall receive a per diem but shall be reimbursed for actual expenses incurred when attending a meeting of the board or any of its committees and for the time spent on behalf of the board on official business not to exceed 10 days in any one month. Each board member shall be reimbursed upon approval of the board as evidenced by voucher for all necessary travel and incidental expenses incurred in carrying out the provisions of the rules of the board. No reimbursement, other than for lawful travel and mileage shall be allowed for attending any regular or special board meetings or for board related activities outside Louisiana. Reimbursement for time spent may be allowed if the board member is engaged in board business in Louisiana for the following, non-exclusive activities: participation as an appointed member of a special investigating entity; inspecting records of persons subject to the law and these rules; and reviewing and processing applications for licensure unconnected with preparation for a board meeting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1474-1475, and R.S. 37:1489.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2744 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 41:

§139. Prohibited Acts: Penalties and Costs

A. The board may suspend or revoke any license, or censure, fine, or impose probationary or other restrictions on any licensee for good cause shown which shall include but not be limited to the following:

1. being convicted of a felony or the entering of a plea of guilty or nolo contendere to a felony charge under the laws of the United States or any other state;

2. - 3. ...
4. attempting to deceive or defraud the public;
5. - 11. ...

B. The board may fine any applicant or any member of the public for good cause shown, for activities which include, but are not limited to, the following:

1. aiding or abetting a person to evade the provisions of this Chapter or knowingly conspiring with any licensed or unlicensed person with the intent to evade the provisions of this Chapter;

2. - 3. ...

C. Violators of any of the provisions of these rules or the law may be fined by the board in an amount not to exceed \$1,000 per each separate violation.

- D. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475 and R.S. 37:1486-1487.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2744 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1688 (August 2004), LR 41:

§141. Cease and Desist Orders; Injunctive Relief

A. In addition to or in lieu of the criminal penalties and administrative sanctions provided for in the law and these rules, the board may issue an order to any person engaged in any activity, conduct or practice constituting a violation of any provision of these rules to cease and desist from such activity, conduct or practice. Such order shall be issued in the name of the state and under the official seal of the board.

B. If the person directed by cease and desist order does not cease and desist the prohibited activity, conduct, or practice within two days of service of such order by certified mail, the board may seek a writ of injunction in any court of competent jurisdiction and proper venue enjoining such person from engaging in the activity, conduct or practice, and recovery of all related costs of the type described in §139.

- C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1488.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2745 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1689 (August 2004), LR 41:

Chapter 3. Standards of Practice

§303. Definitions

A. The definitions in §109 of this Part are incorporated into this Chapter by reference. The following definitions apply to this Chapter.

* * *

Cooling System—a central system that uses ducts to distribute cooled air to more than one room or uses pipes to distribute chilled water to heat exchangers in more than one room, which system is not plugged into an electrical convenience outlet.

* * *

Component—a readily accessible and observable aspect of a system, such as a floor or wall, but not individual pieces such as boards or nails or where many similar pieces make up a *component*.

* * *

Deficient—Repealed.

* * *

Dismantle—to take apart or remove any component, device or piece of equipment that is bolted, screwed, or fastened by other means that would not be taken apart by a homeowner in the course of normal household maintenance.

* * *

Functional Drainage—a drain which empties in a reasonable amount of time and does not overflow when another fixture is drained simultaneously.

* * *

Further Evaluation—examination and analysis by a qualified professional or service technician whose services and qualifications exceed those possessed by a home inspector.

Heating System—a central system that uses ducts to distribute heated air to more than one room which system is not plugged into an electrical convenience outlet.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2745 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1689 (August 2004), LR 36:2861 (December 2010), LR 38:2532 (October 2012), LR 41:

§307. General Limitations

- A. ...

B. This Chapter applies only to residential resale buildings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2746 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 41:

§309. General Exclusions

A. Home inspectors are not required to inspect or report on:

1. - 5. ...

6. solicit to perform repair services on any system or component of the home which the inspector noted as significantly deficient, non-functioning or unsafe in his home inspection report for a period of one year from the date of the inspection;

7. the presence or absence of any suspected or actual adverse environmental condition or hazardous substance, including but not limited to asbestos, radon lead, mold, contaminated drywall or building components, carcinogens, noise, or contaminants, whether in the building or in soil, water, or air; however, if during the course of inspecting the systems and components of the building in accordance with the law and these rules, the home inspector discovers visually observable evidence of suspected mold or microbial growth, he shall report it;

8. - 11. ...

B. Home inspectors are not required to:

1. - 5. ...

6. disturb or move insulation, personal items, panels, furniture, equipment, soil, snow, ice, plant life, debris or other items that may obstruct access or visibility;

7. - 13. ...

14. dismantle any system or component, except as specifically required by these standards of practice; or

15. perform air or water intrusion tests or other tests upon roofs, windows, doors or other components of the structure to determine its resistance to air or water penetration.

C. Home inspectors shall not:

1. - 4. ...

5. report on the presence or absence of pests such as wood damaging organisms, rodents or insects; however the home inspector may advise the client of damages to the building and recommend further inspection by a licensed wood destroying insect inspector;

6. advertise or solicit to perform repair services on any system or component of the home which the inspector noted as deficient, significantly deficient or unsafe in his home inspection report from the time of the inspection until the date of the act of sale on the home inspected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475 and R.S. 37:1478.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2746 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1690 (August 2004), LR 36:2862 (December 2010), LR 38:2532 (October 2012), LR 41:

§311. Structural Systems

A. The home inspector shall inspect structural components including:

1. ...
2. framing;
3. columns; and
4. piers.

B. - C.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2747 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1690 (August 2004), LR 41:

§313. Exterior System

A. - B.4. ...

C. The home inspector is not required to inspect:

1. - 8. ...
9. the presence or condition of buried fuel storage tanks;
10. - 12. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2747 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1691 (August 2004), LR 36:2862 (December 2010), LR 38:2532 (October 2012), LR 41:

§315. Roofing System

A. The home inspector shall inspect:

1. ...
2. roof drainage components;

A.3. - C.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home inspectors, LR 26:2747 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1691 (August 2004), LR 36:2862 (December 2010), LR 38:2532 (October 2012), LR 41:

§317. Plumbing System

A.-A.5. ...

B. The home inspector shall describe:

1. - 2. ...
3. water heating equipment;
4. location of main water supply shutoff device; and

B.5. - D.6.i. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home inspectors, LR 26:2747 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1691 (August 2004), LR 41:

§319. Electrical System

A. - D. ...

E. The home inspector is not required to:

1. - 3. ...
4. inspect:
 - a. ...
 - b. security system devices, heat detectors, carbon monoxide detectors or smoke detectors that are not part of a central system;
 - 4.c. - 5. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home inspectors, LR 26:2748 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1691 (August 2004), LR 36:2863 (December 2010), LR 38:2533 (October 2012), LR 41:

§321. Air Conditioning and Heating System

A. - D. ...

E. The home inspector is not required to:

1. - 3. ...
4. inspect:
 - a. - c. ...
 - d. electronic air filters;
 - e. - h. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home inspectors, LR 26:2748 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1692 (August 2004), LR 36:2863 (December 2010), repromulgated LR 38:2533 (October 2012), amended LR 41:

§325. Interior System

A. The home inspector shall inspect:

1. - 2. ...
3. countertops and a representative number of cabinets and drawers;
4. - 5. ...

B. The home inspector shall:

1. operate a representative number of windows and interior doors;
2. report signs of abnormal or harmful water penetration into the building or signs of abnormal or harmful condensation on building components;
3. report the presence of suspected mold or microbial growth if, during the course of inspecting the systems and components of the structure in accordance with the home inspector licensing law and these rules, the licensed home

inspector discovers visually observable evidence of suspected mold or microbial growth.

C. - C.4. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2749 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1692 (August 2004), LR 37:2406 (August 2011), LR 38:2533 (October 2012), LR 41:

§329. Built-In Kitchen Appliances

A. The home inspector shall inspect and operate the basic functions of the following appliances:

1. - 4. ...
5. ventilation equipment or range hood;
6. permanently installed microwave oven; and
7. ...

B. The home inspector is not required to inspect:

1. ...
2. non built-in appliances such as clothes washers and dryers;
3. refrigeration units such as freezers, refrigerators and ice makers; or
4. central vacuum system.

C. - C.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2749 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1692 (August 2004), LR 41:

Chapter 5. Code of Ethics

§501. Code of Ethics

A. ...

B. Ethical Obligations

1. - 5. ...

6. The LHI shall not accept compensation, directly or indirectly, for referring or recommending contractors or other service providers or products to inspection clients or other parties having an interest in inspected properties, unless disclosed and scheduled prior to the home inspection.

7. The LHI shall not advertise or solicit to repair, replace or upgrade for compensation, any system or component of the home which the inspector noted as significantly deficient or unsafe in his home inspection report, or any other type of service on the home upon which he has performed a home inspection, from the time of the inspection until the date of the act of sale on the home inspected.

8. - 10. ...

11. The LHI shall not disclose inspection results or a client's personal information without approval of the client or the clients designated representative. At his discretion, the LHI may immediately disclose to occupants or interested parties safety hazards observed to which they may be exposed.

12. The LHI shall avoid activities that may harm the public, discredit him or reduce public confidence in the profession.

13. - 15. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2749 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1693 (August 2004), LR 36:2863 (December 2010), LR 37:2406 (August 2011), LR 41:

Chapter 7. Disciplinary Actions

§701. Definitions

A. The following definitions are used in this Chapter. The definitions in the law and these rules are incorporated into Chapter 1, Chapter 3, and Chapter 5 by reference.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475 and R.S. 37:1485-1487.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2750 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1693 (August 2004), LR 41:

§705. Special Investigating Entity

A. For all complaints filed pursuant to §703.A, the board shall appoint a committee, board member, employee, or other qualified licensee to verify whether the allegations listed in the complaint may indicate violations of these rules, the standards of practice, *Code of Ethics* or the law. This committee, board member, employee or licensee shall be referred to as the "special investigating entity." The chairman may appoint a special investigating entity at any time to commence review of a complaint. This appointment shall be ratified by the board in executive session at its next meeting.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2750 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1694 (August 2004), LR 41:

§711. Pre-Hearing Resolution

A. ...

B. The proposed consent agreement shall then be presented to the board at its next meeting. The board may accept the consent agreement as written, modify the agreement and send it back to the licensee for acceptance, or reject the consent agreement. Accepted agreements shall be filed in the record of the docket.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475 and R.S. 37:1485-1487.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2751 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1694 (August 2004), LR 41:

§713. Hearing Procedure; Decision; Notice; Effective Date; Rehearing

A. - B. ...

C. The board shall render any final decision or order by majority vote of the board in open session. The date of the decision or order shall be indicated on the decision or order.

1. - 2. Repealed.

D. ...

E. A board decision or order may be reconsidered by the board at the next board meeting on its own motion, or on motion by a party of record, for good cause shown pursuant to a written request filed at the board's office within 10 days following the decision date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475 and R.S. 37:1485-1487.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home inspectors, LR 26:2751 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1695 (August 2004), LR 38:2533 (October 2012), LR 41:

Family Impact Statement

The proposed Rule amendments have no know impact on family formation, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested parties may submit written comments to Morgan Dampier, Chief Operating Officer, Louisiana State Board of Home Inspectors, 4664 Jamestown, Baton Rouge, LA, 70898-4868 or by facsimile to (225) 248-1335. Comments will be accepted through the close of business December 10, 2014.

Public Hearing

If it becomes necessary to convene a public hearing to receive comments in accordance with the Administrative Procedures Act, the hearing will be held on December 22, 2014 at 9 a.m. at the office of the State Board of Home Inspectors, 4664 Jamestown, Suite 220, Baton Rouge, LA.

Albert J. Nicaud
Board Attorney

**FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Home Inspectors**

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

There are no estimated implementation costs (savings) to state or local governmental units as the result of the proposed rule change other than those directly associated with publication. The purpose of the proposed rule change is to make technical changes to language in Title 46 Part XL as well as implement LSA R.S. 37:1478, as amended by Act 572 of 2014. These changes involve how inspectors are to report potential cases of mold, the period of time officials are to be given notice about special meetings, and restrictions for advertisement/solicitation by home inspectors to repair problems that are discovered during an inspection.

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

The proposed rule change will have no effect on revenue collections of state or local governmental units.

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

There will likely be a substantial increase in costs to licensed home inspectors as a result of the proposed administrative rules. The proposed administrative rules provide for all licensed home inspectors to report visual evidence of suspected mold growth, in accordance to LSA R. S. 37:1478, as amended by Acts 2014 no. 547. This will require additional, costly training and result in substantial liability exposure to the home inspector. There may also be a substantial in cost to the consumer because virtually any evidence of moisture intrusion into the building, including something as simple as a small water stain on a ceiling, will require the home inspector to report evidence of suspected mold growth. This will either prompt the purchaser to expend thousands of dollars for comprehensive mold testing or terminate the real estate transaction. These changes could increase costs to buyers between \$1,000 and \$5,000.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed administrative rule may increase competition among home inspectors. Some home inspectors will likely turn in their licenses to avoid the increased cost of errors and omissions insurance and the increased liability of inspecting for mold.

Albert Nicaud
Board Attorney
1411#013

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Office of the Governor
Division of Administration
Office of Facility Planning and Control**

Uniform Public Work Bid Form (LAC 34:III.313)

In accordance with the provisions of the Administrative Procedure Act (R.S. 49:950 et seq.) and the provisions of R.S. 39:121, the Division of Administration, Office of Facility Planning and Control, hereby gives notice of its intent to amend Title 34, Government Contracts, Procurement and Property Control, Part III, Facility Planning and Control, Chapter 3, Louisiana Uniform Public Work Bid Form. This Rule change updates the Louisiana uniform public work bid form with the correct reference to R.S. 38:2122 as amended in Act No. 759 from the 2014 Regular Legislative Session.

Title 34

GOVERNMENT CONTRACTS, PROCUREMENT AND PROPERTY CONTROL

Part III. Facility Planning and Control

Chapter 3. Louisiana Uniform Public Work Bid Form

§313. Unit Price Form

A. ...

LOUISIANA UNIFORM PUBLIC WORK BID FORM

TO: _____

(Owner to provide name and address of owner)

BID FOR: _____

(Owner to provide name of project and other identifying information)

The undersigned bidder hereby declares and represents that she/he; a) has carefully examined and understands the Bidding Documents, b) has not received, relied on, or based his bid on any verbal instructions contrary to the Bidding Documents or any addenda, c) has personally inspected and is familiar with the project site, and hereby proposes to provide all labor, materials, tools, appliances and facilities as required to perform, in a workmanlike manner, all work and services for the construction and completion of the referenced project, all in strict accordance with the Bidding Documents prepared by: _____ and dated: _____
(Owner to provide name of entity preparing bidding documents.)

Bidders must acknowledge all addenda. The Bidder acknowledges receipt of the following ADDENDA: (Enter the number the Designer has assigned to each of the addenda that the Bidder is acknowledging) _____

TOTAL BASE BID: For all work required by the Bidding Documents (including any and all unit prices designated "Base Bid" * but not alternates) the sum of: _____ Dollars (\$ _____)

ALTERNATES: For any and all work required by the Bidding Documents for Alternates including any and all unit prices designated as alternates in the unit price description.

Alternate No. 1 (Owner to provide description of alternate and state whether add or deduct) for the lump sum of: _____ Dollars (\$ _____)

Alternate No. 2 (Owner to provide description of alternate and state whether add or deduct) for the lump sum of: _____ Dollars (\$ _____)

Alternate No. 3 (Owner to provide description of alternate and state whether add or deduct) for the lump sum of: _____ Dollars (\$ _____)

NAME OF BIDDER: _____

ADDRESS OF BIDDER: _____

LOUISIANA CONTRACTOR'S LICENSE NUMBER: _____

Name OF AUTHORIZED SIGNATORY OF BIDDER: _____

TITLE OF AUTHORIZED SIGNATORY OF BIDDER: _____

SIGNATURE OF AUTHORIZED SIGNATORY OF BIDDER **: _____

DATE: _____

* The Unit Price Form shall be used if the contract includes unit prices. Otherwise it is not required and need not be included with the form. The number of unit prices that may be included is not limited and additional sheets may be included if needed.

** If someone other than a corporate officer signs for the Bidder/Contractor, a copy of a corporate resolution or other signature authorization shall be required for submission of bid. Failure to include a copy of the appropriate signature authorization, if required, may result in the rejection of the bid unless bidder has complied with La. R.S. 38:2212(B)5.

BID SECURITY in the form of a bid bond, certified check or cashier's check as prescribed by LA RS 38:2218.A is attached to and made a part of this bid.

LOUISIANA UNIFORM PUBLIC WORK BID FORM
UNIT PRICE FORM
* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 38:2212.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Facility Planning and Control, LR 35:1522 (August 2009), amended LR 41:

Family Impact Statement

1. The Effect of this Rule on the Stability of the Family. This Rule will have no effect on the stability of the family.

2. The Effect of this Rule on the Authority and Rights of Parents Regarding the Education and Supervision of their Children. This Rule will have no effect on the authority and rights of parents regarding the education and supervision of their children.

3. The Effect of this Rule on the Functioning of the Family. This Rule will have no effect on the functioning of the family.

4. The Effect of this Rule on Family Earnings and Family Budget. This Rule will have no effect on family earnings and family budget.

5. The Effect of this Rule on the Behavior and Personal Responsibility of Children. This Rule will have no effect on the behavior and personal responsibility of children.

6. The Effect of this Rule on the Ability of the Family or Local Government to Perform the Function as Contained in the Proposed Rule. This Rule will have no effect on the ability of the family or local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

In accordance with R.S. 49:965.6, the Office of Facility Planning and Control has determined that this Rule will have no estimated effect on small businesses.

Provider Impact Statement

The proposed rulemaking will have no known or foreseeable effect on:

1. the staffing level requirements or qualifications required to provide the same level of service;

2. the total direct and indirect effect on the cost to the provider to provide the same level of service;

3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit comments to Mark Bell, Facility Planning and Control, P.O. Box 94095, Baton Rouge, LA 70804-9095. Written comments will be accepted through December 10, 2014.

Mark A. Moses
Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Uniform Public Work Bid Form

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

There are no anticipated implementation costs as the result of this rule adoption. Pursuant to Act 759 of 2014, the proposed administrative rule updates the Louisiana Uniform Public Work

Bid Form by updating the references to the sections in R.S. 38:2212 on the bid form.

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

There is no anticipated direct material effect on state or local governmental revenues as a result of this measure.

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

There is no anticipated material impact to directly affected persons or nongovernmental groups as a result of the proposed rule change.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no anticipated direct material effect on competition and employment as a result of the proposed administrative rules.

Mark A. Moses
Director
1411#027

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

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

Employee Benefits
(LAC 32:I.Chapters 1-13, III.Chapters 1-7,
V.Chapters 1-7, and IX.Chapters 1-7)

In accordance with the applicable provisions of R.S. 49:950 et seq., the Administrative Procedure Act, and pursuant to the authority granted by R.S. 42:801(C) and 802(B)(1), vesting the Office of Group Benefits (OGB) with the responsibility for administration of the programs of benefits authorized and provided pursuant to chapter 12 of title 42 of the *Louisiana Revised Statutes*, and granting the power to adopt and promulgate rules with respect thereto, OGB finds that it is necessary to revise and amend several provisions of Title 32 in the *Louisiana Administrative Code*. This action will enhance member clarification and provide for the administration, operation, and management of health care benefits effectively for the program and member. Accordingly, OGB hereby gives Notice of Intent to adopt the following rules to become effective March 1, 2015, unless promulgated thereafter, in which case they would become effective upon promulgation.

Title 32

EMPLOYEE BENEFITS

Part I. General Provisions

Chapter 1. General Information

§101. Organizational Description

A. The Office of Group Benefits operates pursuant to R.S. 42:801 et seq. OGB is responsible for the general administration and management of all aspects of programs of benefits as authorized or provided for under the provisions of this Chapter.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§103. OGB Plan and Other Authorized Plans

A. OGB Plan and Plan Administrator. The OGB Plan is the program of benefits offered by or through OGB. OGB may offer a variety of self-funded or insured plans of benefits.

B. Other Plans: Plan Insurer and Plan Administrator. To the extent any governmental and administrative subdivisions, departments, or agencies of the executive, legislative, or judicial branches, or the governing boards and authorities of each state university, college, or public elementary and secondary school system in the state are authorized to procure private contracts of health insurance and/or operate or contract for all or a portion of the administration of a self-funded plan, such plans not directly operated or offered by OGB shall be governed by the terms and conditions of the applicable plan.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 3. Uniform Provisions—Participation in the Office of Group Benefits

§301. Eligibility for Participation in OGB Health Coverage and Life Insurance [Formerly §303]

A. Employees of a public entity who participate in the Louisiana State Employees Retirement System, Louisiana Teacher's Retirement System, State Police Pension and Retirement System, or the Louisiana School Employees Retirement System due to their status as an employee of such public entity are eligible to participate in OGB group benefit programs pursuant to R.S. 42:808. No individual may participate in a program sponsored by OGB unless the school board, state agency or political subdivision through which the individual is actively employed or retired participates in OGB as a group.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:199 (May 1980), amended LR 8:486 (September 1982), LR 17:891 (September 1991), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§303. Enrollment Procedures for Participation in OGB Health Coverage and Life Insurance

A. Any state agency, school board, political subdivision, or other entity that seeks to participate in programs offered through OGB shall comply with the following.

1. The head of the agency shall submit a written request to OGB to commence participation in its programs, together with a resolution of authorization from the board, commission, or other governing authority, if applicable.

2. The request for participation shall be reviewed to verify the eligibility of the requesting agency.

3. The requesting agency shall obtain an experience rating from OGB.

a. The requesting agency shall submit claims experience under its prior plan for the 36 month period immediately prior to its application together with the required advance payment to cover the cost of the experience rating.

b. The actuarial consultant serving OGB shall conduct the experience rating and determine the premiums due.

c. For any state agency, school board, political subdivision, or other eligible entity that elects to participate in the OGB health and accident programs after participation in another group health and accident insurance program, the premium rate applicable to the employees and former employees of such group shall be the greater of the premium rate based on the loss experience of the group under the prior plan or the premium rate based on the loss experience of the classification into which the group is entering.

d. In the event that the initial premium is based on the loss experience of the group under the prior plan, such premium shall remain in effect for three years and then convert to the published rate for all other OGB enrollees.

B. Open enrollment is a period of time, designated by OGB, during which an eligible employee or retiree may enroll for benefits under an OGB plan. OGB will hold open enrollment for a coverage effective date of January 1 or such other date as may be determined by OGB. Transfer of coverage will only be allowed during open enrollment, unless otherwise allowed or required by OGB or state or federal law.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§305. Retiree Eligibility

A. For the purpose of determining eligibility to participate in OGB health coverage and life insurance, the term *retiree* shall refer only to an individual who was an enrollee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

1. immediately received retirement benefits from an approved state or governmental agency defined benefit plan;

2. was not eligible for participation in such plan or legally opted not to participate in such plan, and either:

a. began employment prior to September 15, 1979, has 10 years of continuous state service, and has reached the age of 65;

b. began employment after September 15, 1979, has 10 years of continuous state service, and has reached the age of 70;

c. began employment after July 8, 1992, has 10 years of continuous state service, has a credit for a minimum of 40 quarters in the Social Security system at the time of employment, and has reached the age of 65; or

d. maintained continuous coverage with an OGB plan of benefits as an eligible dependent until he/she became eligible to receive a retirement benefit from an approved state governmental agency defined benefit plan as a former state employee; or

3. immediately received retirement benefits from a state-approved or state governmental agency approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him/her to receive a retirement allowance from the defined benefit plan of the retirement system for which the employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan is responsible for certification of eligibility to OGB.

B. Retiree also means an individual who was a covered employee and continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any of Paragraphs 1, 2, or 3 above.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§307. Persons to be Covered

A. Employee Coverage

1. For the purpose of determining eligibility to participate in OGB health coverage and life insurance, the term *employee* shall refer to a full-time employee as defined by a participating employer and in accordance with federal and state law.

2. Husband and Wife, Both Employees. No one may be enrolled simultaneously as an employee and as a dependent under an OGB plan, nor may a dependent be covered as a dependent of more than one employee. If a covered spouse is eligible for coverage as an employee and chooses to be covered separately at a later date, that person will be an enrollee effective the first day of the month after the election of separate coverage. The change in coverage will not increase the benefits.

3. Effective Dates of Coverage, New Employee, Transferring Employee. Coverage for each employee who follows the OGB procedures for enrollment and agrees to make the required payroll contributions to his/her participating employer is effective as follows:

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

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

c. employee coverage will not become effective unless the employee completes an enrollment form within 30 days following the date employment begins;

d. an employee who transfers employment to another participating employer shall complete a transfer form within 30 days following the date of transfer to maintain coverage without interruption.

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

a. An employee whose employment terminated while covered who is re-employed within 12 months of the date of termination will be considered a re-enrollment previous employment applicant. A re-enrollment previous employment applicant will be eligible for only that classification of coverage (employee, employee and one dependent, employee and children, family) in force on the date of termination.

b. If an employee acquires an additional dependent during the period of termination, that dependent may be covered if added within 30 days of re-employment.

5. Members of Boards and Commissions. Except as otherwise provided by law, members of boards or commissions are not eligible for participation in an OGB plan of benefits. This section does not apply to members of

school boards or members of state boards or commissions who are determined by the participating employer and in accordance with federal and state law to be full-time employees.

6. Legislative Assistants. Legislative assistants are eligible to participate in an OGB plan if they are determined to be full-time employees by the participating employer under applicable federal and state law or pursuant to R.S. 24:31.5(C), either:

1. receive at least 60 percent of the total compensation available to employ the legislative assistant if a legislator employs only one legislative assistant; or

2. is the *primary legislative assistant* as defined in R.S. 24:31.5(C) when a legislator employs more than one legislative assistant.

B. Retiree Coverage

1. Eligibility

a. Retirees of participating employers are eligible for retiree coverage under an OGB plan.

b. An employee retired from a participating employer may not be covered as an active employee.

2. Effective Date of Coverage

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

C. Documented Dependent Coverage

1. Eligibility. A documented dependent of an eligible employee or retiree will be eligible for dependent coverage on the later of the following dates:

a. date the employee becomes eligible;

b. date the retiree becomes eligible; or

c. date the covered employee or covered retiree acquires a dependent.

2. Effective Dates of Coverage. Application for coverage is required to be made within 30 days of eligibility for coverage.

a. Documented Dependents of Employees. Coverage will be effective on the date of marriage for new spouses, the date of birth for newborn children, or the date acquired for other classifications of dependents, if application is made within 30 days of the date of eligibility.

b. Documented Dependents of Retirees. Coverage for dependents of retirees who were covered immediately prior to retirement will be effective on the first day of the month following the date of retirement. Coverage for dependents of retirees first becoming eligible for dependent coverage following the date of retirement will be effective on the date of marriage for new spouses, the date of birth for newborn children, or the date acquired for other classifications of dependents, if application is made within 30 days of the date of eligibility.

D. Special Enrollments—HIPAA. Certain eligible persons for whom the option to enroll for coverage was previously declined and who would be considered overdue applicants may enroll as provided for by HIPAA under circumstances, terms, and conditions for special enrollments.

E. Health Maintenance Organization (HMO) Option. In lieu of participating in an OGB self-funded health plan, enrollees may elect coverage under an OGB offered fully insured HMO.

F. Medicare Advantage Option for Retirees (effective July 1, 1999). Retirees who are eligible to participate in an OGB sponsored Medicare Advantage plan who cancel participation in an OGB plan of benefits upon enrollment in an OGB sponsored Medicare Advantage plan may re-enroll in an OGB offered plan of benefits upon withdrawal from or termination of coverage in the Medicare Advantage plan at Medicare's open enrollment or OGB's open enrollment period.

G. Tricare for Life Option for Military Retirees. Retirees eligible to participate in the Tricare for Life (TFL) option on and after October 1, 2001 who cancel participation in an OGB plan of benefits upon enrollment in TFL may re-enroll in an OGB offered plan of benefits in the event that the TFL option is discontinued or its benefits are significantly reduced.

H. Eligibility requirements apply to all participants in OGB health coverage and life insurance programs.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§309. Medicare and OGB

A. When an individual is covered by an OGB plan of benefits and by Medicare, Medicare laws and regulations govern the order of benefit determination, that is, whether Medicare is the primary or secondary payer.

B. Except as provided in Subsection C (below), when an individual is covered by an OGB plan of benefits and by Medicare, and:

1. an OGB plan of benefits is the primary payer, benefits will be paid without regard to Medicare coverage;

2. Medicare is the primary payer, eligible expenses under an OGB plan of benefits will be limited to the amount allowed by Medicare, less the amount paid or payable by Medicare. All provisions of an OGB plan of benefits, including all provisions related to deductibles, co-insurance, limitations, exceptions, and exclusions will be applied.

C. The following applies to retirees and their covered spouses who attain or have attained the age of 65 on or after July 1, 2005, and who have no other group health coverage through present (active) employment.

1. A retiree or spouse of a retiree who attains or has attained age 65 when either has sufficient earnings credits to be eligible for Medicare, shall enroll in Medicare Part A and Medicare Part B in order to receive benefits under an OGB plan except as specifically provided in Paragraph 2, below.

2. If such retiree or spouse of a retiree is not enrolled in Medicare Part A and Medicare Part B, no benefits will be paid or payable under an OGB plan of benefits except benefits payable as secondary to the part of Medicare in which the individual is enrolled.

D. A retiree and spouse of a retiree who do not have sufficient earnings credits to be eligible for Medicare shall provide written verification from the Social Security Administration or its successor.

E. Medicare Coordination of Benefits (Retiree 100). Upon enrollment and payment of the additional monthly premium, an enrollee and dependents who are covered under Medicare Parts A and B (both) may choose to have full coordination of benefits with Medicare. Enrollment shall be made within 30 days of eligibility for Medicare, within 30

days of retirement if already eligible for Medicare, or at open enrollment.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§311. Reinstatement to Position Following Civil Service Appeal

A. Self-Funded Plan Participants. When coverage of a terminated employee who was enrolled in an OGB self-funded plan is reinstated by reason of a civil service appeal, coverage will be reinstated to the same level in the OGB plan of benefits retroactive to the date coverage terminated. The employee and participating employer are responsible for the payment of all premiums for the period of time from the date of termination to the date of the final order reinstating the employee to his/her position. The OGB plan is responsible for the payment of all eligible benefits for charges incurred during this period. All claims for expenses incurred during this period shall be filed with the OGB plan within 60 days following the date of the final order of reinstatement.

B. Fully Insured HMO Participants. When coverage of a terminated employee who was enrolled in a fully insured HMO is reinstated by reason of a civil service appeal, coverage will be reinstated in the fully insured HMO in which the employee was participating effective on the date of the final order of reinstatement. There will be no retroactive reinstatement of coverage and no premiums will be owed for the period during which coverage with the fully insured HMO was not effective.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§313. Enrollee Coverage Termination

A. Subject to continuation of coverage and COBRA rules, all benefits of an enrollee will terminate under plans offered by OGB on the earliest of the following dates:

1. date OGB terminates;
2. date the group or agency employing the enrollee terminates or withdraws from OGB;
3. date contribution is due if the group or agency fails to pay the required contribution for the enrollee;
4. date contribution is due if the enrollee fails to make any contribution which is required for the continuation of coverage;
5. last day of the month of the enrollee's death; or
6. last day of the month in which the enrollee is eligible for OGB plan coverage.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§315. Dependent Coverage Termination

A. Subject to continuation of coverage and COBRA rules, dependent coverage will terminate under any OGB plan of benefits on the earliest of the following dates:

1. last day of the month the enrollee is covered;
2. last day of the month in which the dependent, as defined by OGB, is an eligible dependent of the enrollee;
3. for grandchildren for whom the enrollee does not have legal custody or has not adopted, on the date the child's

parent loses eligibility under any OGB plan or the grandchild no longer meets the definition of a child; or

4. upon discontinuance of all dependent coverage under OGB plans.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§317. Change of Classification

A. Adding or Deleting Dependents. When a dependent is added to or deleted from the enrollee's coverage due to a qualifying event, under applicable state or federal law, active enrollees shall notify their HR liaison and retired enrollees shall notify OGB. Notice shall be provided within 30 days of the addition or deletion.

B. Change in Coverage

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

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

C. Notification of Change. It is the enrollee's responsibility to provide notice of any change in classification of coverage that affects the enrollee's contribution amount.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§319. Continued Coverage

A. Leave of Absence. If an enrollee is allowed an approved leave of absence by his/her participating employer, the enrollee may retain the coverage for up to one year if the premium is paid. Failure to pay the premium will result in cancellation of coverage. The enrollee and/or the participating employer shall notify OGB within 30 days of the effective date of the leave of absence.

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

a. An enrollee who is granted leave of absence without pay due to a service related injury may continue coverage and the participating employer shall continue to pay its portion of health plan premiums for up to 12 months.

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

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

2. Leave of Absence without Pay; No Employer Contributions to Premiums. An enrollee granted leave of absence without pay for reasons other than those stated in Paragraph A.1, may continue to participate in an OGB plan for a period up to 12 months upon the enrollee's payment of the full premiums due.

B. Disability. Enrollees who have been granted a waiver of premium for basic or supplemental life insurance prior to July 1, 1984, may continue OGB plan coverage for the duration of the waiver if the enrollee pays the total contribution to the participating employer. Disability waivers were discontinued effective July 1, 1984.

C. Surviving Dependents/Spouse

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

a. The surviving legal spouse of an enrollee may continue coverage unless or until the surviving spouse is or becomes eligible for coverage in a group health plan other than Medicare.

b. The surviving dependent child of an enrollee may continue coverage unless or until such dependent child is or becomes eligible for coverage under a group health plan other than Medicare or until attainment of the termination age for children, whichever occurs first.

c. Surviving dependents will be entitled to receive the same participating employer premium contributions as enrollees, subject to the provisions of *Louisiana Revised Statutes*, title 42, section 851 and rules promulgated pursuant thereto by OGB.

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

2. A surviving spouse or dependent child cannot add new dependents to continued coverage other than a child of the deceased enrollee born after the enrollee's death.

3. Participating Employer/Dependent Responsibilities

a. To continue coverage, it is the responsibility of the participating employer and surviving covered dependent to notify OGB within 60 days of the death of the enrollee.

b. OGB will notify the surviving dependents of their right to continue coverage.

c. Application for continued coverage shall be made in writing to OGB within 60 days of receipt of notification. Premiums for continued coverage shall be paid within 45 days of the coverage application date for the coverage to be effective on the date coverage would have otherwise terminated.

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

i. failure to pay the applicable premium timely;

or

ii. eligibility of the surviving spouse for coverage under a group health plan other than Medicare.

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

- i. failure to pay the applicable premium timely;
- ii. eligibility of the surviving dependent child for coverage under any group health plan other than Medicare; or
- iii. the attainment of the termination age for children.

4. The provisions of Paragraphs 1 through 3 of this Subsection are applicable to surviving dependents who, on or after July 1, 1999, elect to continue coverage following the death of an enrollee. Continued coverage for surviving dependents who made such election before July 1, 1999, shall be governed by the rules in effect at the time.

D. Over-Age Dependents. If a dependent child is incapable of self-sustaining employment by reason of mental or physical incapacity and became incapable prior to attainment of age 26, the coverage for the dependent child may be continued for the duration of incapacity.

1. Prior to such dependent child's attainment of age 26, an application for continued coverage is required to be submitted to OGB together with current medical information from the dependent child's attending physician to establish eligibility for continued coverage.

2. OGB may require additional medical documentation regarding the dependent child's incapacity upon receipt of the application for continued coverage and as often as it may deem necessary thereafter.

3. The incapacity determination shall be a medical determination subject to the appeal procedures of the enrollee's plan of benefits.

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

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

a. continue participation in any OGB self-funded plan during the period of active military service and the participating employer may continue to pay its portion of premiums; or

b. cancel participation in any OGB self-funded plan during the period of active military service and apply for reinstatement of OGB coverage within 30 days of:

- i. the date of the enrollee's reemployment with a participating employer;
- ii. the dependent's date of discharge from active military duty; or
- iii. the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select.

2. Plan participants who elect this option and timely apply for reinstatement of OGB coverage will not experience any adverse consequences with respect to the participation schedule set forth in R.S. 42:851(E) and the corresponding rules promulgated by OGB.

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

a. continue participation in OGB life insurance during the period of active military service, but the accidental death and dismemberment coverage will not be in effect during the period of active military duty; or

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

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§321. COBRA

A. Employees

1. Coverage under OGB for an enrollee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the enrollee no longer meets the definition of an employee, or coverage under a leave of absence has expired, unless the enrollee elects to continue coverage at the enrollee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.

2. It is the responsibility of the participating employer to notify OGB within 30 days of the date coverage would have terminated because of any of the foregoing events, and OGB will notify the enrollee within 14 days of his/her right to continue coverage.

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

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

- a. failure to pay the applicable premium timely;
- b. 18 months from the date coverage would have otherwise terminated;
- c. entitlement to Medicare;
- d. date coverage begins under a group health plan;

or

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

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

B. Surviving Dependents

1. Coverage under an OGB plan for covered surviving dependents will terminate on the last day of the month in which the enrollee's death occurs, unless the surviving covered dependents elect to continue coverage at their own expense.

2. It is the responsibility of the participating employer or surviving covered dependents to notify OGB within 30 days of the death of the enrollee. OGB will notify the surviving dependents of their right to continue coverage. Application for continued coverage shall be made in writing to OGB within 60 days of the date of the election notification.

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

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

- a. failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;
 - c. entitlement to Medicare;
 - d. date coverage begins under a group health plan;
- or
- e. the employer ceases to provide any group health plan coverage for its employees.

C. Divorced Spouse

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

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

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

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

- a. failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;
 - c. entitlement to Medicare;
 - d. date coverage begins under a group health plan;
- or
- e. the employer ceases to provide any group health plan coverage for its employees.

D. Dependent Children

1. Coverage under an OGB plan for a covered dependent child of an enrollee will terminate on the last day of the month during which the dependent child no longer meets the definition of an eligible covered dependent, unless

the dependent elects to continue coverage at his/her own expense.

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

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

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

- a. failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;
 - c. entitlement to Medicare;
 - d. date coverage begins under a group health plan;
- or
- e. the employer ceases to provide any group health plan coverage for its employees.

E. Dependents of COBRA Participants

1. If a covered terminated employee has elected to continue coverage for him/herself and covered dependents, and the enrollee dies, divorces his/her spouse, or the covered dependent child no longer meets the definition of an eligible dependent during the COBRA coverage period, then the dependents may elect to continue COBRA coverage. Coverage will not be continued beyond 36 months from the employee terminated.

2. It is the responsibility of the spouse and/or the dependent child to notify OGB within 60 days of the date COBRA coverage would have terminated.

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

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

- a. failure to pay the applicable premium timely;
 - b. 36 months beyond the date coverage would have otherwise terminated;
 - c. entitlement to Medicare;
 - d. date coverage begins under a group health plan;
- or
- e. the employer ceases to provide any group health plan coverage for its employees.

F. Disability COBRA

1. If a plan participant is determined by the Social Security Administration or by OGB (in the case of a person who is ineligible for Social Security disability benefits due to insufficient "quarters" of employment), to have been totally disabled on the date the plan participant became eligible for continued coverage or within the initial 18

months of coverage, coverage under an OGB plan for the plan participant who is totally disabled may be extended at his/her own expense up to a maximum of 29 months from the date the plan participant first became eligible for COBRA coverage.

2. To qualify, the plan participant shall:

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

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

ii. the date on which the plan participant loses (or would lose) coverage under the terms of the OGB plan as a result of the enrollee's termination or reduction of hours;

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

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

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

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

a. failure to pay the applicable premium timely;

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

c. entitlement to Medicare;

d. date coverage begins under a group health plan;

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

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

G. Medicare COBRA

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

benefits under OGB terminates, the period of continued coverage available for the enrollee's covered dependents will continue until the earliest of the following:

a. failure to pay the applicable premium timely;

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

c. entitlement to Medicare;

d. date coverage begins under a group health plan; or

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

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

H. Miscellaneous Provisions

1. During the COBRA coverage period, benefits will be identical to those provided to others enrolled in an OGB plan under its standard eligibility provisions for enrollees.

2. In the event OGB contracts for COBRA administration services, OGB may direct each plan participant eligible for COBRA coverage to follow the directions provided by OGB's COBRA administrator.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§323. Employer Responsibility

A. It is the responsibility of the participating employer to submit enrollment and coverage changes using OGB's electronic enrollment system and to review and certify all other necessary documentation to OGB on behalf of its employees. Employees of a participating employer will not, by virtue of furnishing any documentation to OGB be considered agents of OGB, and no representation made by any participating employer at any time will change the provisions of an OGB plan of benefits.

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

C. A participating employer that receives a Medicare secondary payer (MSP) collection notice or demand letter shall deliver the MSP notice to OGB within 15 days of receipt. If timely forwarded, OGB will assume responsibility for medical benefits, interest, fines and penalties due to Medicare for a plan participant. If not timely forwarded, OGB will assume responsibility only for covered plan benefits due to Medicare for a plan participant. The participating employer will be responsible for interest, fines, and penalties due.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 5. Uniform Provisions—Plan Administration

§501. Claims

A. To obtain the highest level of benefits available, the plan participant should always verify that a provider is a current network provider in the enrollee's plan of benefits before the service is rendered.

B. For OGB plan of benefits reimbursements, a claim shall include:

1. enrollee's name;
2. name of patient;
3. name, address, and telephone number of the provider of care;
4. diagnosis;
5. type of services rendered, with diagnosis and/or procedure codes that are valid and current for the date of service;
6. date and place of service;
7. charges;
8. enrollee's plan of benefits identification number;
9. provider tax identification number;
10. Medicare explanation of benefits, if applicable.

C. OGB or its agent may require additional documentation in order to determine the extent of coverage or the appropriate reimbursement. Failure to furnish information within the time period allowed by the respective OGB plan of benefits may constitute a reason for the denial of benefits.

D. A claim for benefits, under any self-funded plan of benefits offered by OGB shall be received by the enrollee's plan of benefits within one year from the date on which the medical expenses were incurred. The receipt date for electronically filed claims is the date on which the enrollee's plan of benefits receives the claim, not the date on which the claim is submitted to a clearinghouse or to the provider's practice management system.

E. Requests for review of payment or corrected bills shall be submitted within 12 months of receipt date of the original claim. Requests for review of payment or corrected bills received after that time will not be considered

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§503. Right to Receive and Release Information

A. To the extent permitted by federal or state law, OGB or its contractors may release to or obtain from any company, organization, or person, any information regarding any person which OGB or its contractors deem necessary to carry out the provisions of any OGB plan, or to determine how, or if, they apply. Any claimant under any OGB plan shall furnish OGB or its contractors with any information necessary to implement this provision. OGB or its contractors shall retain information for the minimum period of time required by law. After such time, information may no longer be available.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§505. Automated Claims Adjusting

A. Any OGB plan of benefits may utilize commercially licensed software that applies all claims against its medical

logic program to identify improperly billed charges and charges for which an OGB plan of benefits provides no benefits. Any claim with diagnosis or procedure codes deemed inadequate or inappropriate will be automatically reduced or denied. Providers accepting assignment of benefits cannot bill the plan participant for the differential on the denial amount, in whole or in part.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§507. Legal Limitations and Statement of Contractual Agreement

A. A plan participant's rights and benefits under any OGB plan of benefits are personal to him/her.

B. The OGB self-funded plan, as amended, including the schedule of benefits, together with the application for coverage and any related documents executed by or on behalf of the enrollee, constitute the entire agreement between the parties.

C. In the event of any conflict between the written provisions of the OGB plan or any OGB plan of benefits with any information provided by OGB or its contractors or rules or regulations promulgated by OGB, the written provisions of the OGB plan or plan of benefits shall supersede and control.

D. A plan participant shall exhaust the administrative claims review procedure before filing a suit for benefits. No legal action shall be brought to recover benefits under an OGB plan or plan of benefits more than one year after the time a claim is required to be filed or more than 30 days after mailing of the notice of a final administrative decision, whichever is later, unless otherwise provided in the terms of the participant's plan. A decision is not final until all levels of the administrative appeals process are exhausted.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§509. Benefit Payments to Other Group Health Plans

A. When payments that should have been made under an OGB plan of benefits, have been made by another group health plan, OGB may pay to the other plan the sum proper to satisfy the terms of the enrollee's OGB plan benefits.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§511. Recovery of Overpayments

A. If an overpayment occurs, OGB retains the right to recover the overpayment. The plan participant, institution, or provider receiving the overpayment must return the overpayment. At OGB's discretion, the overpayment may be deducted from future claims. Should legal action be required as a result of fraudulent statements or deliberate omissions on the application for coverage or a claim for benefits, the defendant shall be responsible for attorney fees of 25 percent of the overpayment or \$1,000, whichever is greater. The defendant shall also be responsible for court costs and legal interest from the date of judicial demand until paid.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§513. Subrogation and Reimbursement

A. Upon payment of any eligible benefits covered under an OGB plan of benefits, OGB shall succeed and be subrogated to all rights of recovery of the plan participant or his/her heirs or assigns for whose benefit payment is made and he/she shall execute and deliver instruments and papers and do whatever is necessary to secure such rights and shall do nothing to prejudice such rights.

B. OGB has an automatic lien against and shall be entitled, to the extent of any payment made to a plan participant, to 100 percent of the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of a plan participant against any person or entity legally responsible for the disease, illness, accident, or injury for which said payment was made.

C. To this end, plan participants agree to immediately notify OGB or its agent of any action taken to attempt to collect any sums against any person or entity responsible for the disease, illness, accident, or injury.

D. These subrogation and reimbursement rights also apply, but are not limited to, when a plan participant recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan, worker's compensation plan or any general liability plan.

E. Under these subrogation and reimbursement rights, OGB has a right of first recovery to the extent of any judgment, settlement, or any payment made to the plan participant, his/her heirs or assigns. These rights apply whether such recovery is designated as payment for pain and suffering, medical benefits, or other specified damages, even if he/she is not made whole (i.e., fully compensated for his/her injuries).

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§515. Program Responsibility

A. OGB will administer its self-funded plans in accordance with the plan terms, state and federal law, and OGB's established policies, interpretations, practices, and procedures. OGB will have maximum legal discretionary authority to construe and interpret the terms and provisions of the plan and its plan of benefits, to make determinations regarding eligibility for benefits, and to decide disputes which may arise relative to a plan participant's rights.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§517. Amendments to or Termination of the OGB Plan

A. OGB has the statutory responsibility of providing life, health, and other benefit programs to the extent that funds are available. OGB reserves the right to terminate, amend, or make adjustment to the eligibility and benefit provisions of any OGB plan or any plan benefits from time to time as necessary to prudently discharge its duties. Except for the pharmacy benefits management program, such modifications will be promulgated subject to the applicable provisions of law. Nothing contained herein shall be construed to guarantee or vest benefits for any plan participant.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§519. Eligible Expenses

A. Eligible expenses are the charges incurred for the services, drugs, supplies, and devices covered by the applicable plan of benefits, when performed, prescribed, or ordered by a physician or other authorized provider under a plan of benefits and medically necessary for the treatment of a plan participant. All charges are subject to applicable deductibles, co-payments, and/or co-insurance amounts, fee schedule limitations, schedule of benefits, limitations, exclusions, prior authorization requirements, benefit limits, drug utilization management, pharmacy benefits formulary, and other provisions of the plan of benefits. A charge is incurred on the date that the service, drug, supply, or device is performed or furnished.

B. Eligible expenses may be different depending on the plan of benefits selected by the enrollee. Eligible expenses for each plan of benefits are included in the respective plan document. OGB will make available a copy of its plan documents to its enrollees at the beginning of the plan year.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§521. Severability

A. If any provision or item of these rules or the application thereof is held invalid, such invalidity shall not affect other provisions, items, or applications of these rules which can be given effect without the invalidated provisions, items, or applications and to this end the provisions of these rules are hereby declared severable.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 7. Election Rules and Regulations

§701. Group Benefits Policy and Planning Board

Reserved.

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

HISTORICAL NOTE: Promulgated by Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§703. Candidate Eligibility

A. A candidate for a position on the Group Benefits Policy and Planning Board (OGB board) must be a participant in an OGB plan of benefits as of the specified election date.

B. If elected, the board member must continue to be a participant in an OGB plan of benefits during his/her tenure on the board.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§705. Petitions for Candidacy

A. To become a candidate, a person must be nominated by petition of 25 or more OGB plan enrollees from the ranks of the employees he/she will represent.

B. Each enrollee's signature must be accompanied by his/her Social Security number.

C. Each petition for candidacy must be signed by the appropriate agency head or his designated representative certifying that each candidate and each petitioner is a plan participant from the agency he/she will represent, and an active plan member on the specified election date.

D. Petitions for candidacy must be received by OGB on or before the date indicated on the election materials.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§707. Ballot Preparation and Distribution

A. Ballot positions of candidates will be determined by a drawing.

B. All candidates will be notified of the time and place of the drawing.

C. All candidates or his/her representative may attend the drawing.

D. Ballots and information sheets on candidates will be provided to eligible voters by OGB or its election vendor.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§709. Balloting Procedure

A. All enrollees in an OGB plan of Benefits on the specified election date are eligible to vote.

B. Each eligible enrollee may cast only one vote for any candidate listed on the ballot.

C. Each eligible enrollee must follow the voting directions provided by OGB. In the event OGB contracts with an election vendor for a particular election, each eligible enrollee must follow the voting directions provided by OGB's election vendor for his/her vote to be counted.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§711. Ballot Counting

A. The ballots will be counted by the ballot counting committee.

1. The ballot counting committee shall be composed of OGB employees appointed by the chief executive officer.

2. The ballot counting committee and all candidates will be notified at the time and date fixed for tallying the ballots.

3. The ballot counting committee will be responsible for the opening, preparation, and counting of the ballots.

4. All candidates or his/her representative may observe the ballot counting procedure.

B. In the event OGB contracts with an election vendor for a particular election, the election vendor will handle counting and verification of the ballots.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§713. Election Results

A. The chief executive officer will certify the election results to the OGB board.

B. The chief executive officer will notify the successful candidates of their election.

C. The OGB board will announce the election results at the first regularly scheduled board meeting following the election.

D. The OGB board will certify the election results to the Secretary of State.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§715. Uniform Election Dates

A. For each election date, the following dates will apply:

1. On the first Monday in March, OGB submits nomination sheets to each agency benefits coordinator.

2. The first Monday in April is the nomination cutoff date. Nominees must be certified by their agency before nominations can be accepted by OGB.

3. On the second Monday in April, OGB will hold the drawing at its principal office to determine the position each candidate will have on the ballot. All candidates are invited to attend or send a representative.

4. Prior to the first Monday in May, ballots will be sent to the proper authority for distribution.

5. The second Monday in June is the deadline for OGB to receive ballots.

6. By the third Monday in June, all ballots shall be counted.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 7:122 (March 1981), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§717. Petition Form

[Formerly §719]

A. Nominating Petition. Nominations will be submitted on a form substantially in compliance with the following.

We the undersigned OGB enrollees hereby nominate _____ for membership on the Office of Group Benefits Policy and Planning Board.			
Signature	Social Security Number	Agency	Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
I hereby certify the persons signing this petition are OGB enrollees as of the specified election date.			
_____ Agency Chief Personnel Officer			

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 7:50 (February 1981), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§721. Severability

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 6:200 (May 1980), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 9. Managed Care Arrangements Contracting Criteria

§901. Notice of Intent to Contract

A. Notice of intent to contract with managed care arrangements shall be given by publication in the official journal of the State of Louisiana or by written direct solicitation setting forth OGB’s intent to contract, describing the services sought, and providing a contact point for requesting a detailed explanation of the services sought and the criteria to be used in developing contracts.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 25:859 (May 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§903. Managed Care Arrangements Criteria

A. The following criteria shall govern contracting with managed care arrangements for the OGB plan of benefits.

1. The managed care arrangement shall be appropriately licensed in accordance with the laws of this state.

2. The managed care arrangement shall execute a contract with OGB.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§905. Exclusive Provider Organization (EPO) Criteria

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 25:859 (May 1999), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 11. Contributions

§1101. Collection and Deposit of Contributions

A. OGB shall be responsible for preparing and transmitting to each participating employer a monthly invoice premium statement delineating the enrolled employees of that agency as determined by the employer, each enrollee’s class of coverage, total amount of employer and employee contributions due to OGB, and such other items as are deemed necessary by OGB.

B. It shall be the responsibility of the participating employer to reconcile the monthly invoice premium statement, collect employee contributions by payroll deduction or otherwise, and remit the reconciled monthly invoice premium statement and both the employer and employee contributions to OGB within 30 days after receipt of the monthly premium invoice statement.

C. Payments received by OGB shall be allocated as follows:

1. first, to any late payment penalty due by the participating employer;
2. second, to any balance due from prior invoices; and
3. third, to the amount due under the current invoice.

D. All employer and employee premium contributions for the payment of premiums for OGB offered coverage shall be deposited directly with OGB. OGB shall pay all monies due for such benefits as they become due and payable.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 8:285 (June 1982), amended LR 26:2788 (December 2000), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§1103. Adjustments for Terminated Employees

A. Credit adjustments for premiums paid on behalf of enrollees whose coverage under an OGB plan of benefits is terminated by reason of termination of employment may not be made by the participating employer after reconciliation of the second invoice following the date of termination of employment.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 26:2788 (December 2000), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§1105. Penalty for Late Payment of Premiums

A. If any participating employer fails to remit, in full, both the employer and employee contributions to OGB within 30 days after receipt of the monthly invoice premium statement, then at the request of OGB, the state treasurer shall withhold from state funds due the participating employer the full amount of the delinquent employer and

employee contributions. The state treasurer shall remit this amount directly to OGB the participating employer shall pay a penalty equal to 1 percent of the total amount due and unpaid, compounded monthly.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 26:2788 (December 2000), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§1107. State Contribution toward Retirees' Health Premiums

A. For any person who is an active employee, as defined by R.S. 42:808 or OGB rule, and who does not participate in an OGB plan of benefits before January 1, 2002, but subsequently enrolls in an OGB plan of benefits, or any person who commences employment with an OGB participating employer on or after January 1, 2002, the state contribution of the premium for participation in an OGB plan of benefits plan upon retirement shall be:

1. 19 percent for those persons with less than 10 years of participation in an OGB plan of benefits before retirement;
2. 38 percent for those persons with 10 years of participation but less than 15 years of participation in an OGB plan of benefits before retirement;
3. 56 percent for those persons with 15 years of participation but less than 20 years of participation in an OGB plan of benefits before retirement;
4. 75 percent for those persons with 20 or more years of participation in an OGB plan of benefits before retirement.

B. The foregoing schedule will also apply to the state contribution toward premiums for surviving spouse and/or surviving dependent coverage for survivors of employees who retire on or after January 1, 2002, if such spouse and dependents are not enrolled in an OGB plan of benefits before July 1, 2002.

C. This rule does not affect the contributions paid by the state for:

1. any participant who is a covered retiree before January 1, 2002;
2. any active employee who is enrolled in an OGB plan of benefits before January 1, 2002, and maintains continuous coverage through retirement;
3. surviving spouse and/or surviving dependent coverage for survivors of employees who retire on or after January 1, 2002, if such spouse and dependents are enrolled in an OGB plan of benefits before July 1, 2002, and continuous coverage is maintained until the employee's death.

D. For the purpose of determining the percentage of the state contribution toward premiums in accordance with this rule, the number of years of participation in OGB plan of benefits must be certified by the participating employer from which the employee retires on a form provided by OGB.

1. Such certification must be based upon business records maintained by the participating employer or provided by the employee.

2. Business records upon which certification is based must be available to OGB, the Division of Administration, and to the Legislative Auditor.

3. Not more than 120 days prior an employee's scheduled date of retirement, OGB will provide to the participating employer, upon request, all information in its possession relating to an employee's participation.

4. At the time of application for surviving spouse and/or surviving dependent coverage, OGB will provide, upon request, all information in its possession relating to participation of such surviving spouse and/or surviving dependent.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 28:306 (February 2002), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§1109. Retirees with Medicare Parts A and B

A. Employees who retire on or after July 1, 1997, shall receive a reduced premium rate when enrolled in Medicare Parts A and B.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 28:306 (February 2002), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 13. Cost Assessment and Allocation

§1301. Cost Assessment and Allocation for FY 95/96

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Treasury, Board of Trustees, State Employees Group Benefits Program, LR 21:591 (June 1995), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Part III. Primary Plan of Benefits

Chapter 1. Operation of Primary Plan

§101. HMO Plan Structure—Magnolia Local Plus

A. Pursuant to R.S. 42:851H(1), OGB has authority to designate a primary plan. The Magnolia Local Plus Plan is designated hereby as the OGB primary plan.

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

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§103. Deductibles

Deductible Amount Per Benefit Period		
Individual:	Network	Non-Network
Active Employee/Retirees on or after March 1, 2015	\$400	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	\$800	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$1,200	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage

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

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§105. Out of Pocket Maximums

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
Individual:	Network	Non-Network
Active Employee/Retirees on or after March 1, 2015	\$2,500	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$1,000	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	\$5,000	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$2,000	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$7,500	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$3,000	No Coverage

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

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§107. Schedule of Benefits

A. Benefits, Copayments, and Coinsurance

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Physician Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics 	\$25 Copayment per Visit	No Coverage
Allied Health/Other Professional Visits: <ul style="list-style-type: none"> • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants 	\$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic 	\$50 Copayment per Visit	No Coverage
Ambulance Services – Ground (for Emergency Medical Transportation only)	\$50 Copayment	No Coverage
Ambulance Services – Air (for Emergency Medical Transportation only)	\$250 Copayment	No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	\$100 Copayment ²	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Autism Spectrum Disorders (ASD)	\$25/\$50 Copayment ³ per Visit depending on Provider	No Coverage
Birth Control Devices – Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	No Coverage
Cardiac Rehabilitation (limit of 48 visits per Plan Year)	\$25/\$50 Copayment per day depending on Provider \$50 Copayment - Outpatient Facility ²	No Coverage
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	Office - \$25 Copayment per Visit Outpatient Facility 100% - 0% ^{1,2}	No Coverage
Diabetes Treatment	80% - 20% ¹	No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	\$25 Copayment	No Coverage
Dialysis	100% - 0% ^{1,2}	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2} of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Emergency Room (Facility Charge)	\$150 Copayment; Waived if Admitted	
Emergency Medical Services (Non-Facility Charges)	100% - 0% ¹	100% - 0% ¹
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames – Limited to a Maximum Benefit of \$50 ^{1,3}	No Coverage
Flu shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	No Coverage
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older.)	80% - 20% ^{1,3}	No Coverage
Hearing Impaired Interpreter expense	100% - 0% ¹	No Coverage
High-Tech Imaging – Outpatient <ul style="list-style-type: none"> • CT Scans • MRA/MRI • Nuclear Cardiology • PET/SPECT Scans 	\$50 Copayment ²	No Coverage
Home Health Care (limit of 60 Visits per Plan Year)	100% - 0% ^{1,2}	No Coverage
Hospice Care (limit of 180 Days per Plan Year)	100% - 0% ^{1,2}	No Coverage
Injections Received in a Physician's Office (allergy and allergy serum)	100% - 0% ¹	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Inpatient Hospital Admission, All Inpatient Hospital Services Included	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable	100% - 0% ¹	No Coverage
Mastectomy Bras – Ortho-Mammary Surgical (limited to two (2) per Plan Year)	80% - 20% ^{1,2} of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Mental Health/Substance Abuse – Inpatient Treatment	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Mental Health/Substance Abuse – Outpatient Treatment	\$25 Copayment per Visit	No Coverage
Newborn – Sick, Services excluding Facility	100% - 0% ¹	No Coverage
Newborn – Sick, Facility	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Oral Surgery (Authorization not required when performed in Physician's office)	100% - 0% ^{1,2}	No Coverage
Pregnancy Care – Physician Services	\$90 Copayment per pregnancy	No Coverage
Preventive Care – Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.)	100% - 0% ³	No Coverage
Rehabilitation Services – Outpatient: • Physical/Occupational (Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.) • Speech • Cognitive • Hearing Therapy	\$25 Copayment per Visit	No Coverage
Skilled Nursing Facility – Network (limit of 90 days per Plan Year)	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Sonograms and Ultrasounds (Outpatient)	\$50 Copayment	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Urgent Care Center	\$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	\$25/\$50 Copayment depending on Provider	No Coverage
X-ray and Laboratory Services (low-tech imaging)	100% - 0%	No Coverage
¹ Subject to Plan Year Deductible		
² Pre-Authorization Required		
³ Age and/or Time Restrictions Apply		

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

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§109. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of \$1,500 Is Met	
Tier 1- Generic	\$0
Tier 2- Preferred	\$20
Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40
Prescription drug benefits-31 day refill	
Plan pays balance of eligible expenses	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the \$1,500 out of pocket maximum	
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

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

HISTORICAL NOTE: Promulgated by the by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 2. Termination of Coverage

§201. Active Employee and Retired Employee Coverage

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1888 (October 2006), repealed LR 41:

§203. Dependent Coverage

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1888 (October 2006), repealed LR 41:

Chapter 3. Medical Benefits

§301. Eligible Expenses

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1830 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:480 (March 2002), LR 29:339, 343 (March 2003), LR 30:1192 (June 2004), LR 31:441 (February 2005), LR 32:1888 (October 2006), LR 32:1898 (October 2006), LR 34:646 (April 2008), LR 34:646 (April 2008), effective May 1, 2008, LR 34:649 (April 2008), effective May 1, 2008, LR 34:2562 (December 2008), effective January 1, 2009, LR 36:2287 (October 2010), repealed LR 41:

§303. Fee Schedule

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1890 (October 2006), repealed LR 41:

§305. Automated Claims Adjusting

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1890 (October 2006), repealed LR 41:

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

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1890 (October 2006), repealed LR 41:

§309. Outpatient Procedure Certification (OPC)

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1832 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1890 (October 2006), LR 32:2253 (December 2006), repealed LR 41:

§311. Case Management

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1890 (October 2006), repealed LR 41:

§313. Dental Surgical Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1890 (October 2006), repealed LR 41:

§315. Medicare and OGB

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1833 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1891 (October 2006), LR 34:648 (April 2008), repealed LR 41:

§317. Exceptions and Exclusions

Repealed.

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

HISTORICAL NOTE: Promulgated Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1834 (October 1999), amended LR 26:488 (March 2000), LR 27:720 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:2343 (November 2002), LR 31:441 (February 2005), LR 32:1891 (October 2006), LR 34:647 (April 2008), effective May 1, 2008, repealed LR 41:

§321. Preferred Provider Program

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1835 (October 1999), amended LR 27:722 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:339 (March 2003), LR 32:1892 (October 2006), repealed LR 41:

§323. Prescription Drug Benefits

Repealed.

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

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

27:720, 721 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 27:1887 (November 2001), LR 28:2344 (November 2002), LR 29:342 (March 2003), LR 32:1892 (October 2006), LR 32:2254 (December 2006), LR 36:2286 (October 2010), repealed LR 41:

Chapter 4. Uniform Provisions

§401. Statement of Contractual Agreement

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1893 (October 2006), repealed LR 41:

§403. Properly Submitted Claim

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1893 (October 2006), repealed LR 41:

§405. When Claims Must Be Filed

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:479 (March 2002), LR 32:1893 (October 2006), repealed LR 41:

§407. Right to Receive and Release Information

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1893 (October 2006), repealed LR 41:

§409. Legal Limitations

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1836 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:479 (March 2002), LR 32:1893 (October 2006), repealed LR 41:

§411. Benefit Payments to Other Group Health Plans

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§413. Recovery of Overpayments

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:479 (March 2002), LR 32:1893 (October 2006), repealed LR 41:

§415. Subrogation and Reimbursement

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1893 (October 2006), repealed LR 41:

§417. Employer Responsibility

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:1819 (September 2003), LR 32:1894 (October 2006), repealed LR 41:

§419. Program Responsibility

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1894 (October 2006), repealed LR 41:

§421. Reinstatement to Position following Civil Service Appeal

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1837 (October 1999), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§423. Amendments to or Termination of the Plan and/or Contract

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1838 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1894 (October 2006), repealed LR 41:

Chapter 5. Claims Review and Appeal

§501. Administrative Review

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1838 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:479 (March 2002), LR 28:2344 (November 2002), repealed LR 41:

§503. Appeals from Medical Necessity Determinations

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 25:1838 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:479 (March 2002), LR 28:2344 (November 2002), repealed LR 41:

Chapter 6. Definitions

§601. Definitions

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1840 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:339 (March 2003), LR 32:1894 (October 2006), LR 35:66 (January 2009), repealed LR 41:

Chapter 7. Schedule of Benefits—PPO

§701. Comprehensive Medical Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1843 (October 1999), amended LR 26:488 (March 2000), LR 27:719, 720, 722 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 27:1887 (November 2001), LR 28:2345 (November 2002), LR 29:340, 342, 343 (March 2003), repromulgated LR 29:578 (April 2003), amended LR 30:1192 (June 2004), LR 32:1897 (October 2006), LR 33:644 (April 2007), LR 33:1122 (June 2007), LR 34:646 (April 2008), effective May 1, 2008, LR 36:2287 (October 2010), repealed LR 41:

§703. Mental Health and Substance Abuse

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1844 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:340 (March 2003), LR 36:2286 (October 2010), repealed LR 41:

Part V. Additional Plans and Operations

Chapter 1. Authority for OGB Alternative Plan Options

§101. OGB Authority

A. Pursuant to R.S. 42:851H(1) OGB may adopt, administer, operate, or contract for all or a portion of the administration, operation, or both of a primary self-funded program or additional programs with premium rate structures and state contribution rates which are different from the primary program.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§103. Continued Coverage

Repealed

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees, State Employees Group Benefits Program, LR 25:1806 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits LR 30:1190 (June 2004), LR 32:1856 (October 2006), repealed LR 41:

§105. COBRA

Repealed

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1807 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1857 (October 2006), repealed LR 41:

§107. Change of Classification

Repealed

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1859 (October 2006), repealed LR 41:

§109. Contributions

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 2. PPO Plan Structure - Magnolia Open Access Plan

§201. Deductibles

Deductible Amount Per Benefit Period		
Individual:	Network	Non-Network
Active Employee/Retirees on or after March 1, 2015	\$900	\$900
Retirees prior to March 1, 2015 (With and Without Medicare)	\$300	
Individual, Plus One Dependent (Spouse or Child):		
Active Employee/Retirees on or after March 1, 2015	\$1,800	\$1,800
Retirees prior to March 1, 2015 (With and Without Medicare)	\$600	
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$2,700	\$2,700
Retirees prior to March 1, 2015 (With and Without Medicare)	\$900	

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1809 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1860 (October 2006), repealed LR 41:

§203. Out of Pocket Maximums

Includes All Eligible Copayments, Coinsurance Amounts and Deductibles					
	Active Employee/Retirees on or after March 1, 2015		Retirees prior to March 1, 2015 Without Medicare		Retirees prior to March 1, 2015 With Medicare
	Network	Non-Network	Network	Non-Network	Network and Non-Network
Individual Only	\$2,500	\$3,700	\$1,300	\$3,300	\$2,300
Individual Plus One (Spouse or Child)	\$5,000	\$7,500	\$2,600	\$6,600	\$4,600
Individual Plus Two	\$7,500	\$11,250	\$3,900	\$9,900	\$6,900
Individual Plus Three	\$7,500	\$11,250	\$4,900	\$12,700	\$8,900
Individual Plus Four	\$7,500	\$11,250	\$5,900	\$12,700	\$10,900
Individual Plus Five	\$7,500	\$11,250	\$6,900	\$12,700	\$12,700
Individual Plus Six	\$7,500	\$11,250	\$7,900	\$12,700	\$12,700
Individual Plus Seven	\$7,500	\$11,250	\$8,900	\$12,700	\$12,700
Individual Plus Eight	\$7,500	\$11,250	\$9,900	\$12,700	\$12,700
Individual Plus Nine	\$7,500	\$11,250	\$10,900	\$12,700	\$12,700
Individual Plus Ten	\$7,500	\$11,250	\$11,900	\$12,700	\$12,700
Individual Plus Eleven or More	\$7,500	\$11,250	\$12,700	\$12,700	\$12,700

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§205. Schedule of Benefits

A. Benefits and Coinsurance

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Physician Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics 	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Allied Health/Other Professional Visits: <ul style="list-style-type: none"> • Chiropractors • Federally Funded Qualified Rural Health Clinics • Nurse Practitioners • Retail Health Clinics • Optometrists • Physician Assistants 	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Specialist (Physician) Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • Physician • Podiatrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic 	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Ambulance Services - Ground (for Medically Necessary Transportation only)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Ambulance Services - Air (for Medically Necessary Transportation only)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Ambulatory Surgical Center and Outpatient Surgical Facility	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Autism Spectrum Disorders (ASD)	90% - 10% ^{1,3}	70% - 30% ^{1,3}	80% - 20% ^{1,3}

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Care Article in the Benefit Plan)	100% - 0%	70% - 30% ¹	Network Providers 100% - 0% Non-Network Providers 80% - 20% ¹
Cardiac Rehabilitation (must begin within six months of qualifying event)	90% - 10% ^{1,2,3}	70% - 30% ^{1,2,3}	80% - 20% ^{1,3}
Chemotherapy/Radiation Therapy	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Diabetes Treatment	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	90% - 10% ¹	Not Covered	80% - 20% ¹
Dialysis	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Emergency Room (Facility Charge)	\$150 Separate Deductible ¹ ; Waived if Admitted		
Emergency Medical Services (Non-Facility Charges)	90% - 10% ¹	90% - 10% ¹	80% - 20% ¹
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (purchased within six months following cataract surgery)	Eyeglass Frames - Limited to a Maximum Benefit of \$50 ^{1,3}		
Flu shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	100% - 0%	100% - 0%
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older)	90% - 10% ^{1,3}	70% - 30% ^{1,3}	80% - 20% ^{1,3}
High-Tech Imaging – Outpatient <ul style="list-style-type: none"> • CT Scans • MRA/MRI • Nuclear Cardiology • PET/SPECT Scans 	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Home Health Care (limit of 60 Visits per Plan Year)	90% - 10% ^{1,2}	70% - 30% ^{1,2}	Not Covered
Hospice Care (limit of 180 Days per Plan Year)	80% - 20% ^{1,2}	70% - 30% ^{1,2}	Not Covered
Injections Received in a Physician's Office (when no other health service is received)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Inpatient Hospital Admission, All Inpatient Hospital Services Included Per Day Copayment Day Maximum Coinsurance	\$0 Not Applicable 90% - 10% ^{1,2}	\$50 5 Days 70% - 30% ^{1,2}	\$0 Not Applicable 80% - 20% ¹
Inpatient and Outpatient Professional Services	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Mastectomy Bras - Ortho-Mammary Surgical (limit of three (3) per Plan Year)	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Mental Health/Substance Abuse - Inpatient Treatment Per Day Copayment Day Maximum Coinsurance	\$0 Not Applicable 90% - 10% ^{1,2}	\$50 5 Days 70% - 30% ^{1,2}	\$0 Not Applicable 80% - 20% ¹
Mental Health/Substance Abuse - Outpatient Treatment	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Newborn - Sick, Services Excluding Facility	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Newborn - Sick, Facility Per Day Copayment Day Maximum Coinsurance	\$0 Not Applicable 90% - 10% ^{1,2}	\$50 5 Days 70% - 30% ^{1,2}	\$0 Not Applicable 80% - 20% ¹

	Coinsurance		
	Active Employees/ Non-Medicare Retirees (regardless of retire date)		Retirees with Medicare (regardless of retire date)
	Network Providers	Non-Network Providers	Network and Non-Network Providers
Oral Surgery for Impacted Teeth (<i>Authorization not required when performed in Physician's office</i>)	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Pregnancy Care - Physician Services	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (<i>For a complete list of benefits, refer to the Preventive and Wellness Care Article in the Benefit Plan.</i>)	100% - 0% ³	70% - 30% ^{1,3}	Network 100% - 0 ³
			Non-Network 80% - 20% ^{1,3}
Rehabilitation Services - Outpatient: <ul style="list-style-type: none"> Speech Physical/Occupational <i>(Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.)</i> <i>(Visit limits do not apply when services are provided for Autism Spectrum Disorders)</i>	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Skilled Nursing Facility <i>(limit 90 days per Plan Year)</i>	90% - 10% ^{1,2}	70% - 30% ^{1,2}	80% - 20% ¹
Sonograms and Ultrasounds (<i>Outpatient</i>)	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Urgent Care Center	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
Vision Care (Non-Routine) Exam	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
X-ray and Laboratory Services <i>(low-tech imaging)</i>	90% - 10% ¹	70% - 30% ¹	80% - 20% ¹
¹ Subject to Plan Year Deductible			
² Pre-Authorization Required			
³ Age and/or Time Restrictions Apply			

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§207. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of \$1,500 Is Met	
Tier 1- Generic	\$0
Tier 2- Preferred	\$20
Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40
Prescription drug benefits-31 day refill	
Plan pays balance of eligible expenses	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the \$1,500 out of pocket maximum	

Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 3. Narrow Network HMO Plan Structure—Magnolia Local Plan (in certain geographical areas)

§301. Deductibles

Deductible Amount Per Benefit Period		
Individual:	Network	Non-Network
Active Employee/Retirees on or after March 1, 2015	\$400	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	\$800	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$1,200	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$0	No Coverage

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§303. Out of Pocket Maximums

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
Individual:	Network	Non-Network
Active Employee/Retirees on or after March 1, 2015	\$2,500	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$1,000	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	\$5,000	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$2,000	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	\$7,500	No Coverage
Retirees prior to March 1, 2015 (With and Without Medicare)	\$3,000	No Coverage

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§305. Schedule of Benefits

A. Benefits, Copayments, and Coinsurance

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Physician Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics 	\$25 Copayment per Visit	No Coverage
Allied Health/Other Professional Visits: <ul style="list-style-type: none"> • Chiropractors • Federally Funded Qualified Rural • Health Clinics • Nurse Practitioners • Retail Health Clinics • Physician Assistants 	\$25 Copayment per Visit	No Coverage
Specialist Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic 	\$50 Copayment per Visit	No Coverage
Ambulance Services - Ground (for Emergency Medical Transportation only)	\$50 Copayment	No Coverage
Ambulance Services - Air (for Emergency Medical Transportation only)	\$250 Copayment	No Coverage
Ambulatory Surgical Center and Outpatient Surgical Facility	\$100 Copayment ²	No Coverage
Autism Spectrum Disorders (ASD)	\$25/\$50 Copayment ³ per Visit depending on Provider	No Coverage
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan.)	100% - 0%	No Coverage
Cardiac Rehabilitation (limit of 48 visits per Plan Year)	\$25/\$50 Copayment per day depending on Provider \$50 Copayment - Outpatient Facility ²	No Coverage
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	Office - \$25 Copayment per Visit Outpatient Facility 100% - 0% ^{1,2}	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Diabetes Treatment	80% - 20% ¹	No Coverage
Diabetic/Nutritional Counseling - Clinics and Outpatient Facilities	\$25 Copayment	No Coverage
Dialysis	100% - 0% ^{1,2}	No Coverage
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2} of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Emergency Room (<i>Facility Charge</i>)	\$150 Copayment; Waived if Admitted	
Emergency Medical Services (<i>Non-Facility Charges</i>)	100% - 0% ¹	100% - 0% ¹
Eyeglass Frames and One Pair of Eyeglass Lenses or One Pair of Contact Lenses (<i>purchased within six months following cataract surgery</i>)	Eyeglass Frames – Limited to a Maximum Benefit of \$50 ^{1,3}	No Coverage
Flu shots and H1N1 vaccines (<i>administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair</i>)	100% - 0%	No Coverage
Hearing Aids (<i>Hearing Aids are not covered for individuals age eighteen (18) and older.</i>)	80% - 20% ^{1,3}	No Coverage
Hearing Impaired Interpreter expense	100% - 0% ¹	No Coverage
High-Tech Imaging - Outpatient <ul style="list-style-type: none"> •CT Scans •MRA/MRI •Nuclear Cardiology •PET/SPECT Scans 	\$50 Copayment ²	No Coverage
Home Health Care (<i>limit of 60 Visits per Plan Year</i>)	100% - 0% ^{1,2}	No Coverage
Hospice Care (<i>limit of 180 Days per Plan Year</i>)	100% - 0% ^{1,2}	No Coverage
Injections Received in a Physician's Office (<i>allergy and allergy serum</i>)	100% - 0% ¹	No Coverage
Inpatient Hospital Admission, All Inpatient Hospital Services Included	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Inpatient and Outpatient Professional Services for Which a Copayment Is Not Applicable	100% - 0% ¹	No Coverage
Mastectomy Bras - Ortho-Mammary Surgical (<i>limited to two (2) per Plan Year</i>)	80% - 20% ^{1,2} of first \$5,000 Allowable per Plan Year; 100% - 0% of Allowable in Excess of \$5,000 per Plan Year	No Coverage
Mental Health/Substance Abuse - Inpatient Treatment	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Mental Health/Substance Abuse - Outpatient Treatment	\$25 Copayment per Visit	No Coverage
Newborn - Sick, Services excluding Facility	100% - 0% ¹	No Coverage

	Copayments and Coinsurance	
	Network Providers	Non-Network Providers
Newborn - Sick, Facility	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Oral Surgery (<i>Authorization not required when performed in Physician's office</i>)	100% - 0% ^{1,2}	No Coverage
Pregnancy Care - Physician Services	\$90 Copayment per pregnancy	No Coverage
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (<i>For a complete list of benefits, refer to the Preventive and Wellness Article in the Benefit Plan.</i>)	100% - 0% ³	No Coverage
Rehabilitation Services - Outpatient: <ul style="list-style-type: none"> •Physical/Occupational (<i>Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.</i>) •Speech •Cognitive •Hearing Therapy 	\$25 Copayment per Visit	No Coverage
Skilled Nursing Facility - Network (<i>limit of 90 days per Plan Year</i>)	\$100 Copayment per day ² , maximum of \$300 per Admission	No Coverage
Sonograms and Ultrasounds (<i>Outpatient</i>)	\$50 Copayment	No Coverage
Urgent Care Center	\$50 Copayment	No Coverage
Vision Care (Non-Routine) Exam	\$25/\$50 Copayment depending on Provider	No Coverage
X-ray and Laboratory Services (<i>low-tech imaging</i>)	100% - 0%	No Coverage

¹Subject to Plan Year Deductible
²Pre-Authorization Required
³Age and/or Time Restrictions Apply

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§307. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of \$1,500 Is Met	
Tier 1- Generic	\$0
Tier 2- Preferred	\$20
Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40

Prescription drug benefits-31 day refill
Plan pays balance of eligible expenses
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the \$1,500 out of pocket maximum
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§309. Outpatient Procedure Certification (OPC)

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1862 (October 2006), LR 32:2253 (December 2006), repealed LR 41:

§311. Case Management

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1812 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1862 (October 2006), repealed LR 41:

§313. Dental Surgical Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1862 (October 2006), repealed LR 41:

§315. Medicare and OGB

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1862 (October 2006), LR 34:648 (April 2008), repealed LR 41:

§317. Exceptions and Exclusions

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1813 (October 1999), amended LR 26:487 (March 2000), LR 27:717 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:2340 (November 2002), LR 31:440 (February 2005), LR 32:1863 (October 2006), LR 34:647 (April 2008), effective May 1, 2008, repealed LR 41:

§319. Coordination of Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1814 (October 1999), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§321. Exclusive Provider Program

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1814 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1864 (October 2006), repealed LR 41:

§325. Prescription Drug Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1815 (October 1999), amended LR 27:717 (May 2001), LR 27:718 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 27:1886 (November 2001), LR 28:2340 (November 2002), LR 29:337 (March 2003), LR 32:1864 (October 2006), LR 32:2254 (December 2006), repealed LR 41:

Chapter 4. PPO/Consumer-Driven Health Plan Structure—Pelican HSA 775 Plan

§401. Deductibles

Deductible Amount Per Benefit Period:	Network	Non-Network
Individual:	\$2,000	\$4,000
Family:	\$4,000	\$8,000
Coinsurance:	Plan	Plan Participant
Network Providers	80%	20%
Non-Network Providers	60%	40%

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§403. Out of Pocket Maximums

A. Out-of-Pocket Maximum Per Benefit Period

Includes All Eligible Deductibles Coinsurance Amounts and Prescription Drug Copayments:		
	Network	Non-Network
Individual:	\$5,000	\$10,000
Family:	\$10,000	\$20,000

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

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§405. Schedule of Benefits

A. Benefits and Coinsurance

	Coinsurance	
	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics 	80% - 20% ¹	60% - 40% ¹
Allied Health/Other Office Visits: <ul style="list-style-type: none"> • Chiropractors • Federally Funded Qualified Rural Health Clinics • Retail Health Clinics • Nurse Practitioners • Physician's Assistants 	80% - 20% ¹	60% - 40% ¹
Specialist Office Visits including surgery performed in an office setting: <ul style="list-style-type: none"> • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic 	80% - 20% ¹	60% - 40% ¹
Ambulance Services (for Emergency Medical Transportation Only) <ul style="list-style-type: none"> • Ground Transportation • Air Ambulance 	80% - 20% ¹	80% - 20% ¹
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Autism Spectrum Disorders (ASD) - Office Visits	80% - 20% ^{1,3}	60% - 40% ^{1,3}
Autism Spectrum Disorders (ASD) - Inpatient Hospital	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	60% - 40% ¹
Cardiac Rehabilitation (must begin within six months of qualifying event; limited to 26 visits per Plan Year)	80% - 20% ^{1,2,3}	60% - 40% ^{1,2,3}
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	80% - 20% ^{1,2}	60% - 40% ^{1,2}

	Coinsurance	
	Network Providers	Non-Network Providers
Diabetes Treatment	80% - 20% ¹	60% - 40% ¹
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20% ¹	Not Covered
Dialysis	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Emergency Room (Facility Charge)	80% - 20% ¹	80% - 20% ¹
Emergency Medical Services (Non-Facility Charge)	80% - 20% ¹	80% - 20% ¹
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	100% - 0%
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older)	80% - 20% ^{1,3}	Not Covered
High-Tech Imaging – Outpatient ² (CT Scans, MRI/MRA, Nuclear Cardiology, PET/SPECT Scans)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Home Health Care (limit of 60 Visits per Plan Year, combination of Network and Non-Network) (one Visit = 4 hours)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Hospice Care (limit of 180 Days per Plan Year, combination of Network and Non-Network)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Injections Received in a Physician's Office (when no other health service is received)	80% - 20% ¹ per injection	60% - 40% ¹ per injection
Inpatient Hospital Admission (all Inpatient Hospital services included)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Inpatient and Outpatient Professional Services	80% - 20% ¹	60% - 40% ¹
Mastectomy Bras – Ortho-Mammary Surgical (limited to two (2) per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Mental Health/Substance Abuse – Inpatient Treatment	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Mental Health/Substance Abuse – Outpatient Treatment	80% - 20% ¹	60% - 40% ¹
Newborn – Sick, Services excluding Facility	80% - 20% ¹	60% - 40% ¹
Newborn – Sick, Facility	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Oral Surgery for Impacted Teeth (Authorization not required when performed in Physician's office)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Pregnancy Care - Physician Services	80% - 20% ¹	60% - 40% ¹
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan.)	100% - 0% ³	100% - 0% ³
Rehabilitation Services - Outpatient: <ul style="list-style-type: none"> • Physical/Occupational (Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.) • Speech (Visit limits are a combination of Network and Non-Network Benefits; visit limits do not apply when services are provided for Autism Spectrum Disorders.)	80% - 20% ¹	60% - 40% ¹

	Coinsurance	
	Network Providers	Non-Network Providers
Skilled Nursing Facility (<i>limit 90 Days per Plan Year</i>)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Sonograms and Ultrasounds - Outpatient	80% - 20% ¹	60% - 40% ¹
Urgent Care Center	80% - 20% ¹	60% - 40% ¹
Vision Care (Non-Routine) Exam	80% - 20% ¹	60% - 40% ¹
X-Ray and Laboratory Services (<i>low-tech imaging</i>)	80% - 20% ¹	60% - 40% ¹
¹ Subject to Plan Year Deductible		
² Pre-Authorization Required		
³ Age and/or Time Restrictions Apply		

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

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§407. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Generic	\$10 co-pay
Preferred	\$25 co-pay
Non-preferred	\$50 co-pay
Specialty	\$50 co-pay
Prescription drug benefits-31 day refill	
Maintenance drugs: not subject to deductible; subject to applicate co-payments above.	
Plan pays balance of eligible expenses	
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug	
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.	
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.	
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.	

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

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

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1865 (October 2006), repealed LR 41:

§409. Legal Limitations

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 28:477 (March 2002), amended, LR 32:1865 (October 2006), repealed LR 41:

§411. Benefit Payment to Other Group Health Plans

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§413. Recovery of Overpayments

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1816 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1865 (October 2006), repealed LR 41:

§415. Subrogation and Reimbursement

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1817 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1865 (October 2006), repealed LR 41:

§417. Employer Responsibility

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1817 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:1819 (September 2003), LR 32:1866 (October 2006), repealed LR 41:

§419. Program Responsibility

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1817 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1866 (October 2006), repealed LR 41:

§421. Reinstatement to Position following Civil Service Appeal

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1817 (October 1999), repealed by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§423. Amendments to or Termination of the Plan and/or Contract

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1818 (October 1999), by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 32:1866 (October 2006), repealed LR 41:

Chapter 5. PPO/Consumer-Driven Health Plan Structure—Pelican HRA 1000 Plan

§501. Deductibles

Deductible Amount Per Benefit Period:	Network	Non-Network
Individual:	\$2,000	\$4,000
Family:	\$4,000	\$8,000
Coinsurance:	Plan	Plan Participant
Network Providers	80%	20%
Non-Network Providers	60%	40%

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

HISTORICAL NOTE: Promulgated by the Office of the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§503. Out of Pocket Maximums

A. Out-of-Pocket Maximum per Benefit Period

Includes All Eligible Deductibles, Coinsurance Amounts and Copayments		
	Network	Non-Network
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§505. Schedule of Benefits

A. Benefits and Coinsurance

	Coinsurance	
	Network Providers	Non-Network Providers
Physician's Office Visits including surgery performed in an office setting: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	80% - 20% ¹	60% - 40% ¹
Allied Health/Other Office Visits: • Chiropractors • Federally Funded Qualified Rural Health Clinics • Retail Health Clinics • Nurse Practitioners • Physician's Assistants	80% - 20% ¹	60% - 40% ¹
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist	80% - 20% ¹	60% - 40% ¹

	Coinsurance	
	Network Providers	Non-Network Providers
• Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic		
Ambulance Services (for Emergency Medical Transportation Only) • Ground Transportation • Air Ambulance	80% - 20% ¹	80% - 20% ¹
Ambulatory Surgical Center and Outpatient Surgical Facility	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Autism Spectrum Disorders (ASD) - Office Visits	80% - 20% ^{1,3}	60% - 40% ^{1,3}
Autism Spectrum Disorders (ASD) - Inpatient Hospital	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Birth Control Devices - Insertion and Removal (as listed in the Preventive and Wellness Article in the Benefit Plan)	100% - 0%	60% - 40% ¹
Cardiac Rehabilitation (must begin within six months of qualifying event; limited to 26 visits per Plan Year)	80% - 20% ^{1,2,3}	60% - 40% ^{1,2,3}
Chemotherapy/Radiation Therapy (Authorization not required when performed in Physician's office)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Diabetes Treatment	80% - 20% ¹	60% - 40% ¹
Diabetic/Nutritional Counseling – Clinics and Outpatient Facilities	80% - 20% ¹	Not Covered
Dialysis	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Emergency Room (Facility Charge)	80% - 20% ¹	80% - 20% ¹
Emergency Medical Services (Non-Facility Charge)	80% - 20% ¹	80% - 20% ¹
Flu Shots and H1N1 vaccines (administered at Network Providers, Non-Network Providers, Pharmacy, Job Site or Health Fair)	100% - 0%	100% - 0%
Hearing Aids (Hearing Aids are not covered for individuals age eighteen (18) and older)	80% - 20% ^{1,3}	Not Covered
High-Tech Imaging - Outpatient (CT Scans, MRI/MRA, Nuclear Cardiology, PET/SPECT Scans)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Home Health Care (limit of 60 Visits per Plan Year, combination of Network and Non-Network) (one Visit = 4 hours)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Hospice Care (limit of 180 Days per Plan Year, combination of Network and Non-Network)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Injections Received in a Physician's Office (when no other health service is received)	80% - 20% ¹ per injection	60% - 40% ¹ per injection
Inpatient Hospital Admission (all Inpatient Hospital services included)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Inpatient and Outpatient Professional Services	80% - 20% ¹	60% - 40% ¹
Mastectomy Bras - Ortho-Mammary Surgical (limited to two (2) per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Mental Health/Substance Abuse - Inpatient Treatment	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Mental Health/Substance Abuse - Outpatient Treatment	80% - 20% ¹	60% - 40% ¹

	Coinsurance	
	Network Providers	Non-Network Providers
Newborn - Sick, Services excluding Facility	80% - 20% ¹	60% - 40% ¹
Newborn - Sick, Facility	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Oral Surgery for Impacted Teeth (Authorization not required when performed in Physician's office)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Pregnancy Care - Physician Services	80% - 20% ¹	60% - 40% ¹
Preventive Care - Services include screening to detect illness or health risks during a Physician office visit. The Covered Services are based on prevailing medical standards and may vary according to age and family history. (For a complete list of benefits, refer to the Preventive and Wellness/Routine Care Article in the Benefit Plan.)	100% - 0% ³	100% - 0% ³
Rehabilitation Services - Outpatient: • Physical/Occupational (Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.) • Speech (Visit limits are a combination of Network and Non-Network Benefits; visit limits do not apply when services are provided for Autism Spectrum Disorders.)	80% - 20% ¹	60% - 40% ¹
Skilled Nursing Facility (limit 90 Days per Plan Year)	80% - 20% ^{1,2}	60% - 40% ^{1,2}
Sonograms and Ultrasounds - Outpatient	80% - 20% ¹	60% - 40% ¹
Urgent Care Center	80% - 20% ¹	60% - 40% ¹
Vision Care (Non-Routine) Exam	80% - 20% ¹	60% - 40% ¹
X-Ray and Laboratory Services (low-tech imaging)	80% - 20% ¹	60% - 40% ¹
¹ Subject to Plan Year Deductible		
² Pre-Authorization Required		
³ Age and/or Time Restrictions Apply		

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

§507. Prescription Drug Benefits

A. Prescription Drug Benefits

Network Pharmacy	Member pays
Tier 1- Generic	50% up to \$30
Tier 2- Preferred	50% up to \$55
Tier 3- Non-preferred	65% up to \$80
Tier 4- Specialty	50% up to \$80
90 day supplies for maintenance drugs from mail order OR at participating 90-day retail network pharmacies	Two and a half times the cost of your applicable co-payment
Co-Payment after the Out Of Pocket Amount of \$1,500 Is Met	
Tier 1- Generic	\$0
Tier 2- Preferred	\$20
Tier 3- Non-preferred	\$40
Tier 4- Specialty	\$40
Prescription drug benefits-31 day refill	
Maintenance drugs: not subject to deductible; subject to applicable co-payments above.	

Plan pays balance of eligible expenses
Member who chooses a brand-name drug for which an approved generic version is available, pays the cost difference between the brand-name drug & the generic drug, plus the co-pay for the brand-name drug; the cost difference does not apply to the \$1,500 out of pocket maximum
Medications available over-the-counter in the same prescribed strength are not covered under the pharmacy plan.
Smoking Cessation Medications: Benefits are available for Prescription and over-the-counter (OTC) smoking cessation medications when prescribed by a physician. (Prescription is required for over-the-counter medications). Smoking cessation medications are covered at 100%.
This plan allows benefits for drugs and medicines approved by the Food and Drug Administration or its successor that require a prescription. Utilization management criteria may apply to specific drugs or drug categories to be determined by PBM.

B. OGB shall have discretion to adopt a pharmacy benefits formulary to help enrollees select the most appropriate, lowest-cost options. The formulary will be reviewed on a quarterly basis to reassess drug tiers based on the current prescription drug market. The formulary may be changed from time to time subject to any applicable advance notice requirements. The amount enrollees pay toward prescription medications will depend on whether they purchase a generic, preferred brand, non-preferred brand, or specialty drug.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Chapter 6. Definitions

§601. Definitions

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1820 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:335 (March 2003), LR 32:1866 (October 2006), LR 35:67 (January 2009), repealed LR 41:

Chapter 7. Schedule of Benefits—EPO

§701. Comprehensive Medical Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees' Group Benefits Program, LR 25:1823 (October 1999), amended LR 26:487 (March 2000), LR 27:717 and 719 (May 2001), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 27:1886 (November 2001), LR 28:476 (March 2002), LR 28:2342, 2343 (November 2002), repromulgated LR 28:2509 (December 2002), amended LR 29:335, 337, 338 (March 2003), LR 30:1190 (June 2004), LR 32:1869 (October 2006), LR 33:644 (April 2007), LR 33:1122 (June 2007), LR 34:647 (April 2008), effective May 1, 2008, repealed LR 41:

§703. Mental Health and Substance Abuse

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Board of Trustees of the State Employees Group Benefits Program, LR 25:1824 (October 1999), amended by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:335 (March 2003), repealed LR 41:

Part IX. Managed Care Option (MCO)—Plan of Benefits

Chapter 1. Eligibility

§101. Persons to be Covered

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:883 (June 2003), amended LR 32:1870 (October 2006), repealed LR 41:

§103. Continued Coverage

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:885 (June 2003), amended LR 30:1191 (June 2004), LR 32:1870 (October 2006), repealed LR 41:

§105. COBRA

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:886 (June 2003), amended LR 32:1871 (October 2006), repealed LR 41:

§107. Change of Classification

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:887 (June 2003), amended LR 32:1874 (October 2006), repealed LR 41:

§109. Contributions

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:888 (June 2003), repealed LR 41:

Chapter 2. Termination of Coverage

§201. Active Employee and Retired Employee Coverage

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:888 (June 2003), amended LR 32:1874 (October 2006), repealed LR 41:

§203. Dependent Coverage Only

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:888 (June 2003), amended LR 32:1874 (October 2006), repealed LR 41:

Chapter 3. Medical Benefits

§301. Eligible Expenses

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:888 (June 2003), amended LR 30:1191 (June 2004), LR 31:440 (February 2005), LR 32:1874 (October 2006), LR 32:1899 (October 2006), repealed LR 41:

§303. Fee Schedule

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:890 (June 2003), amended LR 32:1876 (October 2006), repealed LR 41:

§305. Automated Claims Adjusting

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:890 (June 2003), amended LR 32:1876 (October 2006), repealed LR 41:

§307. Utilization Review—Pre-Admission

Certification, Continued Stay Review

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:890 (June 2003), amended LR 32:1876 (October 2006), repealed LR 41:

§309. Outpatient Procedure Certification (OPC)

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:891 (June 2003), amended LR 32:1877 (October 2006), LR 32:2253 (December 2006), repealed LR 41:

§311. Case Management

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:891 (June 2003), amended LR 32:1877 (October 2006), repealed LR 41:

§313. Dental Surgical Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:891 (June 2003), amended LR 32:1877 (October 2006), repealed LR 41:

§315. Medicare Reduction

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:891 (June 2003), amended LR 32:1877 (October 2006), repealed LR 41:

§317. Exceptions and Exclusions

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 25:1834 (October 1999), amended LR 26:488 (March 2000), LR 27:720 (May 2001), LR 28:2343 (November 2002), LR 29:892 (June 2003), LR 31:441 (February 2005), LR 32:1877 (October 2006), repealed LR 41:

§319. Coordination of Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:893 (June 2003), repealed LR 41:

§321. Managed Care Option

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:893 (June 2003), repealed LR 41:

§323. Prescription Drug Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:893 (June 2003), amended LR 32:1878 (October 2006), LR 32:2255 (December 2006), repealed LR 41:

Chapter 4. Uniform Provisions

§401. Statement of Contractual Agreement

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:894 (June 2003), amended LR 32:1879 (October 2006), repealed LR 41:

§403. Properly Submitted Claim

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits LR 29:894 (June 2003), amended LR 32:1879 (October 2006), repealed LR 41:

§405. When Claims Must Be Filed

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), amended LR 32:1879 (October 2006), repealed LR 41:

§407. Right to Receive and Release Information

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits,

LR 29:895 (June 2003), amended LR 32:1879 (October 2006), repealed LR 41:

§409. Legal Limitations

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), amended LR 32:1879 (October 2006), repealed LR 41:

§411. Benefit Payment to other Group Health Plans

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), repealed LR 41:

§413. Recovery of Overpayments

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), amended LR 32:1879 (October 2006), repealed LR 41:

§415. Subrogation and Reimbursement

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:895 (June 2003), amended LR 32:1880 (October 2006), repealed LR 41:

§417. Employer Responsibility

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:896 (June 2003), amended LR 32:1880 (October 2006), repealed LR 41:

§419. Program Responsibility

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:896 (June 2003), amended LR 32:1880 (October 2006), repealed LR 41:

§421. Reinstatement to Position following Civil Service Appeal

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:896 (June 2003), repealed LR 41:

§423. Amendments to or Termination of the Plan and/or Contract

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:896 (June 2003), amended LR 32:1880 (October 2006), repealed LR 41:

Chapter 5. Claims Review and Appeal

§501. Administrative Review

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:896 (June 2003), repealed LR 41:

§503. Appeals from Medical Necessity Determinations

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:897 (June 2003), repealed LR 41:

Chapter 6. Definitions

§601. Definitions

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:898 (June 2003), amended LR 32:1880 (October 2006), repealed LR 41:

Chapter 7. Schedule of Benefits—MCO

§701. Comprehensive Medical Benefits

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:901 (June 2003), amended LR 30:435 (March 2004), LR 33:645 (April 2007), LR 33:1123 (June 2007), repealed LR 41:

§703. Mental Health and Substance Abuse

Repealed.

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 29:902 (June 2003), repealed LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this Rule may have no net impact on family functioning, stability and autonomy as described in R.S. 49:972. However, if a member is a low utilizer of benefits, they may see a reduction in the amount of premiums paid, if they move from an existing plan with high premiums to a new plan with lower premiums. Conversely, if a member is a high utilizer of benefits, they may see an increase in out of pocket costs if they move from an existing plan without a deductible (or low deductible) to a new plan with a deductible (or higher deductible), which may have an impact on the family budget pursuant to R.S. 49:972(B)(4).

Poverty Impact Statement

Because the impact of the proposed action is based on the plan selected by each individual enrollee, the impact is indeterminable as to:

1. household income, assets, and financial security;
2. early childhood or educational development;
3. employment and workforce development;
4. taxes and tax credits; or
5. child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

However, if a member is a low utilizer of benefits, they may see a reduction in the amount of premiums paid, if they move from an existing plan with high premiums to a new plan with lower premiums. Conversely, if a member is a high utilizer of benefits, they may see an increase in out of pocket costs if they move from an existing plan without a deductible (or low deductible) to a new plan with a deductible (or higher deductible), which may have an impact on the financial security pursuant to R.S. 49:973(B)(1).

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the effect on the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments via the U.S. Mail until 4:30 p.m., December 11, 2014, to Susan T. West, Chief Executive Officer, Office of Group Benefits, P.O. Box 44036, Baton Rouge, LA 70804.

Public Hearing

A public hearing on this proposed Rule may be scheduled for December 29, 2014, at 10 a.m. in the Louisiana Purchase Room, located on the first floor of the Claiborne Building, located at 1201 N. Third Street, Baton Rouge LA 70802, if requested.

Susan T. West
Chief Executive Officer

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Employee Benefits

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

The proposed administrative rule changes are anticipated to result in aggregate net overall state expenditure savings in the amount of \$94.2 M in FY 15 due to various health plan design changes and prescription drug benefit changes.

The Office of Group (OGB) is anticipating approximately \$4.1 M in costs associated with the implementation of the administrative rule changes. The specific expenditures are as follows: \$4.1 M – additional annual enrollment expenditures incurred due to health plan redesign including paid overtime, mailing and postage costs for post cards and enrollment guides, temporary employees to assist in annual enrollment data entry, call center contractor, website development and enrollment

guide design contractor and contracted plan management and redesign consulting services.

OGB is anticipating net expenditure savings in the amount of \$67.2 M due to the following: standardization of prior authorization schedule, standardization of health benefits limits, prescription drug benefit changes including drug formulary design, 90 day fill option, clinical utilization management, high cost compound management, over utilization management, Acetaminophen management, polypharmacy management and excluding medical foods. These saving calculations are projected from September 30, 2014 to June 30, 2015. Even though the proposed rule changes provide for these provisions to be effective March 1, 2015, September 30, 2014 is the date that these benefit changes were actually implemented through the emergency rule, which has resulted in FY 15 expenditure savings to the Office of Group Benefits.

In addition, OGB anticipates expenditures savings of \$31.1 M in claims due to health plan design changes. The specific savings are attributable as follows: health plan redesign, which includes increasing co-payments, increasing deductibles and the out-of-pocket maximums as well as offering additional consumer driven health plan options, removal of vision coverage, removal of standard excluded benefits, which includes acupuncture, prior authorizations for massages, impacted teeth and TMJ and, Medicare retiree migration to One Exchange (Medicare Advantage Plan marketplace). These savings calculations are anticipated from March 1, 2014 to June 30, 2015. Note: Changing the benefit option start date from January 1, 2015 to March 1, 2015 reduced anticipated savings a total of approximately \$20 M.

The anticipated cost decreases of \$98.3 M and anticipated cost increases of \$4.1 M equate to a total net expenditure decrease of \$94.2 M as a result of the proposed administrative rule changes.

Local participating school boards and political subdivisions would only experience a direct expenditure decrease if OGB current plan members enroll in the lower premium health plan options (Pelican HSA 775, Pelican HRA 1000), which would reduce the employer share of premium.

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

The specific revenue impact to OGB as a result of the proposed rule change depends upon the OGB members' health plan choice and the premium charges related to that health plan choice. When comparing current premium rates of the current health plans to the proposed health plans, OGB member premiums could decrease by up to 62% (current PPO member choosing the Pelican HSA 775 option) or increase by up to 29% (current CDHSA member choosing the Magnolia Open Access option). This varied range will impact OGB revenue collections. According to OGB, revenue losses of approximately \$3.4 M are anticipated to be realized from March 1, 2015 through June 30, 2015, due to the loss of premiums associated with the assumed net migration of PPO and HMO members to the Pelican HRA 1000 and HSA 775 plans.

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

The cost or economic benefits to directly affected persons or non-governmental groups cannot be specifically determined, as each member's use of services and experience is different. If a member is a low utilizer of benefits, they may see a reduction in the amount of premiums paid, if they move from an existing plan with high premiums to a new plan with lower premiums.

Conversely, if a member is a high utilizer of benefits, they may see an increase in out of pocket costs if they move from an existing plan without a deductible (or low deductible) to a new plan with a deductible (or higher deductible).

OGB is anticipating the PPO plan members' economic benefit to be \$181,409 in reduced annual premium costs to be realized from March 1, 2015 through June 30, 2015, due to the assumed net migration of 622 active PPO plan members to the Pelican HRA 1000 plan and 156 active PPO plan members to the Pelican HSA 775 plan, as these plans have lower premium costs.

OGB is anticipating the HMO plan members' economic benefit to be \$667,293 in reduced annual premium costs to be realized from March 1, 2015 through June 30, 2015, due to the assumed net migration of 2,666 active HMO plan members to the Pelican HRA 1000 plan and 666 active HMO plan members to the Pelican HSA 775 plan, as these plans have lower premium costs.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The effect on competition and employment is unknown. The proposed rule changes a significant component of the compensation package of state and certain local public sector employment. Individuals consider compensation packages across alternative private and public sector employment opportunities and for some these changes make the compensation package less beneficial. The proposed rule changes may influence the decisions to seek and accept employment in both the public and private sectors.

Susan T. West
Chief Executive Officer
1411#095

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Office of the Governor Division of Administration Office of State Procurement

Procurement (LAC 34:V.118, 121, and 2101)

In accordance with provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Office of the Governor, Division of Administration, Office of State Procurement, proposes to amend Chapters 1 and 3 of LAC 34:V, Procurement.

The laws governing procurement by state executive branch agencies defines "written" or "in writing" as including "information that is electronically transmitted and stored." As currently written, the rules governing the review of professional, personal, consulting, and social service contracts require original contracts with original signatures to be submitted to the Office of State Procurement. The following amendments to LAC 34:V.118 and LAC 34:V.121.E.1 are necessary in order to allow for the review of electronically transmitted documents.

The amendment to LAC 34:V.121.M is necessary to correct an inconsistency between the rule as now written and governing law (see R.S. 39:1595(B)(10)(a)).

The amendment to LAC 34:V.2101 is necessary to be consistent with the provisions of R.S. 39:1661.

Title 34
GOVERNMENT CONTRACTS, PROCUREMENT
AND PROPERTY CONTROL

Part V. Louisiana Procurement Code

**Chapter 1. Procurement of Professional, Personal,
Consulting, Social Services,
and Energy Efficiency Contracts**

Subchapter A. General Provisions

§118. Submission of Contracts

A. At least one copy of said contract and attachments shall be submitted to the Office of State Procurement. The Office of State Procurement shall submit a list of all contracts for \$25,000 or more to the Legislative Fiscal Office. Copies of such contracts shall be forwarded to the Legislative Fiscal Office upon request. The Office of State Procurement will not accept for review and approval any contract that is not accompanied by the necessary attachments and copies as required herein. (Attachments being submittal letters, R.S. 39:1497 certification, BA-22, etc.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 4:497 (December 1978), amended LR 7:182 (April 1981), LR 8:592 (November 1982), LR 10:456 (June 1984), LR 11:1068 (November 1985), LR 13:653 (November 1987), amended by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:

§121. Contractual Review Process

A. Contracts arriving in the Office of State Procurement will be date stamped and logged in. Contracts should be submitted prior to their effective dates and no contract shall be approved which has been submitted 60 days after its effective date unless written justification is provided by the using agency and approval granted by the state chief procurement officer or his designee. All submittals will be required to have a cover letter attached thereto in conformity with §195, Appendix D of this Part.

B. If a contract does not appear to be out of the ordinary and appears to have the necessary attachments and inclusions, it will be routed as appropriate to the Division of Administration budget analyst for the submitting agency. A BA-22, or its equivalent, shall be submitted with every contract submitted to the Office of State Procurement, which contains any expenditures or reduction in expenditures.

C. Contracts that are incomplete as to form may be returned to the submitting agency. If a contract is merely missing an attachment then the necessary attachment may be secured from the submitting agency.

D. Contracts Returned from Budget

1. Not Recommended for Approval. If a contract is not recommended for approval, the Office of State Procurement shall discuss the reason with the budget analyst. If the problem cannot be resolved, the contract shall be returned to the submitting agency with a letter explaining the problem.

2. Recommended for Approval. If a contract is recommended for approval the review process shall continue.

E. Legal and Content Review. There are a number of different types of contracts, and content requirements may vary a little. All contracts shall contain the following:

1. signatures of both the head of the using agency or his designee and the contractor.

E.2. - L. ...

M. A performance evaluation for every personal, professional, consulting or social services contract shall be done by the using agency in accordance with R.S. 39:1500. This performance evaluation shall be retained by the using agency for all small purchase contracts approved under delegated authority. For all other contracts this performance evaluation shall be submitted to the Office of State Procurement within 60 days after the termination of the contract. An example evaluation form can be found in §195, Appendix F of this Part. Using agencies should use their own formats.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1490(B).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Contractual Review, LR 7:182 (April 1981), amended LR 8:592 (November 1982), LR 10:456 (June 1984), LR 11:1069 (November 1985), LR 13:87 (February 1987), LR 13:653 (November 1987), LR 15:81 (February 1989), amended by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:

Chapter 21. Miscellaneous Provisions

§2101. Contract Provisions

[Formerly LAC 34:I.2101]

A. When a contract is to contain an option for renewal, extension, or purchase, notice of such provision shall be included in the solicitation. When such a contract is awarded by competitive sealed bidding, exercise of the option shall be at the state's discretion only, and shall be at the mutual agreement of the state and the contractor.

B. Contract Clauses. Contracts may include clauses providing for equitable adjustments in prices, time for performance, or other contract provisions, as appropriate, covering the following subjects:

1. the unilateral right of the state to order in writing changes in the work within the general scope of the contract in any one or more of the following:

a. drawings, designs, or specifications, if the supplies to be furnished are to be specially manufactured for the state in accordance therewith;

b. method of shipment or packing; or

c. place of delivery;

d. security for contract performance;

e. insurance requirements including as appropriate but not limited to general liability, automobile coverage, workers' compensation, and errors and omissions;

f. beginning and ending dates of the contract;

g. maximum compensation to be paid the contractor;

2. the unilateral right of the state to order in writing temporary stopping of the work or delaying of performance;

3. variations between estimated quantities of work in a contract and actual quantities;

4. manufacturers' design drawings shall be supplied in duplicate for all state buildings, to the appropriate state agency at the conclusion of the contract.

C. Additional Contract Clauses. Contracts shall include clauses providing for appropriate remedies and covering the following subjects:

1. liquidated damages as may be appropriate;

2. specified excuses for delay or nonperformance as may be appropriate;
3. termination of the contract for default; and
4. termination of the contract in whole or in part for the convenience of the state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 39:1581.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of State Purchasing, LR 8:337 (July 1982), amended LR 21:566 (June 1995), repromulgated LR 40:1362 (July 2014), amended by the Office of the Governor, Division of Administration, Office of State Procurement, LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

It is anticipated that the proposed action will have no significant impact on:

1. household income, assets, and financial security;
2. early childhood or educational development;
3. employment and workforce development;
4. taxes and tax credits; or
5. child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Small Business Statement

The impact of the proposed Rule on small businesses has been considered and it is estimated that the proposed action is not expected to have a significant adverse impact on small businesses as defined in the Regulatory Flexibility Act.

The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact of the proposed Rule on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of the 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on:

1. the staffing level requirements or qualifications required to provide the same level of service;
2. the total direct and indirect effect on the cost to the providers to provide the same level of service; or
3. the overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments to George Grazioso, Office of State Purchasing, P.O. Box 94095, Baton Rouge, LA 70804-9095. He is responsible for responding to inquiries regarding this proposed Rule. All comments must be received by December 10, 2014, by close of business.

Jan B. Cassidy
Assistant Commission

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Procurement

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

The proposed rule changes are anticipated to result in no significant cost or savings for either state or local governmental entities. The laws governing procurement by state executive branch agencies defines "written" or "in writing" as including "information that is electronically transmitted and stored." As currently written, the rules governing the review of professional personal, consulting, and social service contracts require original contracts with original signature to be submitted to the Office of State Procurement. The following amendments to LAC 34:V.118 and LAC 34:V.121(E)(1) are necessary in order to allow for the review of electronically transmitted documents. These modifications will likely result in non-quantifiable time savings for various state employees handling contracts and procurement in the various state agencies.

The amendment to LACV.121(m) is necessary to correct an inconsistency between the rule as now written and governing law (see, R.S. 39:1595(b)(10)(a)).

The amendment to LAC 34:V.2101(M) is necessary to correct an inconsistency between the rule as now written and governing law (see, R.S. 39:1595(B)(10)(a)).

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

Implementing the rule changes will have no effect on revenue collections of state or local governmental entities.

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

There will be no specific costs to directly affected persons or non-governmental groups as a result of the proposed rule. However, there will likely be a non-quantifiable economic benefit to the state through the ability to accept for review electronically transmitted documents.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There will be no effect on competition and employment as a result of implementing this rule.

Jan B. Cassidy
Assistant Commissioner
1411#020

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing and Office of Behavioral Health

Adult Behavioral Health Services
(LAC 50:XXXIII.6103, 6301, 6303, and Chapter 65)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.6103, §§6301, 6303 and Chapter 65 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing currently provides behavioral health services to adults with serious and persistent mental illness or co-occurring disorders of mental illness through a coordinated behavioral health services system under the Medicaid Program.

The department now proposes to amend the provisions governing adult behavioral health services in order to ensure the provider certification, assessment, and reevaluation criteria are in alignment with the approved Medicaid state plan.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXXIII. Behavioral Health Services

Subpart 7. Adult Mental Health Services

Chapter 61. General Provisions

§6103. Recipient Qualifications

A. Individuals over the age of 18, and not otherwise eligible for Medicaid, who meet Medicaid eligibility and clinical criteria established in §6103.B, shall qualify to receive adult behavioral health services.

B. Qualifying individuals who meet one of the following criteria shall be eligible to receive adult behavioral health services.

1. Person with Acute Stabilization Needs

a. The person currently presents with mental health symptoms that are consistent with a diagnosable mental disorder specified within the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* or the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*, or subsequent revisions of these documents.

b. ...

2. Person with Major Mental Disorder (MMD)

a. The person has at least one diagnosable mental disorder which is commonly associated with higher levels of impairment. These diagnoses may include:

i. schizophrenia spectrum and other psychotic disorders;

ii. bipolar and related disorders; or

iii. depressive disorders.

b. ...

c. A person with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for a major mental disorder diagnosis.

3. Persons with Serious Mental Illness (SMI)

a. The person currently has, or at any time during the past year, had a diagnosable qualifying mental health diagnosis of sufficient duration to meet the diagnostic criteria specified within the DSM-V or the ICD-10-CM, or subsequent revisions of these documents.

b. ...

c. A person with a primary diagnosis of a substance use disorder without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for a SMI diagnosis.

4. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:358 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 63. Services

§6301. General Provisions

A. - C.4. ...

D. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license.

E. - F. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§6303. Assessments

A. Each recipient shall undergo an independent assessment prior to receiving behavioral health services. The individual performing the assessment, eligibility, and plan of care shall meet the independent assessment conflict free criteria established by the department.

B. - C. ...

D. The evaluation and re-evaluation must be finalized through the SMO using the universal needs assessment criteria and qualified SMO personnel. Needs-based eligibility evaluations are conducted at least every 12 months.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 65. Provider Participation

§6501. Provider Responsibilities

A. - C. ...

D. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. - E.6. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family

functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this Emergency Rule has been considered. It is anticipated that this Emergency Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 708219030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Adult Behavioral Health Services

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

In FY 14-15, it is anticipated that implementation of this proposed rule will result in an indeterminable decrease in programmatic expenditures in the Medicaid program. The decrease reflects a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16 and FY 16-17, it is anticipated that implementation of this proposed rule will result in an indeterminable increase in programmatic expenditures in the Medicaid program. In FY 15-16, the increase reflects the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the State Management Organization (SMO). In FY 16-17, the increase reflects the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. The increase in programmatic expenditures is at no net cost to the state because premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It

is anticipated that \$574 (\$287 SGF and \$287 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

In FY 14-15, it is anticipated that the implementation of this proposed rule will decrease revenue collections for the federal share of programmatic expenditures reflecting a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16, it is anticipated that the implementation of this proposed rule will increase revenue collections for the federal share of programmatic expenditures for the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, it is anticipated that the implementation of this proposed rule will increase revenue collections for the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. Premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$287 will be collected in FY 15-16 for the federal share of the expense for promulgation of this proposed rule and the final rule.

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

This proposed Rule amends the provisions governing adult behavioral health services in order to ensure the provider certification, assessment, and reevaluation criteria are in alignment with the approved Medicaid State Plan. It is anticipated that implementation of this proposed rule will not have economic cost or benefits to behavioral health providers or recipients in FY 14-15, FY 15-16, and FY 16-17. The decrease in programmatic expenditures in FY 14-15, reflecting one time savings from a change in the timing of capitation payments made to the SMO, will have no impact on providers as requirements for timely claims payment by the SMO are unchanged.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#074

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing

Adult Residential Care Providers
Licensing Standards
(LAC 48:I.Chapters 68 and 88)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to repeal and replace LAC 48:I.Chapter 68 governing the licensing standards for adult residential care providers, and to repeal LAC 48:I.Chapter 88 governing the licensing standards for adult residential care homes, in its entirety, as authorized by R.S. 36:254 and R.S. 40:2166.1-2166.8, and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Health Standards Section was transferred authority for the licensing standards governing adult residential care providers from the Department of Children and Family Services (formerly the Department of Social Services), inclusive of the provisions of LAC 48:I.Chapter 88.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated a Notice of Intent which proposed to repeal and replace the provisions governing the licensing standards for adult residential care providers and adult residential care homes in order to incorporate these provisions under a single comprehensive Rule in the *Louisiana Administrative Code (Louisiana Register, Volume 40, Number 3)*. As a result of the comments received, the department abandoned the Notice of Intent published in the March 20, 2014 edition of the *Louisiana Register*.

The department now proposes to promulgate a revised Notice of Intent in order to repeal and replace the provisions governing the licensing standards for adult residential care providers and adult residential care homes in order to incorporate these provisions under a single comprehensive Rule in the *Louisiana Administrative Code*. Therefore, the provisions of LAC 48:I.Chapter 88 shall be repealed in their entirety and all of the provisions governing the licensing standards for adult residential care providers will be repromulgated under LAC 48:I.Chapter 68.

Title 48

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part I. Administration

Subpart 3. Licensing

Chapter 68. Adult Residential Care Providers

Subchapter A. General Provisions

§6801. Introduction

A. These rules and regulations contain the minimum licensure standards for adult residential care providers (ARCPs), pursuant to R.S. 40:2166.1-2166.8.

B. An adult residential care provider (ARCP) serves individuals in a congregate setting and is operational 24 hours per day, 7 days per week, with a coordinated array of supportive personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities and health-related services that are designed to:

1. allow the individual to reside in the least restrictive setting of his/her choice;
2. accommodate the individual resident's changing needs and preferences;
3. maximize the resident's dignity, autonomy, privacy and independence; and
4. encourage family and community involvement.

C. An ARCP shall have at least one published business telephone number.

D. Adult residential care services include, at a minimum, assistance with activities of daily living, assistance with instrumental activities of daily living, lodging, and meals.

E. The Department of Health and Hospitals (DHH) does not require, and will not issue ARCP licenses for the provision of lodging and meals only or homeless shelters.

1. For the purposes of this Rule, homeless shelters shall be defined as entities that provide only temporary or emergency shelter to individuals who would otherwise be

homeless and may provide services to alleviate homelessness.

F. There are four levels of adult residential care. The levels differ in the services they are licensed to offer and the physical environment requirements.

G. All levels of ARCPs shall comply with all regulations in this Chapter unless the language of the regulations pertains to a specific level.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1 - 2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6803. Definitions and Abbreviations

Abuse—the infliction of physical or mental injury or the causing of the deterioration of a resident by means including, but not limited to:

1. sexual abuse;
2. exploitation; or
3. extortion of funds or other things of value.

Activities of Daily Living—ambulating, transferring, grooming, bathing, dressing, eating, toileting, and for the purposes of this Rule, taking medication.

Adult—a person who has attained 18 years of age.

Adult Residential Care Provider—a facility, agency, institution, society, corporation, partnership, company, entity, residence, person or persons, or any other group which provides adult residential care for compensation to two or more adults who are unrelated to the licensee or operator.

Alterations, Additions, or Substantial Rehabilitation—rehabilitation that involves structural changes in which hard costs are equal to or exceed the per unit cost for *substantial rehabilitation* as defined by the Louisiana Housing Finance Authority.

Change of Ownership (CHOW)—the sale or transfer of all or a portion of the assets or other equity interest in an ARCP. Examples of actions that constitute a *change of ownership* include:

1. unincorporated sole proprietorship. Transfer of title and property of another party constitutes *change of ownership*;
2. corporation. The merger of the provider corporation into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation constitutes *change of ownership*. Transfer of corporate stock or the merger of another corporation into the provider corporation does not constitute a *change of ownership*. Admission of a new member to a nonprofit corporation is not a *change of ownership*;
3. limited liability company. The removal, addition or substitution of a member in a limited liability company does not constitute a *change of ownership*;
4. partnership. In the case of a partnership, the removal, addition, or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable state law, constitutes a *change of ownership*.

Chemical Restraint—a psychopharmacologic drug that is used for discipline or convenience and not required to directly treat medical symptoms or medical diagnoses. The use of *chemical restraints* is prohibited in ARCPs.

Common Area (Space)—the interior *space(s)* made available for the free and informal use by all residents or the

guests of the ARCP. *Common areas* may include activity rooms, libraries, and other areas exclusive of resident's rooms and bathrooms. Corridors, passageways, kitchens and laundry areas are not included as *common areas*.

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

DAL—Division of Administrative Law or its successor.

Department—the Louisiana Department of Health and Hospitals (DHH).

Direct Care Staff—any employee of the ARCP that provides personal care services to the residents.

Director—the person who is in charge of the daily operation of the ARCP.

Facility Need Review (FNR)—a review conducted for level 4 ARCPs to determine whether there is a need for additional ARCP residential living units to be licensed.

Health Care Services—any service provided to a resident by an ARCP or third-party provider that is required to be provided or delegated by a licensed, registered or certified health care professional. Any other service, whether or not ordered by a physician, that is not required to be provided by a licensed, registered or certified health care professional shall not be considered a *health care service*.

HSS—the Department of Health and Hospitals, Office of the Secretary, Office of Management and Finance, Health Standards Section.

Incident—any occurrence, situation or circumstance affecting the health, safety or well-being of a resident or residents.

Intermittent Nursing Services—services that are provided episodically or for a limited period of time by licensed nursing staff. *Intermittent nursing services* may be provided by level 4 ARCPs only.

Instrumental Activities of Daily Living—the functions or tasks that are not necessary for fundamental functioning but assist an individual to be able to live in a community setting. These include activities such as:

1. light house-keeping;
 2. food preparation and storage;
 3. grocery shopping;
 4. laundry;
 5. scheduling medical appointments;
 6. financial management;
 7. arranging transportation to medical appointments;
- and
8. accompanying the client to medical appointments.

Level 1 ARCP—an ARCP that provides adult residential care for compensation to two or more residents but no more than eight who are unrelated to the licensee or operator in a setting that is designed similarly to a single-family dwelling.

Level 2 ARCP—an ARCP that provides adult residential care for compensation to 9 or more residents but no more than 16 who are unrelated to the licensee or operator in a congregate setting that does not provide independent apartments equipped with kitchenettes, whether functional or rendered nonfunctional for reasons of safety.

Level 3 ARCP—an ARCP that provides adult residential care for compensation to 17 or more residents who are unrelated to the licensee or operator in independent apartments equipped with kitchenettes, whether functional or rendered nonfunctional for reasons of safety.

Level 4 ARCP—an ARCP that provides adult residential care including intermittent nursing services for compensation to 17 or more residents who are unrelated to the licensee or operator in independent apartments equipped with kitchenettes, whether functional or rendered nonfunctional for reasons of safety.

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

May—indicates permissible practices or services.

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

NFPA—National Fire Protection Association.

Nursing Director—a registered nurse licensed by the state of Louisiana who directs or coordinates nursing services in the ARCP.

OSFM—Office of the State Fire Marshal.

OPH—Office of Public Health.

Person-Centered Service Plan (PCSP)—a written description of the functional capabilities of a resident, the resident's need for personal assistance and the services to be provided to meet the resident's needs.

Personal Assistance—services that directly assist a resident with certain activities of daily living and instrumental activities of daily living.

Physical Restraint—any manual method, physical or mechanical device, material, or equipment attached to or adjacent to a resident's body that the individual cannot easily remove which restricts freedom of movement or normal access to the body and is not used as an assistive device. The use of *physical restraints* is prohibited in ARCPs.

PRN—commonly used in medicine to mean as needed or as the situation arises.

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

Resident Apartment—a separate unit configured to permit residents to carry out, with or without assistance, all the functions necessary for independent living, including:

1. sleeping;
 2. sitting;
 3. dressing;
 4. personal hygiene;
 5. storing, preparing, serving and eating food;
 6. storing clothing and other personal possessions;
 7. handling personal correspondence and paperwork;
- and
8. entertaining visitors.

Resident's Representative—a person who has been authorized by the resident in writing to act upon the resident's direction regarding matters concerning the resident's health or welfare, including having access to personal records contained in the resident's file and receiving information and notices about the overall care, condition and services for the resident. No member of the governing body, administration or staff or an ARCP or any member of their family shall serve as the resident's representative unless they are related to the resident by blood or marriage.

Shall—indicates mandatory requirements.

Specialized Dementia Care Program—as defined in R.S. 40:1300.123, a special program or unit for residents with a diagnosis of probable Alzheimer's disease or a related disorder so as to address the safety needs of such residents, and that advertises, markets, or otherwise promotes the ARCP as providing specialized Alzheimer's/dementia care services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6805. Licensure Requirements

A. All ARCPs shall be licensed by the Department of Health and Hospitals. The department is the only licensing authority for ARCPs in the state of Louisiana. It shall be unlawful to operate an ARCP without possessing a current, valid license issued by the department. The license shall:

1. be issued only to the person or entity named in the license application;
2. be valid only for the ARCP to which it is issued and only for the specific geographic address of that ARCP;
3. be valid for one year from the date of issuance, unless revoked, suspended, modified, or terminated prior to that date, or unless a provisional license is issued;
4. expire on the last day of the twelfth month after the date of issuance, unless timely renewed by the ARCP;
5. not be subject to sale, assignment, donation, or other transfer, whether voluntary or involuntary; and
6. be posted in a conspicuous place on the licensed premises at all times.

B. In order for the ARCP to be considered operational and retain licensed status, the ARCP shall meet the following conditions.

1. The ARCP shall always have at least one employee awake and on duty at the business location 24 hours per day, seven days per week.
2. There shall be staff employed, sufficient in number with appropriate training, available to be assigned to provide care and services according to each resident's PCSP.
3. The ARCP shall have provided services that included lodging, meals and activities of daily living to at least two residents unrelated to the licensee or operator within the preceding 12 months prior to their licensure renewal date.

C. The ARCP shall abide by and adhere to any state laws, rules, policies, procedures, manuals, or memorandums issued by the department pertaining to ARCPs.

D. A separately licensed ARCP shall not use a name which is substantially the same as the name of another ARCP licensed by the department.

E. The ARCP shall maintain insurance policies in force at all times with at least the minimum required coverage for general and professional liability and worker's compensation insurance at the levels specified in §6807. Failure to maintain compliance may constitute the basis for license revocation and/or sanction.

F. The ARCP shall market itself only as the level licensed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6807. Initial Licensure Application Process

A. An initial application for licensing as an ARCP shall be obtained from the department. A completed initial license application packet for an ARCP shall be submitted to and approved by the department prior to an applicant providing ARCP services. An applicant shall submit a completed initial licensing packet to the department, which shall include:

1. a completed ARCP license application and the appropriate non-refundable licensing fee as established by statute;
2. a copy of the on-site inspection report with approval for occupancy by the OSFM;
3. a copy of the health inspection report from the OPH;
4. a copy of criminal background checks on all owners;
5. proof of financial viability which entails:
 - a. verification of sufficient assets equal to \$100,000 or the cost of three months of operation, whichever is less; or
 - b. a letter of credit issued from a federally insured, licensed lending institution in the amount of at least \$100,000 or the cost of three months of operation, whichever is less;
6. proof of general and professional liability insurance of at least \$300,000;
7. proof of worker's compensation insurance;
8. if applicable, a clinical laboratory improvement amendments (CLIA) certificate or a CLIA certificate of waiver;
9. a completed disclosure of ownership and control information form;
10. a floor sketch or drawing of the premises to be licensed;
11. the days and hours of operation;
12. a facility need review approval for a level 4 ARCP;
13. a copy of the letter approving architectural plans from the OSFM;
14. the organizational chart of the ARCP; and
15. any documentation or information required by the department for licensure.

B. If the initial licensing packet is incomplete, the applicant will be notified of the missing information and shall have 90 days to submit the additional requested information. If the additional requested information is not submitted to the department within 90 days, the application will be closed. After an initial licensing application is closed, an applicant who is still interested in becoming an ARCP must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process.

C. Once the initial licensing application packet has been approved by the department, the ARCP applicant shall notify the department of readiness for an initial licensing survey within 90 days. If an applicant fails to notify the department of readiness for an initial licensing survey within 90 days of approval, the initial licensing application shall be closed. After an initial licensing application is closed, an applicant who is still interested in becoming an ARCP must submit a new initial licensing packet with a new initial licensing fee to start the initial licensing process subject to any facility need review requirements.

D. Applicants must be in compliance with all appropriate federal, state, departmental, or local statutes, laws, ordinances, rules, regulations and fees before the department will issue the ARCP an initial license to operate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6809. Initial Licensing Surveys

A. Prior to the initial license being issued to the ARCP, an initial licensing survey shall be conducted on-site at the ARCP to assure compliance with ARCP licensing standards. No resident shall be provided services by the ARCP until the initial licensing survey has been performed, the ARCP has been found in compliance and the initial license has been issued to the ARCP by the department.

B. In the event that the initial licensing survey finds that the ARCP is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the provider. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

C. In the event that the initial licensing survey finds that the ARCP is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules or regulations that present a potential threat to the health, safety, or welfare of the residents, the department shall deny the initial license.

D. In the event that the initial licensing survey finds that the ARCP is noncompliant with any licensing laws or regulations, any required statutes, laws, ordinances, rules or regulations, but the department, in its sole discretion, determines that the noncompliance does not present a threat to the health, safety, or welfare of the residents, the department may issue a provisional initial license for a period not to exceed six months.

1. The provider shall submit an acceptable plan of correction to DHH for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

2. If all such noncompliance or deficiencies are determined by the department to be corrected on a follow-up survey, then a full license may be issued.

3. If all such noncompliance or deficiencies are not corrected on the follow-up survey, or if new deficiencies are cited on the follow-up survey, the provisional license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet, fee and any required facility need review approval.

E. When issued, the initial ARCP license shall specify the maximum number of apartments and/or resident capacity for which the ARCP is licensed.

F. The initial licensing survey of an ARCP shall be an announced survey. Follow-up surveys to the initial licensing surveys are unannounced.

G. Once an ARCP has been issued an initial license, the department shall conduct licensing and other surveys at intervals deemed necessary by the department to determine compliance with licensing standards and regulations, as well as other required statutes, laws, ordinances, rules, regulations, and fees. These surveys shall be unannounced.

1. A plan of correction may be required from an ARCP for any survey where deficiencies have been cited. Such plan of correction shall be approved by the department.

2. A follow-up survey may be conducted for any survey where deficiencies have been cited to ensure correction of the deficient practices.

H. The department may issue appropriate sanctions, including, but not limited to:

1. civil fine;
2. directed plans of correction;
3. denial of license renewal;
4. provisional licensure;
5. license revocation; and/or
6. any sanctions allowed under state law or regulation.

I. The department's surveyors and staff shall be given access to all areas of the ARCP and all relevant files during any licensing or other survey or investigation, and shall be allowed to interview any provider staff or residents as necessary to conduct the on-site investigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6811. Types of Licenses and Expiration Dates

A. The department shall have the authority to issue the following types of licenses.

1. Full License. In the event that the initial licensing survey finds that the ARCP is compliant with all licensing laws and regulations, and is compliant with all other required statutes, laws, ordinances, rules, regulations, and fees, the department shall issue a full license to the provider. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

2. Provisional Initial License. In the event that the initial licensing survey finds that the ARCP is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, the department is authorized to issue a provisional initial license pursuant to the requirements and provisions of these regulations.

3. Full Renewal License. The department may issue a full renewal license to an existing licensed ARCP who is in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules, regulations and fees. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, suspended, or terminated.

4. Provisional License

a. The department, in its sole discretion, may issue a provisional license to an existing licensed ARCP for a period not to exceed six months, for any of the following reasons, including but not limited to:

- i. the existing ARCP has more than five deficient practices or deficiencies cited during any one survey;
- ii. the existing ARCP has more than three validated complaints in one licensed year period;
- iii. the existing ARCP has been issued a deficiency that involved placing a participant at risk for serious harm or death;
- iv. the existing ARCP has failed to correct deficient practices within 60 days of being cited for such deficient practices or at the time of a follow-up survey; or

v. the existing ARCP is not in substantial compliance with all applicable federal, state, departmental, and local statutes, laws, ordinances, rules regulations and fees at the time of renewal of the license.

b. When the department issues a provisional license to an existing licensed ARCP, the department shall conduct a follow-up survey of the ARCP prior to the expiration of the provisional license.

i. If that follow-up survey determines that the ARCP has corrected the deficient practices and has maintained compliance during the period of the provisional license, then the department may issue a full license for the remainder of the year until the anniversary date of the ARCP license.

ii. If that follow-up survey determines that the ARCP has not corrected the deficient practices or has not maintained compliance during the period of the provisional license, the provisional license shall expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet, fee and any required facility need approval.

B. If an existing licensed ARCP has been issued a notice of license revocation, suspension, or termination, and the provider's license is due for annual renewal, the department shall deny the license renewal application.

1. If a timely administrative appeal has been filed by the provider regarding the license revocation, suspension, or termination, the administrative appeal shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the Division of Administrative Law (DAL) or department issues a decision on the license revocation, suspension, or termination.

2. If the secretary of the department determines that the violations of the ARCP pose an imminent or immediate threat to the health, welfare, or safety of a participant, the imposition of such action may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the ARCP will be notified in writing.

3. The denial of the license renewal application does not affect in any manner the license revocation, suspension, or termination.

C. The renewal of a license does not in any manner affect any sanction, civil monetary penalty, or other action imposed by the department against the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6813. Changes in Licensee Information or Personnel

A. Any change regarding the ARCP's entity name, doing business as name, geographical address, mailing address, telephone number, or any combination thereof, shall be reported in writing to the department five business days prior to the change.

B. Any change regarding the ARCP's key administrative personnel shall be reported in writing to the department within 10 business days of the change.

1. Key administrative personnel include the:

- a. director;
- b. assistant director; and
- c. nursing director.

2. The ARCP's notice to the department shall include the individual's:

- a. name;
- b. address;
- c. telephone;
- d. facsimile (fax) number;
- e. e-mail address;
- f. hire date; and
- g. qualifications.

C. A change of ownership (CHOW) of the ARCP shall be reported in writing to the department within five business days of the CHOW. The license of an ARCP is not transferable or assignable; the license of an ARCP cannot be sold. The new owner shall submit the legal CHOW document, all documents required for a new license, and the applicable licensing fee. Level 4 ARCPs shall also submit a facility need review application for approval. Once all application requirements have been completed and approved by the department, a new license shall be issued to the new owner.

D. If the ARCP changes its name without a CHOW, the ARCP shall report such change to the department in writing within five business days prior to the change. The notification of the name change shall include an updated license application and the required fee for such change.

E. Any request for a duplicate license shall be accompanied by the appropriate designated fee.

F. An ARCP that is under provisional licensure, license revocation, or denial of license renewal may not undergo a CHOW.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6815. Renewal of License

A. License Renewal Application. The ARCP shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the existing current license. The license renewal application packet shall include:

1. the license renewal application;
2. the days and hours of operation;
3. a current fire marshal inspection report;
4. a current OPH inspection report;
5. the non-refundable license renewal fee;
6. proof of financial viability to include:

a. verification and maintenance of a letter of credit issued from a federally insured, licensed lending institution in the amount of at least \$100,000 or the cost of three months of operation, whichever is less; or

b. affidavit of verification of sufficient assets equal to \$100,000 or the cost of three months of operation, whichever is less;

7. general and professional liability insurance of at least \$300,000;

8. proof of worker's compensation insurance;

and

9. any other documentation required by the department.

B. The department may perform an on-site survey and inspection upon annual renewal of a license.

C. Failure to submit to the department a completed license renewal application packet prior to the expiration of the current license will be considered a voluntary non-renewal of the license and the license shall expire on its face.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6817. Denial of License, Revocation of License, Denial of License Renewal, Operation without License, Penalty

A. The department may deny an application for a license, deny a license renewal or revoke a license in accordance with the provisions of the Administrative Procedure Act.

B. Denial of an Initial License

1. The department shall deny an initial license in the event that the initial licensing survey finds that the ARCP is noncompliant with any licensing laws or regulations that present a potential threat to the health, safety, or welfare of the residents.

2. The department shall deny an initial license in the event that the initial licensing survey finds that the ARCP is noncompliant with any other required statutes, laws, ordinances, rules or regulations that present a potential threat to the health, safety, or welfare of the residents.

3. The department shall deny an initial license for any of the reasons stated in §6817.D for which a license may be revoked or a license renewal may be denied.

C. Voluntary Non-Renewal of a License. If a provider fails to timely renew its license, the license expires on its face and is considered voluntarily non-renewed or voluntarily surrendered. There are no appeal rights for such surrender or non-renewal of the license, as this is a voluntary cessation of business.

D. Revocation of License or Denial of License Renewal. An ARCP license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. failure to be in substantial compliance with the ARCP licensing laws, rules and regulations;

2. failure to be in substantial compliance with other required statutes, laws, ordinances, rules, or regulations;

3. failure to comply with the terms and provisions of a settlement agreement or education letter;

4. failure to uphold resident rights whereby deficient practices may result in harm, injury, or death of a resident;

5. failure to protect a resident from a harmful act of an employee or other resident including, but not limited to:

a. abuse, neglect, exploitation, or extortion;

b. any action posing a threat to a resident's health and safety;

c. coercion;

d. threat or intimidation; or

e. harassment;

6. failure to notify the proper authorities of all suspected cases of neglect, criminal activity, mental or physical abuse, or any combination thereof;

7. knowingly making a false statement in any of the following areas, including but not limited to:

a. application for initial license or renewal of license;

b. data forms;

c. clinical records, resident records, or provider records;

d. matters under investigation by the department, Office of the Attorney General, or any law enforcement agency; or

e. information submitted for reimbursement from any payment source;

8. knowingly making a false statement or providing false, forged, or altered information or documentation to the department's employees or to law enforcement agencies;

9. the use of false, fraudulent or misleading advertising;

10. fraudulent operation of an ARCP by the owner, director, officer, member, manager, or other key personnel as defined by §6813;

11. an owner, officer, member, manager, director or person designated to manage or supervise resident care who has been convicted of, or has entered a plea of guilty or nolo contendere (no contest) to, or has pled guilty or nolo contendere to a felony, or has been convicted of a felony, as documented by a certified copy of the record of the court:

a. for purposes of this Paragraph, conviction of a felony means a felony relating to the violence, abuse, or negligence of a person, or a felony relating to the misappropriation of property belonging to another person;

12. failure to comply with all reporting requirements in a timely manner as required by the department;

13. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview provider staff or residents;

14. failure to allow or refusal to allow access to authorized departmental personnel to records; or

15. bribery, harassment, or intimidation of any resident designed to cause that resident to use the services of any particular ARCP.

E. In the event an ARCP license is revoked or renewal is denied, any owner, officer, member, manager, or director of such ARCP is prohibited from owning, managing, directing or operating another ARCP for a period of two years from the date of the final disposition of the revocation or denial action.

F. Operation without License and Penalty

1. An adult residential care provider shall not operate without a license issued by the department. Any such provider operating without a license shall be guilty of a misdemeanor and upon conviction shall be fined not more than \$100 for each day of operation without a license up to a maximum of \$1,000 or imprisonment of not more than six months, or both. It shall be the responsibility of the department to inform the appropriate district attorney of the alleged violation to assure enforcement.

2. If an adult residential care provider is operating without a license issued by the department, the department shall have the authority to issue an immediate cease and desist order to that provider. Any such provider receiving such a cease and desist order from the department shall immediately cease operations until such time as that provider is issued a license by the department.

3. The department shall seek an injunction in the Nineteenth Judicial District Court against any provider who receives a cease and desist order from the department under Subsection B of this Section and who does not cease

operations immediately. Any such provider against whom an injunction is granted shall be liable to the department for attorney fees, costs, and damages.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6819. Notice and Appeal of License Denial, License

Revocation and Denial of License Renewal

A. Notice of a license denial, license revocation or denial of license renewal shall be given to the provider in writing.

B. The ARCP has a right to an administrative reconsideration of the license denial, license revocation, or denial of license renewal. There is no right to an administrative reconsideration of a voluntary non-renewal or surrender of a license by the provider.

1. The ARCP shall request the administrative reconsideration within 15 days of the receipt of the notice of the license denial, license revocation, or denial of license renewal. The request for administrative reconsideration shall be in writing and received by the department within 15 calendar days of the provider's receipt of the notice letter from the department.

2. The request for administrative reconsideration shall include any documentation that demonstrates that the determination was made in error.

3. If a timely request for an administrative reconsideration is received by the Health Standards Section (HSS), an administrative reconsideration shall be scheduled and the provider will receive written notification.

4. The provider shall have the right to appear in person at the administrative reconsideration and may be represented by counsel.

5. Correction of a violation or deficiency which is the basis for the license denial, license revocation or denial of license renewal shall not be a basis for reconsideration.

6. The administrative reconsideration process is not in lieu of the administrative appeals process.

7. The provider will be notified in writing of the results of the administrative reconsideration.

C. The ARCP has a right to an administrative appeal of the license denial, license revocation, or denial of license renewal. There is no right to an administrative appeal of a voluntary non-renewal or surrender of a license by the provider.

1. The ARCP shall request the administrative appeal within 30 days of the receipt of the results of the administrative reconsideration. The ARCP may forego its rights to an administrative reconsideration, and if so, the ARCP shall request an administrative appeal within 30 days of the receipt of the notice of the license denial, license revocation, or denial of license renewal. The request for administrative appeal shall be in writing and shall be submitted to the Division of Administrative Law (DAL) or its successor.

2. The request for administrative appeal shall include any documentation that demonstrates that the determination was made in error and shall include the basis and specific reasons for the appeal.

3. If a timely request for an administrative appeal is received by the DAL or its successor, the administrative appeal of the license revocation or denial of license renewal

shall be suspensive, and the provider shall be allowed to continue to operate and provide services until such time as the DAL or its successor issues a final administrative decision.

4. If the secretary of the department determines that the violations of the ARCP pose an imminent or immediate threat to the health, welfare, or safety of a resident, the imposition of the license revocation or denial of license renewal may be immediate and may be enforced during the pendency of the administrative appeal. If the secretary of the department makes such a determination, the ARCP will be notified in writing.

5. Correction of a violation or a deficiency which is the basis for the license denial, license revocation, or denial of license renewal, shall not be a basis for the administrative appeal.

D. If an existing licensed ARCP has been issued a notice of license revocation and the provider's license is due for annual renewal, the department shall deny the license renewal application.

1. The denial of the license renewal application does not affect in any manner the license revocation.

2. If the final decision by DAL or its successor is to reverse the license denial, the denial of license renewal, or the license revocation, the provider's license will be reinstated or granted upon the payment of any licensing or other fees due to the department.

E. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license to a new ARCP. An existing provider who has been issued a provisional license remains licensed and operational and also has no right to an administrative reconsideration or an administrative appeal. The issuance of a provisional license to an existing ARCP is not considered to be a denial of license, a denial of license renewal, or a license revocation.

1. A follow-up survey may be conducted prior to the expiration of a provisional initial license to a new ARCP or the expiration of a provisional license to an existing provider.

2. A new provider that is issued a provisional initial license or an existing provider that is issued a provisional license shall be required to correct all noncompliance or deficiencies at the time the follow-up survey is conducted.

3. If all noncompliance or deficiencies have not been corrected at the time of the follow-up survey, or if new deficiencies that are a threat to the health, safety, or welfare of residents are cited on the follow-up survey, the provisional initial license or provisional license shall expire on its face and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and fee.

4. The department shall issue written notice to the provider of the results of the follow-up survey.

5. A provider with a provisional initial license or an existing provider with a provisional license that expires due to noncompliance or deficiencies cited at the follow-up survey, shall have the right to an administrative reconsideration and the right to an administrative appeal of the deficiencies cited at the follow-up survey.

a. The correction of a violation, noncompliance, or deficiency after the follow-up survey shall not be the basis

for the administrative reconsideration or for the administrative appeal.

b. The administrative reconsideration and the administrative appeal are limited to whether the deficiencies were properly cited at the follow-up survey.

c. The provider must request the administrative reconsideration of the deficiencies in writing, which shall be received by the HSS within five calendar days of receipt of the notice of the results of the follow-up survey from the department. The request for an administrative reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

d. The provider must request the administrative appeal within 15 calendar days of receipt of the notice of the results of the follow-up survey from the department. The request for administrative appeal shall be in writing and shall be submitted to the DAL or its successor. The request for an administrative appeal must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

e. A provider with a provisional initial license or an existing provider with a provisional license that expires under the provisions of this section must cease providing services unless the DAL or its successor issues a stay of the expiration. The stay may be granted by the DAL or its successor upon application by the provider at the time the administrative appeal is filed and only after a contradictory hearing, and only upon a showing that there is no potential harm to the residents being served by the provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6821. Complaint Investigations

A. The department shall conduct complaint investigations in accordance with R.S. 40:2009.13 et seq.

B. Complaint investigations shall be unannounced.

C. Upon request by the department, an acceptable plan of correction must be submitted to the department for any complaint investigation where deficiencies have been cited.

D. A follow-up survey may be conducted for any complaint investigation where deficiencies have been cited to ensure correction of the deficient practices.

E. The department may issue appropriate sanctions, including but not limited to, civil fines, directed plans of correction, provisional licensure, denial of license renewal, and license revocation for non-compliance with any state law or regulation.

F. The department's surveyors and staff shall be given access to all areas of the ARCP and all relevant files during any complaint investigation. The department's surveyors and staff shall be allowed to interview any provider staff or resident as necessary or required to conduct the investigation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6823. Statement of Deficiencies

A. Any statement of deficiencies issued by the department to the ARCP must be posted in a readily accessible place on the licensed premises.

B. Any statement of deficiencies issued by the department to an ARCP must be available for disclosure to the public 30 days after the provider receives the statement of deficiencies or after the receipt of an acceptable plan of correction, whichever occurs first.

C. Unless otherwise provided in statute or in this licensing rule, a provider shall have the right to an administrative reconsideration of any deficiencies cited as a result of a survey or investigation.

1. Correction of the violation, noncompliance or deficiency shall not be the basis for the reconsideration.

2. The administrative reconsideration of the deficiencies shall be requested in writing and received by the department within 10 calendar days of receipt of the statement of deficiencies.

3. The request for an administrative reconsideration must identify each disputed deficiency or deficiencies and the reason for the dispute and include any documentation that demonstrates that the determination was made in error.

4. The request for administrative reconsideration of the deficiencies must be made to the department's Health Standard Section.

5. Except as provided for complaint surveys pursuant to R.S. 40:2009.13 et seq., and as provided for license denials, license revocations and denials of license renewals, the decision of the administrative reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

6. The provider shall be notified in writing of the results of the administrative reconsideration.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6825. Cessation of Business

A. Except as provided in §6881 of these licensing regulations, a license shall be immediately null and void if an ARCP ceases to operate.

B. A cessation of business is deemed to be effective the date on which the ARCP stopped offering or providing services to the community.

C. Upon the cessation of business, the provider shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the provider. The provider does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the ARCP shall:

1. give 30 days' advance written notice to:

a. HSS;

b. each resident's physician; and

c. each resident or resident's legal representative, if applicable; and

2. provide for an orderly discharge and transition of all of the residents in the ARCP.

F. In addition to the advance notice of voluntary closure, the ARCP shall submit a written plan for the disposition of all resident medical records for approval by the department. The plan shall include the following:

1. the effective date of the voluntary closure;
2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed ARCP's residents' medical records;
3. an appointed custodian(s) who shall provide the following:
 - a. access to records and copies of records to the resident or authorized representative, upon presentation of proper authorization(s); and
 - b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and
4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing provider, at least 15 days prior to the effective date of closure.

G. If an ARCP fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning an ARCP for a period of two years.

H. Once the ARCP has ceased doing business, the ARCP shall not provide services until the provider has obtained a new initial license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter B. Administration and Organization

§6827. Governing Body

A. Each ARCP shall have an identifiable governing body with responsibility for, and authority over, the policies and activities of the ARCP and ultimate authority for:

1. the overall operation of the ARCP;
2. the adequacy and quality of care;
3. the financial solvency of the ARCP and the appropriate use of its funds;
4. the implementation of the standards set forth in these regulations; and
5. the adoption, implementation and maintenance, in accordance with the requirement of state and federal laws and regulations and these licensing standards, of adult residential care and administrative policies governing the operation of the ARCP.

B. The ARCP shall have documents identifying the following information regarding the governing body:

1. names and addresses of all members;
2. terms of membership;
3. officers of the governing body; and
4. terms of office of any officers.

C. The governing body shall be composed of one or more persons. When the governing body is composed of only one person, this person shall assume all of the responsibilities of the governing body.

D. When the governing body is composed of two or more persons, the governing body shall hold formal meetings at least twice a year. There shall be written minutes

of all formal meetings and bylaws specifying frequency of meetings and quorum requirements.

E. Responsibilities of a Governing Body. The governing body of an ARCP shall:

1. ensure the ARCP's compliance and conformity with the provider's charter or other organizational documents;
2. ensure the ARCP's continual compliance and conformity with all relevant federal, state, local, and municipal laws and regulations;
3. ensure that the ARCP is adequately funded and fiscally sound;
4. review and approve the ARCP's annual budget;
5. designate a person to act as director and delegate sufficient authority to this person to manage the ARCP;
6. formulate and annually review, in consultation with the director, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management;
7. annually evaluate the director's performance;
8. have the authority to dismiss the director; and
9. meet with designated representatives of the department whenever required to do so.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6829. Policy and Procedures

A. The ARCP shall have written policies and procedures approved by the governing body that, at a minimum, address the following:

1. confidentiality and security of files;
2. publicity and marketing;
3. personnel;
4. resident's rights;
5. grievance procedures;
6. resident's funds;
7. emergency preparedness planning procedures to include plans for evacuation and sheltering in place;
8. abuse and neglect;
9. incidents and accidents;
10. pre-residency screening and residency criteria and limitations;
11. medication management;
12. nursing services;
13. smoking;
14. pet policy;
15. resident responsibilities;
16. record-keeping;
17. infection control; and
18. any other area required in accordance with memorandums issued by the department's Health Standards Section.

B. Personnel Policies. An ARCP shall have written personnel policies that include:

1. a plan for recruitment, screening, orientation, ongoing training, development, supervision, and performance evaluation of staff members;
2. written job descriptions for each staff position;
3. policies which provide for staff, upon offer of employment, to have a health assessment as defined by the provider and in accordance with state *Sanitary Code*;
4. an employee grievance procedure;

5. abuse reporting procedures that require all employees to report any incidents of abuse or mistreatment whether that abuse or mistreatment is done by another staff member, a family member, a resident or any other person; and

6. a policy to prevent discrimination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter C. Residency Criteria, Person-Centered Service Plans, and Residency Agreements

§6833. Pre-Residency and Continued Residency

A. Information to Prospective Residents. The ARCP shall provide to prospective residents written information regarding conditions for residency, services, costs, fees and policies/procedures. This written information shall include, but is not limited to the following:

1. the application process and the possible reasons for rejection of an application;
2. types of residents suitable to the ARCP;
3. services offered and allowed in the ARCP;
4. resident's responsibilities;
5. policy regarding smoking;
6. policy regarding pets;
7. fee structure, including but not limited to any additional costs for providing services to residents during natural disasters (e.g. tropical storms, hurricanes, floods, etc.):

a. the ARCP shall develop and provide a formula with cost parameters for any additional charges incurred due to disasters; and

8. criteria for termination of residency agreement.

B. The ARCP shall complete and maintain a pre-residency screening of the prospective resident to assess the applicant's needs and appropriateness for residency.

1. The pre-residency screening shall include:
 - a. the resident's physical and mental status;
 - b. the resident's need for personal assistance;
 - c. the resident's need for assistance with activities of daily living and instrumental activities of daily living; and
 - d. the resident's ability to evacuate the ARCP in the event of an emergency.

2. The pre-residency screening shall be completed and dated before the residency agreement is signed.

C. Prohibited Health Conditions. There are individuals who are not eligible for residency in ARCPs because their conditions and care needs are beyond the scope of the ARCP's capacity to deliver services and ensure residents' health, safety, and welfare. ARCPs may not enter into agreements with residents with such conditions. These prohibited health conditions include:

1. stage 3 or stage 4 pressure ulcers;
2. nasogastric tubes;
3. ventilator dependency;
4. dependency on BiPap, CPAP or other positive airway pressure device without the ability to self-administer at all times:

a. exception. The resident may remain in the ARCP when a third party is available at all times to administer the positive airway pressure device during the hours of use;

5. coma;

6. continuous IV/TPN therapy (TPN—total parental nutrition, intravenous form of complete nutritional sustenance);

7. wound vac therapy (a system that uses controlled negative pressure, vacuum therapy, to help promote wound healing);

8. active communicable tuberculosis; and

9. any condition requiring chemical or physical restraints.

D. ARCP residents with a prohibited condition may remain in residence on a time limited basis provided that the conditions listed below are met. *Time limited* is defined as 90 days.

1. The resident, the resident's representative, if applicable, the resident's physician and the provider shall agree that the resident's continued residency is appropriate.

2. The resident's physician has certified that the condition is time limited and not permanent.

3. The ARCP is prepared to coordinate with providers who may enter the ARCP to meet time limited needs. Level 4 ARCPs may deliver or contract for the additional services to meet time limited needs pursuant to this Section.

4. In accordance with the terms of the residency agreement, the resident or the resident's representative, if applicable, shall provide for or contract with a third-party provider for the delivery of services necessary to meet the residents' increased health and service needs which are beyond the scope of the services of the ARCP.

a. It is the responsibility of the ARCP to assure that needed services are provided, even if those services are provided by the resident's family or by a third party or contracted provider. A copy of such third party contract shall be verifiable, in writing, and retained in the resident's record. The ARCP retains responsibility for notifying the resident or the resident's representative, if applicable, if services are not delivered or if the resident's condition changes.

5. The ARCP or an affiliated business owned in full or in part by the owner or any member of the board of directors shall not be the third party providing the services.

6. The care provided, as allowed under this section, shall not interfere with ARCP operations or create a danger to others in the ARCP.

E. In level 4 ARCPs, residents whose health needs increase may continue to reside in the ARCP and receive intermittent nursing services from the ARCP in accordance with the PCSP if the services are within the scope provided for in these regulations.

F. In accordance with the terms of the residency agreement, residents who are receiving hospice services may continue to reside in all levels of the ARCP as long as the resident's physician, the ARCP, the resident and/or resident's legal representative, if applicable, deem that the resident's needs can be met.

G. Residency Agreement. The ARCP shall complete and maintain individual residency agreements with all persons who move into the ARCP or with the resident's representative where appropriate.

1. The ARCP residency agreement shall specify the following:

a. clear and specific criteria for residency, continued residency and termination of residency

agreements and procedures for termination of residency agreements;

- b. basic services provided;
- c. optional services;
- d. payment provisions for both basic and optional services, including the following:

i. service packages and any additional charges for services;

- ii. regular/ordinary and extra fees;
- iii. payer source;
- iv. due dates; and
- v. deposits;

e. procedures for the modification of the residency agreement, including provision of at least 30 days prior written notice to the resident of any rate change;

f. requirements around notice before voluntarily terminating the residency agreement;

g. refund policy;

h. the delineation of responsibility among the following parties: the ARCP, the resident, the family, the resident's representative and/or others;

- i. residents' rights; and
- j. grievance procedures.

2. The ARCP shall allow review of the residency agreement by an attorney or other representative chosen by the resident.

3. The residency agreement shall be signed by the director, or designee, and by the resident or the resident's representative if applicable.

4. The residency agreement shall conform to all relevant federal, state and local laws and requirements.

5. The residency agreement shall provide a process for involuntary termination of the residency agreement that includes, at a minimum, the following:

a. an informal administrative grievance process for providing to the resident or resident's responsible party, if applicable, written notice of any adverse action for violation(s) of the terms of the residency agreement that includes the following:

i. notice shall allow the resident a minimum of 30 calendar days from date of delivery of written notice to vacate the ARCP premises; however, the advance notice period may be shortened to 15 calendar days for nonpayment of a bill for a stay at the ARCP; and

ii. the notice shall allow a minimum of 10 calendar days for resident's corrective action; and

b. the grievance process shall be offered upon the date of delivery of written notice to vacate the ARCP premises that includes, at a minimum:

i. an offer of request for an informal meeting provided to the resident or the resident's responsible party, if applicable;

ii. the informal meeting shall be held within 5 working days from the date of such request; and

iii. written notice of final decision shall be provided within five calendar days of the meeting.

6. The residency agreement shall include provisions for the opportunity for a formal appeal to the DAL for any involuntary termination of the residency agreement in accordance with §6837.B.2-4, including but not limited to, contact information for the DAL.

7. A formal appeal to the DAL shall not be available until the informal administrative grievance process is concluded and a final decision has been rendered.

a. A request for appeal shall be made within 30 calendar days of receipt of the results of the informal meeting, and the hearing shall be conducted by the DAL in accordance with the Administrative Procedure Act.

H. When the resident moves in, the ARCP shall:

1. obtain from the resident or if appropriate, the resident's representative, the resident's plan for both routine and emergency medical care which shall include:

- a. the name of physician(s); and
- b. provisions and authorization for emergency medical care;

2. provide the resident with a copy of the ARCP's emergency and evacuation procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6835. Person-Centered Service Plan

A. An assessment shall be initiated upon entry to the ARCP and completed within seven calendar days of the date that the resident moves into the ARCP to determine the service needs and preferences of the resident.

1. This assessment shall be kept in the resident's record.

2. If the resident's person-centered service plan includes staff administration of medication or intermittent nursing services, the assessment for those services shall be completed by a registered nurse.

B. Within 30 calendar days after the date the resident moves in, the ARCP designated staff in conjunction with the resident or the resident's representative, if applicable, shall develop a PCSP using information from the assessment. The PCSP shall include:

- 1. the services required to meet the resident's individual needs;
- 2. the scope, frequency, and duration of services;
- 3. monitoring that will be provided; and
- 4. who is responsible for providing the services, including contract or arranged services.

C. If the resident is enrolled in a home and community-based services waiver that includes ARCP as a service, a comprehensive plan of care prepared in accordance with policies and procedures established by Medicaid, or by a department program office, for reimbursement purposes may be substituted for the PCSP. If the resident needs services beyond those provided for in the comprehensive plan of care, the PCSP must be coordinated with the comprehensive plan of care.

D. A documented review of the PCSP shall be made at least every 90 calendar days and on an ongoing basis to determine its continued appropriateness and to identify when a resident's condition or preferences have changed. Changes to the plan may be made at any time, as necessary.

E. All plans, reviews and updates shall be signed by the resident, ARCP staff, and the resident's representative, if applicable. If the resident's PCSP includes staff administration of medication or intermittent nursing services, a registered nurse shall also sign the plans, reviews and updates.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6837. Termination of Residency Agreements

A. Voluntary Termination of Residency Agreement

1. The residency agreement shall specify:

a. the number of days and the process for notice required for voluntary termination of the residency agreement; and

b. the circumstances under which prepaid service charges and deposits are not refundable to the individual.

B. Involuntary Termination of Residency Agreements

1. The resident shall be allowed to continue residency in the ARCP unless one of the following occurs:

a. the resident's mental or physical condition deteriorates to a level requiring services that cannot be provided in accordance with these licensing regulations;

b. the resident's mental or physical condition deteriorates to a level requiring services that exceed those agreed upon in the residency agreement and PCSP;

c. the safety of other residents or staff in the ARCP is endangered;

d. the health of other residents or staff in the ARCP would otherwise be endangered;

e. the resident or resident's representative has failed to pay for a resident's stay at the ARCP; or

f. the ARCP ceases to operate.

2. Involuntary Termination Process

a. The resident, the resident's representative, if applicable, and the state and local long-term care ombudsman shall be notified in writing of the intent to terminate the residency agreement.

b. The notice shall be written in a language and in a manner that the resident and the resident's representative understand.

c. The written notice shall be given no less than 30 calendar days in advance of the proposed termination; however, the advance notice period may be shortened to 15 days for nonpayment of a bill for a stay at the ARCP.

d. The written notice shall contain:

i. the reason for the involuntary termination of the residency agreement;

ii. the right to informally dispute the ARCP's decision of the termination; and

iii. the right to formally appeal the results of the informal administrative grievance process.

3. The resident and/or the resident's representative, if applicable, shall have the right to dispute any involuntary termination of the residency agreement in accordance with §6833.G.5-7. If the resident and/or the resident's representative, if applicable, are not satisfied with the results of the informal meeting, an opportunity shall be afforded for an appeal of the involuntary termination to the DAL.

4. The involuntary termination of the residency agreement shall be suspended until a final determination is made by:

a. the ARCP in the informal process; or

b. the DAL, in the formal process if the resident or the resident's representative, if applicable, appeals the ARCP decision.

5. If the involuntary termination of the residency agreement is upheld, the ARCP shall provide assistance in locating an appropriate residence and services.

C. Emergencies. If an emergency arises whereby the resident presents a direct threat of serious harm, serious injury or death to the resident, another resident, or staff, the ARCP shall immediately contact appropriate authorities to determine an appropriate course of action.

1. The resident's removal from the premises in response to an emergency does not constitute termination of the residency agreement. Required notice as described above shall be provided if the ARCP wishes to terminate the residency agreement.

2. The ARCP shall document the nature of the emergency and the ARCP's response to it.

3. The ARCP shall notify the resident's representative of all emergencies immediately after notification of the appropriate authorities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter D. Adult Residential Care Provider Services

§6839. General Provisions

A. The services provided by the ARCP are dependent in part upon the level for which they are licensed and in part upon the optional services that the ARCP elects to provide.

B. An ARCP shall ensure that services meet a resident's personal and health care needs as identified in the resident's PCSP, meet scheduled and unscheduled care needs, and make emergency assistance available 24 hours a day. These services shall be provided in a manner that does not pose an undue hardship on residents.

1. An ARCP shall respond to changes in residents' needs for services by revising the PCSP and, if necessary, by adjusting its staffing.

2. The ARCP shall provide adequate services and oversight/supervision including adequate security measures, 24 hours per day as needed for any resident.

3. The ARCP shall provide a sanitary environment to avoid sources and transmission of infections and communicable diseases with its policy meeting or exceeding the latest criteria established by the Centers for Disease Control and state *Sanitary Code*.

C. Number of Residents. The maximum number of residents that an ARCP shall serve will be based upon the level and plan as approved by the OSFM and/or the department's Health Standards Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6841. Required and Optional Services

A. Required services. The ARCP must provide or coordinate, to the extent needed or desired by each resident, the following required services:

1. assistance with activities of daily living and instrumental activities of daily living;

2. meals;

3. basic personal laundry services or laundry facilities;

4. opportunities for individual and group socialization including regular access to the community resources;

5. transportation either provided or arranged by the ARCP;

6. housekeeping services essential for health and comfort of the resident (e.g., floor cleaning, dusting, changing of linens); and

7. a recreational program.

B. Optional Services

1. All Levels of ARCPs may provide the services listed below. If these optional services are provided, they must be provided in accordance with the PCSP:

- a. medication administration;
- b. financial management; and
- c. specialized dementia care programs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6843. Medication Administration

A. The ARCP shall have written policies and procedures on medication administration including self-administration, assistance with self-administration, gratuitous administration or third-party administration, and staff administration of medications. There shall also be policies regarding obtaining and refilling medications, storing and controlling medications, disposing of medications, and documentation of medication administration.

B. The ARCP shall record in the resident's PCSP whether the resident can self-administer medication, needs assistance with self-administration, has gratuitous administration, or third-party administration or requires staff administration of medication. The determination of the need for staff administration of medication will be made by the resident's physician after assessment of the resident, and after consultation with the resident, resident's legal representative if applicable, and the ARCP staff. The PCSP shall also include how the medication will be obtained and stored.

C. Levels of Administration

1. Self-Administration. Unless otherwise indicated in the PCSP, residents shall have the option to self-administer their own medications. Residents who are appropriate for this service will be aware of what the medication is, what it is for and the need for the medication. Self-medication means residents can maintain possession and control of their medications. However, the ARCP shall require the resident to undertake reasonable precautions to ensure the safety of other residents.

2. Assistance with Self-Administration. Unless otherwise indicated in the PCSP, residents may elect assistance with self-medication if it is a service offered by the ARCP. Residents who are appropriate for this service will be aware of what the medication is, what it is for and the need for the medication.

a. Assistance with self-administration may be provided by staff members who hold no professional licensure, as long as that employee has documented training on the policies and procedures for medication assistance, including the limitations of assistance. This training must be repeated at least annually.

b. Assistance with self-administration of medication shall be limited to the following:

i. reminding residents that it is time to take medication(s), where such medications have been prescribed

for a specific time of day, a specific number of times per day, specific intervals of time or for a specific time in relation to mealtimes or other activities such as arising from bed or retiring to bed;

ii. reading the medication regimen as indicated on the container to the resident;

iii. physically assisting residents who are familiar with their medications by opening a medication container and/or providing assistance with pouring medications;

iv. offering liquids to residents who are familiar with their medications to assist that resident in ingesting oral medications; and

v. physically bringing a container of oral medications to residents.

c. Assistance with self-administration of medications shall not include:

i. administering injections of any kind;

ii. administering any prescription medications including, but not limited to, eye drops, ear drops, nose drops, liquid medications, inhalers, suppositories, or enemas;

iii. prompting or reminding a resident that it is time to take a PRN, or as-needed medication;

iv. crushing or splitting medications;

v. placing medications in a feeding tube; or

vi. mixing medications with foods or liquids.

3. Staff Administration of Medication

a. The ARCP shall administer medications to ARCP residents in accordance with their PCSP. Staff administration of medications may be provided by all levels of ARCPs.

b. Medications shall be administered only by an individual who is currently licensed to practice medicine or osteopathy by the appropriate licensing agency for the state, or by an individual who is currently licensed as an RN or LPN by the appropriate state agency.

c. In level 4 ARCPs only, staff administration of medication may include intravenous therapy. Intravenous therapy is permitted on a time limited basis and must be under the supervision of a licensed RN, physician, or advanced practice nurse.

d. The ARCP shall require pharmacists to perform a monthly review of all ordered medication regimens for possible adverse drug interactions and to advise the ARCP and the prescribing health care provider when adverse drug interactions are detected. The ARCP shall notify the prescribing health care provider of the pharmacist's review related to possible adverse drug interactions, and shall have documentation of this review and notification in the resident's record.

e. Medication Orders and Records

i. Medications, including over-the-counter medications, may be administered to a resident of an ARCP only after the medications have been prescribed specifically for the resident by an individual currently licensed to prescribe medications. All orders for medications shall be documented, signed and dated by the resident's licensed practitioner.

ii. Only an authorized licensed medical professional shall accept telephone orders for medications from a physician or other authorized practitioner. All telephone orders shall be documented in the resident's record. The telephone order shall be signed by the prescriber within 14 days of the issuance of the order.

- iii. The ARCP is responsible for:
 - (a) complying with the physician orders, associated with medication administration;
 - (b) clarifying orders as necessary;
 - (c) notifying the physician of resident refusal of the medication or treatment; and
 - (d) notifying the physician of any adverse reactions to medications or treatments.

iv. All medications administered by staff to residents in an ARCP, including over the counter medications, shall be recorded on a medication administration record at the same time or immediately after the medications are administered.

v. The medication administration record shall include at least the following:

- (a) the name of the resident to whom the medication was administered;
- (b) the name of the medication administered (generic, brand or both);
- (c) the dosage of the medication administered;
- (d) the method of administration, including route;
- (e) the site of injection or application, if the medication was injected or applied;
- (f) the date and time of the medication administration;
- (g) any adverse reaction to the medication; and
- (h) the printed name and written or electronic signature of the individual administering the medication.

vi. Medication administration records and written physician orders for all over-the-counter medications, legend drugs and controlled substances shall be retained for period of not less than five years. They shall be available for inspection and copying on demand by the state regulatory agency.

vii. The most current edition of drug reference materials shall be available.

viii. All medication regimes and administration charting shall be reviewed by a licensed RN at least weekly to:

- (a) determine the appropriateness of the medication regime;
- (b) evaluate contraindications;
- (c) evaluate the need for lab monitoring;
- (d) make referrals to the primary care physician for needed monitoring tests;
- (e) report the efficacy of the medications prescribed; and
- (f) determine if medications are properly being administered in the ARCP.

4. Contracted Third-Party Administration

a. The ARCP or the resident or the resident's representative, if applicable, may contract with an individual or agency to administer resident's prescribed medications. The ARCP shall ensure that medications shall be administered by an individual who is currently professionally licensed in Louisiana to administer medications.

b. A copy of such third-party contract shall be verifiable in writing and retained in resident's record. The ARCP retains responsibility for notifying the resident or

resident's legal representative, if applicable, if services are not delivered or if the resident's conditions changes.

D. Storage of Medications

1. An ARCP shall not stock or dispense resident medications. Where medications are kept under the control or custody of an ARCP, the medications shall be packaged by the pharmacy and shall be maintained by the ARCP as dispensed by the pharmacist.

2. Medication stored by the ARCP shall be stored in an area inaccessible to residents and accessible only to authorized personnel. This area must be kept locked. Any other staff (e.g., housekeeping, maintenance, etc.) needing access to storage areas must be under the direct visual supervision of authorized personnel.

3. All medications must be stored in accordance with industry standards or according to manufacturer's recommendations.

4. If controlled substances prescribed for residents are kept in the custody of the ARCP, they shall be stored in a manner that is compliant with local, state and federal laws. At a minimum, controlled substances in the custody of the ARCP shall be stored using a double lock system, and the ARCP shall maintain a system to account for the intake, distribution, and disposal of all controlled substances in its possession and maintain a written policy and procedure regarding such.

5. All other medications in the ARCP shall be stored using at least a single lock mechanism. This shall include medications stored in a resident's room whereby the staff and the resident have access to the medications. When residents self-administer their medications, the medications shall be stored in a locked area or container accessible only to the resident, resident's family and staff or may be stored in the resident's living quarters, if the room is single occupancy and has a locking entrance.

6. Any medication stored by the ARCP requiring refrigeration shall be kept separate from foods in separate containers within a refrigerator and shall be stored at appropriate temperatures according to the medication specifications. A daily temperature log must be maintained at all times for the refrigerator. No lab solutions or lab specimens may be stored in refrigerators used for the storage of medications or food.

7. The medication preparation area shall have an operable hand washing sink with hot and cold water, paper towels and soap or an alternative method for hand sanitization.

8. Medications shall be under the direct observation of the person administering the medications or locked in a storage area.

E. Labeling of Medications

1. All containers of medications shall be labeled in accordance with the rules of the Board of Pharmacy and any local, state, and federal laws.

2. Medication labels shall include appropriate cautionary labels. (e.g., shake well, take with food, or for external use only.)

3. Medications maintained in storage must contain the original manufacturer's label with expiration date or must be appropriately labeled by the pharmacy supplying the medications.

4. Any medications labeled for single resident use may not be used for more than one resident. One resident's medications cannot be used for another resident.

5. Any medication container with an unreadable label shall be returned to the issuing pharmacy for relabeling. Conditions that might affect readability include but are not limited to detachment, double labeling, excessive soiling, wear or damage.

F. Disposal of Medications

1. All medications and biologicals disposed of by the ARCP shall be according to ARCP policy and subject to all local, state and federal laws.

2. Expired medications shall not be available for resident or staff use. They shall be destroyed no later than 30 days from their expiration/discontinuation date.

3. Medications awaiting disposition must be stored in a locked storage area.

4. Medications of residents who no longer reside in the ARCP shall be returned to the resident or the resident's representative, if applicable. The resident or the resident's representative shall sign a statement that these medications have been received. The statement shall include the pharmacy, prescription number, date, resident's name, name and strength of the medication and amount returned. This statement shall be maintained in the resident's termination of services record.

5. When medication is destroyed on the premises of the ARCP, a record shall be made and filed at the ARCP according to ARCP policy.

a. This record shall include, but is not limited to:

- i. name of ARCP;
- ii. name of the medication;
- iii. method of disposal;
- iv. pharmacy;
- v. prescription number;
- vi. name of the resident;
- vii. strength of medication;
- viii. dosage of medication;
- ix. amount destroyed; and
- x. reason for disposition.

b. This record shall be signed and dated by the individual performing the destruction and by at least one witness.

c. The medication must be destroyed by a licensed pharmacist, RN or physician.

6. Controlled dangerous substances shall be destroyed in accordance with the provisions of LAC 46:LIII.2749.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6845. Intermittent Nursing Services

A. Intermittent nursing services may be provided by level 4 ARCPs only. At no time shall an ARCP serve as provider for a resident whose condition is so unstable as to require continuous monitoring by licensed professional staff.

B. Where intermittent nursing services are provided, the following provisions shall apply.

1. All nursing services shall be provided in accordance with acceptable standards of practice and shall be delivered as prescribed by the resident's physician and in accordance with the PCSP.

2. The ARCP shall have written policies and procedures governing intermittent nursing services, including but not limited to the following:

a. responding to medical emergencies on all shifts;

b. ensuring that there is sufficient nursing staff to meet the needs of the residents;

c. ensuring that the ARCP's licensed nurse is notified of nursing needs as identified in the PCSP for each resident;

d. defining the duties, responsibilities and limitations of the ARCP licensed nurse in policy and procedures;

e. defining the policy for conducting nursing assessments;

f. delegating and training of ARCP staff to assist with nursing services;

g. coordinating with other third party contracted health service providers;

h. documentation by nursing personnel; and

i. infection control.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6847. Transportation

A. If the resident's condition is such that they are unable to manage their own transportation needs, the ARCP shall provide or arrange transportation for the following:

1. all medical services, including ancillary services for medically-related care;

2. scheduled personal services, including barber/beauty services;

3. scheduled personal errands; and

4. social/recreational opportunities.

B. The ARCP shall ensure and document that any vehicle used in transporting residents, whether such vehicles are operated by a staff member or any other person acting on behalf of the provider, is inspected and licensed in accordance with state law. The ARCP shall also have current commercial liability insurance.

C. When transportation services are provided by the ARCP, whether directly or by third-party contract, the provider shall:

1. document and ensure that drivers have a valid driver's license;

2. document and ensure that drivers have a valid chauffeur's license or commercial driver's license with passenger endorsement upon hire, if applicable.

D. When transportation services are provided by the ARCP, the ARCP shall:

1. ensure drivers are trained in assisting residents in accordance with the individual resident's needs;

2. obtain documentation to ensure a safe driving record from the Louisiana Department of Motor Vehicles (DMV) upon hire and annually; and

3. ensure drivers meet personnel and health qualifications of other staff and receive necessary and appropriate training to ensure competence to perform duties assigned.

E. Vehicles shall be handicapped accessible or otherwise equipped to meet the needs of residents served.

F. Verifications by the ARCP shall not be required if the ARCP utilizes a third-party transportation company that is authorized by the department to participate as an NEMT provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6849. Meals Provided by the ARCP

A. For meals that are prepared and/or served by the ARCP, the ARCP shall offer to residents who choose to participate, a minimum of three varied, palatable meals per day, seven days a week.

1. Foods shall be prepared and served in a way that assures that they are appetizing, attractive, and nutritious and that promotes socialization among the residents.

2. The ARCP is permitted to offer liberalized diets. The nutritionist or licensed dietician may recommend to the physician to temporarily abate dietary restrictions and liberalize the diet to improve the resident's food intake.

B. The ARCP shall make reasonable accommodations, as stated in the residents' PCSP to:

1. meet dietary requirements, including following medically prescribed diets; however, nothing herein shall be construed to prohibit the ARCP from offering liberalized diets as recommended by the nutritionist or licensed dietician;

2. meet religious and ethnic preferences;

3. meet the temporary need for meals delivered to the resident's living area;

4. meet residents' personal routines and preferences; and

5. ensure snacks, fruits and beverages are available to residents at all times.

C. Staff shall be available in the dining area to assist with meal service, meal set up and to give individual attention as needed.

1. Dietary staff shall not store personal items within the food preparation and storage areas.

2. The kitchen shall not be used for dining of residents or unauthorized personnel.

3. Dietary staff shall use good hygienic practices.

4. 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.

5. Staff with communicable diseases or infected skin lesions shall not have contact with food if that contact will transmit the disease.

6. Garbage and refuse shall be kept in durable, easily cleanable, covered containers that do not leak and do not absorb liquids.

7. Containers used in food preparation and utensil washing areas shall be kept covered when meal preparation is completed and when full.

D. If a licensed dietician is not employed full-time, the ARCP shall designate a full-time person to serve as the dietary manager.

1. The dietary manager who oversees food preparation may also fulfill other staff roles in the ARCP.

2. The dietary manager shall have Servsafe® certification.

E. Serving times for meals prepared and/or served by the ARCP shall be posted.

F. The menus for meals prepared and/or served by the ARCP, at a minimum, shall be reviewed and approved by a nutritionist or licensed dietician to assure their nutritional appropriateness for the setting's residents.

1. Menus shall be planned and written at least one week in advance and dated as served. The current week's menu shall be posted in one or more prominent place(s) for the current week in order to facilitate resident's choices about whether they wish to join in the meals prepared and/or served by the ARCP.

2. The ARCP shall furnish medically prescribed diets to all residents for which it is designated in the service plan.

3. Records of all menus as serviced shall be kept on file for at least 30 days.

4. All substitutions made on the master menu shall be recorded in writing.

G. Medically prescribed diets, prepared and/or served by the ARCP, shall be documented in the resident's record. There shall be a procedure for the accurate transmittal of dietary orders to the dietary manager when the resident does not receive the ordered diet or is unable to consume the diet, with action taken as appropriate.

H. Food shall be in sound condition, free from spoilage, filth, or other contamination and shall be safe for human consumption.

I. All food preparation areas (excluding areas in residents units) shall be maintained in accordance with LAC Title 51 state *Sanitary Code*. Pets are not allowed in food preparation and serving areas.

J. If food is prepared in a central kitchen and delivered to separate physical sites, provision shall be made for proper maintenance of food temperatures and a sanitary mode of transportation.

K. Refrigeration

1. The ARCP's refrigerator(s) shall be maintained at a temperature of 41 degrees Fahrenheit or below.

2. The ARCP shall maintain daily temperature logs for all refrigerators and freezers.

3. Food stored in the refrigerator shall be covered, labeled, and dated.

L. The water supply shall be adequate, of a safe sanitary quality and from an approved source. Clean sanitary drinking water shall be available and accessible in adequate amounts at all times.

M. The ice scoop for ice machines shall be maintained in a sanitary manner with the handle at no time coming in contact with the ice.

N. Poisonous and toxic materials shall be appropriately identified, labeled and placed in locked cabinets which are used for no other purpose.

O. Written reports of inspections by OPH shall be kept on file in the ARCP.

P. If meals are provided by a third party service, the ARCP retains the responsibility to ensure that all regulations of this part are met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6851. Specialized Dementia Care Programs

A. Scope and Purpose. The ARCP may establish a separate and distinct program to meet the needs of residents with Alzheimer's disease or a related disorder. The ARCP shall provide a program of individualized care based upon an assessment of the cognitive and functional abilities of residents who have been included in the program.

B. Any ARCP that offers such a program shall disclose this program to the department upon establishing the program or upon its discontinuance.

C. Policies and Procedures

1. An ARCP that advertises, promotes or markets itself as offering a specialized dementia care program shall have written policies and procedures for the program that are retained by the administrative staff and available to all staff, to members of the public, and to residents, including those participating in the program.

2. The ARCP shall have established criteria for inclusion in the specialized dementia care program.

3. Guidelines for inclusion shall be provided to the resident, his/her family, and his/her legal representative.

4. Door locking arrangements to create secured areas may be permitted where the clinical needs of the residents require specialized protective measures for their safety, provided that such locking arrangements are approved by the OSFM and satisfy the requirements established by the OSFM and in accordance with R.S. 40:1300.121, et seq.

a. If the services are provided in a secured area where special door locking arrangements are used, the ARCP shall comply with the requirements established for limited health care occupancies in accordance with the laws, rules and codes adopted by the OSFM.

b. The secured areas shall be designed and staffed to provide the care and services necessary for the resident's needs to be met.

c. There shall be sufficient staff to respond to emergency situations in the locked unit at all times.

d. PCSPs shall address the reasons for the resident being in the unit and how the ARCP is meeting the resident's needs.

e. 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.

f. Inclusion in a program on the unit must be in compliance with R.S. 40:1299.53.

D. Staff Training. Training in the specialized care of residents who are diagnosed by a physician as having Alzheimer's disease, or a related disorder, shall be provided to all persons employed by the ARCP in accordance with the provisions established in §6867 of this Chapter.

E. Disclosure of Services. An ARCP that advertises or markets itself as offering a specialized dementia care program shall provide in writing the following to any member of the public seeking information about the program:

1. the form of care or treatment provided that distinguishes it as being especially applicable to or suitable for such persons;

2. the philosophy and mission reflecting the needs of residents living with dementia;

3. the criteria for inclusion in the program and for discontinuance of participation should that become appropriate;

4. the assessment, care planning and the processes for ensuring the care plan's responsiveness to the changes in the resident's condition;

5. the staffing patterns, training and continuing education;

6. the physical environment and design features appropriate to support the functioning of residents living with dementia;

7. the involvement of families and the availability of family support programs;

8. the activities that are specifically directed toward residents diagnosed with Alzheimer's or a related disorder including, but not limited to, those designed to maintain the resident's dignity and personal identity, enhance socialization and success, and accommodate the cognitive and functional ability of the resident;

9. the frequency of the activities that will be provided to such residents;

10. the safety policies and procedures and any security monitoring system that is specific to residents diagnosed with Alzheimer's or a related disorder including, but not limited to safety and supervision within the secured unit and within the secured exterior area; and

11. the program fees.

F. An ARCP that advertises or markets itself as having a specialized dementia care program shall provide a secured exterior area for residents to enjoy the outdoors in a safe and secure manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8 and R.S. 40:1300.121-125.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter E. Resident Protection

§6855. Resident Rights

A. ARCPs shall have a written policy on resident rights and shall post and distribute a copy of those rights. In addition to the basic civil and legal rights enjoyed by other adults, residents shall have the rights listed below. ARCP policies and procedures must be in compliance with these rights. Residents shall:

1. be encouraged in the exercise of their civil or legal rights, benefits or privileges guaranteed by the Constitution of the United States and the Constitution of the State of Louisiana including the right to be free of discrimination or segregation based upon race, sex, handicap, religion, creed, national background or ancestry with respect to residency;

2. be treated as individuals in a manner that supports their dignity;

3. be assured choice and privacy and the opportunity to act autonomously, take risks to enhance independence and share responsibility for decisions;

4. participate and have family participate, if desired, in the planning of activities and services;

5. receive care and services that are adequate, appropriate, and in compliance with contractual terms of residency, relevant federal and state laws, rules and regulations and shall include the right to refuse such care and services;

6. receive upon moving in, and during his or her stay, a written statement of the services provided by the ARCP and the charges for these services;

7. be free from mental, emotional, and physical abuse and neglect, from chemical or physical restraints, and from financial exploitation and misappropriation of property;

8. have records and other information about the resident kept confidential and released only with the written consent of the resident or resident's representative or as required by law;

9. expect and receive a prompt response regarding requests (service, information, etc.) from the director and/or staff;

10. have the choice to contract with a third-party provider for ancillary services for medically related care (e.g., physician, pharmacist, therapy, podiatry, hospice,) and other services necessary as long as the resident remains in compliance with the contractual terms of residency;

11. be free to receive visitors of their choice without restriction except where the residents share bedrooms or apartments:

a. Where residents do share bedrooms or apartments, reasonable restrictions that provide for the health, safety, and privacy of other residents shall be allowed.

12. manage their personal funds unless this authority has been delegated to the ARCP or to a third party by the resident, the resident's legal representative, or an agency that has the authority to grant representative payee status or fiscal management authority to a third party;

13. be notified, along with their representative in writing by the ARCP when the ARCP's license status is modified, suspended, revoked or denied renewal and to be informed of the basis of the action;

14. have choices about participation in community activities and in preferred activities, whether they are part of the formal activities program or self-directed;

15. share a room with a spouse or other consenting adult if they so choose;

16. voice grievances and suggest changes in policies and services to staff, advocates or outside representatives without fear of restraint, interference, coercion, discrimination, or reprisal and the ARCP shall make prompt efforts to address grievances including with respect to the behavior of other residents;

17. remain in their personal living area unless a change in the area is related to resident preference or to conditions stipulated in their contract, or necessitated by situations or incidents that create hazardous conditions in the living area;

18. live in a physical environment which ensures their physical and emotional security and well-being;

19. bring service animals into the ARCP;

20. bring pets into the ARCP if allowed by the ARCP and kept in accordance with the policies of the ARCP;

21. contact their advocates as provided by law;

22. be fully informed of all residents' rights and all rules governing resident conduct and responsibilities;

23. be informed of proposed policy changes 30 days in advance;

24. be informed of how to lodge a complaint with the Health Standards Section, the Office of Civil Rights, the Americans with Disabilities Act, the Office of the State

Ombudsman, and the Advocacy Center. Contact information including telephone numbers and addresses for these entities shall be posted in a prominent location which is easily accessible to residents; and

25. have the right to privacy in his/her apartment or room(s), including the right to have:

a. a closed apartment or room door(s); and

b. the ARCP personnel knock before entering the apartment or room(s) and not enter without the resident's consent, except in case of an emergency or unless medically contraindicated.

B. Publicity. No resident shall be photographed or recorded without the resident's prior informed, written consent.

1. Such consent cannot be made a condition for joining, remaining in, or participating fully in the activities of the ARCP.

2. Consent agreements shall clearly notify the resident of his/her rights under this regulation and shall specify precisely what use is to be made of the photograph or recordings. Residents are free to revoke such agreements at any time, either orally or in writing.

3. All photographs and recordings shall be used in a way that respects the dignity and confidentiality of the resident. Recordings from security cameras placed in common areas of the building are not subject to publicity requirements for consent and shall not be used for publicity purposes.

C. Each resident shall be fully informed of their rights and responsibilities, as evidenced by written acknowledgment, prior to or at the time of occupancy and when changes occur. Each resident's file shall contain a copy of the written acknowledgment, which shall be signed and dated by the director and the resident and/or the resident's representative, if applicable.

D. The ARCP shall prominently post the grievance procedure, resident's rights, and abuse and neglect procedures in an area accessible to all residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6857. Restraints

A. ARCPs are prohibited from the use of physical and chemical restraints. The ARCP shall establish and maintain a restraint free environment by developing individual approaches to the care of the resident as determined by resident assessments and PCSPs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6859. Resident Representation and Grievance Procedures

A. Resident Association

1. The provider shall have a formal process and structure by which residents, in representative groups and/or as a whole, are given the opportunity to advise the director regarding resident services and life at the ARCP.

a. Any resident association requests, concerns or suggestions presented through this process shall be addressed by the director within a reasonable time frame, as necessitated by the concern, request or suggestion.

2. Staff may attend the residency association meetings only upon invitation made by the residents of the ARCP.

B. Grievance Procedure. A provider shall establish and have written grievance procedures to include, but not limited to:

1. a formal process to present grievances;
2. a formal appeals process for grievances;
3. a process to respond to residents and resident association requests and written grievances within seven days; and
4. the maintenance of a log to record grievances, investigation and disposition of grievances.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6861. Resident Personal Property and Funds

A. Personal Possessions. The ARCP may, at its discretion, offer safekeeping of valuable possessions. The ARCP shall have a written statement of its policy regarding the safekeeping of valuable possessions.

1. If the ARCP offers such a service, a copy of the written policy and procedures shall be given to a resident at the time of his/her occupancy.

2. The ARCP shall give the resident a receipt listing each item that the ARCP is holding in trust for the resident. A copy of the receipt shall be placed in the resident's record. The list shall be revised as items are added or removed.

B. Resident Funds

1. An ARCP may offer to safe keep residents' readily accessible personal funds up to \$200 and/or assist with management of funds in excess of \$200. The ARCP shall ensure that the resident's funds are readily available upon resident's request.

2. The residency agreement shall include the resident's rights regarding access to the funds, limits on incremental withdrawals, and the charges for the service, if any.

3. The ARCP shall provide a surety bond or otherwise provide assurance satisfactory to the secretary to assure the security of all personal funds entrusted to the ARCP.

4. If an ARCP offers the service of safekeeping readily accessible personal funds up to \$200, and if a resident wishes to entrust funds, the ARCP shall:

- a. obtain written authorization from the resident and/or the resident's representative, if applicable, as to safekeeping of funds;
- b. provide each resident with a receipt listing the amount of money the ARCP is holding in trust for the resident;
- c. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the resident for each transaction; and
- d. afford the resident the right to examine the account during routine business hours.

5. If an ARCP offers the service of assisting with management of funds in excess of \$200, the following shall apply.

- a. The ARCP shall obtain written authorization to manage the resident's funds from the resident and the representative if applicable.
- b. The resident shall have access through quarterly statements and, upon request, financial records.

c. The ARCP shall keep funds received from the resident for management in an individual account in the name of the resident.

d. Unless otherwise provided by state law, upon the death of a resident, the ARCP shall provide the executor or director of the resident's estate, or the resident's representative, if applicable, with a complete accounting of all the resident's funds and personal property being held by the ARCP. The ARCP shall release the funds and property in accordance with all applicable state laws.

6. If ARCP staff is named as representative payee by Social Security or the Railroad Retirement Board or as fiduciary by the US Department of Veterans Affairs, in addition to meeting the requirements of those agencies, the ARCP shall hold, safeguard, manage and account for the personal funds of the resident as follows.

a. The ARCP shall deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) separate from the ARCP's operating accounts, and that credits all interest earned on the resident's funds to that account. In pooled accounts, there shall be a separate accounting for each resident's share.

b. The ARCP shall maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest bearing account, or petty cash fund.

c. The ARCP shall establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the ARCP on the resident's behalf.

i. The system shall preclude any comingling of resident funds with ARCP funds or with the funds of any person other than another resident.

ii. The individual financial record shall be available through quarterly statements and on request to resident and/or the resident's representative, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter F. Requirements Related to Staff, Record-Keeping and Incident Reports

§6863. General Provisions

A. The ARCP shall have qualified staff sufficient in number to meet the scheduled and unscheduled needs of residents and to respond in emergency situations.

B. Sufficient direct care staff shall be employed or contracted to ensure provision of personal assistance as required by the resident's PCSP.

C. Additional staff shall be employed as necessary to perform office work, cooking, house cleaning, laundering, and maintenance of buildings, equipment and grounds.

D. A staff member trained in the use of cardio pulmonary resuscitation (CPR) and first aid shall be on duty at all times.

E. Staff shall have sufficient communication and language skills to enable them to perform their duties and interact effectively with residents and staff.

F. The ARCP shall maintain a current work schedule for all employees showing actual coverage for each 24-hour day.

G. Criminal history checks and offers of employment shall be completed in accordance with R.S. 40:1300.52.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6865. Staffing Requirements

A. At a minimum the following staff positions are required. For ARCPs level 2 through 4, one person may occupy more than one position in the ARCP but shall not be in this position on the same shift. In a level 1 ARCP, one person may occupy more than one staff position on the same shift.

1. Director. Each ARCP shall have a qualified director who is responsible for the day-to-day management, supervision, and operation of the ARCP and who shall be on-site no less than 20 hours per week.

a. One or more assistant directors may be required, based upon the licensed capacity of the ARCP. The department may make a determination that one or more assistant directors are necessary based upon compliance history.

b. During periods of temporary absence of the director, there shall be a responsible staff person designated to be in charge that has the knowledge and responsibility to handle any situation that may occur.

c. The director shall be at least 21 years of age and have the responsibility and authority to carry out the policies of the provider.

d. Director Qualifications

i. For levels 1 and 2, the director shall meet one of the following criteria upon date of hire:

(a). have at least an associate's degree from an accredited college plus one year of experience in the fields of health, social services, geriatrics, management or administration; or

(b). in lieu of an associate's degree from an accredited college three years of experience in health, social services, geriatrics, management, administration; or

(c). a bachelor's degree in geriatrics, social services, nursing, health care administration or related field.

ii. For levels 3 and 4, the director shall meet one of the following criteria upon date of hire:

(a). a bachelor's degree plus two years of administrative experience in the fields of health, social services, or geriatrics;

(b). in lieu of a bachelor's degree, six years of administrative experience in health, social services, or geriatrics;

(c). a master's degree in geriatrics, health care administration, or in a human service related field; or

(d). be a licensed nursing facility administrator.

iii. Additionally, for level 4 ARCPs the director shall have successfully completed an adult residential care/assisted living director certification/training program consisting of, at a minimum, 12 hours of training that has been approved by any one of the following organizations:

(a). Louisiana Board of Examiners of Nursing Facility Administrators;

(b). Louisiana Assisted Living Association (LALA);

(c). LeadingAge Gulf States;

(d). Louisiana Nursing Home Association (LNHA); or

(e). any of the national assisted living associations, including the:

(i). National Center for Assisted Living (NCAL);

(ii). Assisted Living Federation of America (ALFA); or

(iii). LeadingAge.

iv. Training shall begin within 6 months and completed within 12 months of being appointed director.

v. Two years of experience as an assisted living director may be substituted in lieu of the certification requirements.

vi. Documentation of the director's qualifications shall be maintained on file at the ARCP.

2. Designated Recreational/Activity Staff. There shall be an individual designated to organize and oversee the recreational and social programs of the ARCP.

3. Direct Care Staff

a. The ARCP shall demonstrate that sufficient and trained direct care staff is scheduled and on-site to meet the 24-hour scheduled and unscheduled needs of the residents.

b. The ARCP shall be staffed with direct care staff to properly safeguard the health, safety and welfare of clients.

c. The ARCP shall employ direct care staff to ensure the provision of ARCP services as required by the PCSP.

d. Staff shall not work simultaneously at more than one ARCP on the same shift.

e. A direct care staff person who is not in the ARCP, but who is scheduled on the shift as on call shall not be included as direct care staff on any shift.

f. The ARCP shall maintain a current work schedule for all employees indicating adequate coverage for each 24-hour day.

B. Nursing Staff

1. In ARCPs that offer staff medication administration and level 4 ARCPs, the ARCP shall provide a sufficient number of RNs and LPNs to provide services to all residents in accordance with each resident's PCSP 24 hours per day.

2. Nursing Director

a. Level 4 ARCPs shall employ or contract with at least one RN who shall serve as the nursing director and who shall manage the nursing services. The nursing director need not be physically present at all times at the ARCP; however, the nursing director or his or her designee shall be on call and readily accessible to the ARCP 24 hours a day.

b. The nursing director, in conjunction with the resident's physician, shall be responsible for the preparation, coordination and implementation of the health care services section of the resident's PCSP.

c. The nursing director shall review and oversee all LPNs and direct care personnel with respect to the performance of health related services.

d. The nursing director shall be licensed by, and in good standing with, the Louisiana State Board of Nursing, and shall comply with all applicable licensing requirements.

3. Licensed Practical Nurses (LPNs). LPNs employed by or contracted with shall be licensed by, and in good standing with, the Louisiana State Board of Practical Nursing, and shall comply with all applicable nursing requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6867. Staff Training

A. All staff shall receive the necessary and appropriate training to assure competence to perform the duties that are assigned to them.

1. All staff shall receive any specialized training required by law or regulation to meet resident's needs.

2. The ARCP shall maintain documentation that orientation and annual training has been provided for all current employees.

3. Orientation shall be completed within seven days of hire and shall include, in addition to the topics listed in §6867.B, the following topics:

- a. the ARCP's policies and procedures; and
- b. general overview of the job specific requirements.

B. The following training topics shall be covered in orientation and annually thereafter for all staff and ARCP contracted providers having direct contact with residents:

1. residents' rights;
2. procedures and requirements concerning the reporting of abuse, neglect, exploitation, misappropriation and critical incidents;
3. building safety and procedures to be followed in the event of any emergency situation including instructions in the use of fire-fighting equipment and resident evacuation procedures including safe operation of fire extinguishers and evacuation of residents from the building;
4. basic sanitation and food safety practices;
5. requirements for reporting changes in resident's health conditions; and
6. infection control.

C. Training for Direct Care Staff

1. In addition to the topics listed in §6867.A.3 and §6867.B, orientation for direct care staff shall include five days of direct observation of the performance of ADL and IADL assistance. A new employee shall not be assigned to carry out a resident's PCSP until competency has been demonstrated and documented.

2. In addition to the required dementia training in §6867.F, direct care staff shall receive 12 hours of annual training which shall be recorded and maintained in the employee personnel file.

3. Annual training shall address the special needs of individual residents and address areas of weakness as determined by the direct care staff performance reviews.

4. All direct care staff shall receive certification in cardiac pulmonary resuscitation and adult first aid within the first 90 days of employment. The ARCP shall maintain the documentation of current certification in the staff's personnel file.

5. Orientation and five days of supervised training may qualify as the first year's annual training requirements. However, normal supervision shall not be considered to meet this requirement on an annual basis.

D. Continuing Education for Directors. All directors shall obtain 12 continuing education units per year. Topics shall include, but shall not be limited to:

1. person-centered care;
2. specialty training in the population served;
3. supervisory/ management techniques; and/or
4. geriatrics.

E. Third-Party Providers. A general orientation and review of ARCP policies and procedures is required to be provided to third-party providers entering the building to serve residents.

F. Dementia Training

1. All employees shall be trained in the care of persons diagnosed with dementia and dementia-related practices that include or that are informed by evidence-based care practices. New employees must receive such training within 90 days from the date of hire.

2. All employees who provide care to residents in a specialized dementia care program shall meet the following training requirements.

a. Employees who provide direct face-to-face care to residents shall be required to obtain at least eight hours of dementia-specific training within 90 days of employment and eight hours of dementia-specific training annually. The training shall include the following topics:

- i. an overview of Alzheimer's disease and other forms of dementia;
- ii. communicating with persons with dementia;
- iii. behavior management;
- iv. promoting independence in activities of daily living; and
- v. understanding and dealing with family issues.

b. Employees who have regular contact with residents, but who do not provide direct face-to-face care, shall be required to obtain at least four hours of dementia-specific training within 90 days of employment and two hours of dementia training annually. This training shall include the following topics:

- i. an overview of dementias; and
- ii. communicating with persons with dementia.

c. Employees who have only incidental contact with residents shall receive general written information provided by the ARCP on interacting with residents with dementia.

3. Employees who do not provide care to residents in a special dementia care program shall meet the following training requirements.

a. Employees who provide direct face-to-face care to residents shall be required to obtain at least two hours of dementia-specific training annually. This training shall include the following topics:

- i. an overview of Alzheimer's disease and related dementias; and
- ii. communicating with persons with dementia.

b. All other employees shall receive general written information provided by the ARCP on interacting with residents with dementia.

4. Any dementia-specific training received in a nursing or nursing assistant program approved by the department or its designee may be used to fulfill the training hours required pursuant to this Section.

5. ARCPs may offer a complete training curriculum themselves, or they may contract with another organization, entity, or individual to provide the training.

6. The dementia-specific training curriculum shall be approved by the department or its designee. To obtain training curriculum approval, the organization, entity, or individual shall submit the following information to the department or its designee:

- a. a copy of the curriculum;

- b. the name of the training coordinator and his/her qualifications;
- c. a list of all instructors;
- d. the location of the training; and
- e. whether or not the training will be web-based.

7. A provider, organization, entity, or individual shall submit any content changes to an approved training curriculum to the department, or its designee, for review and approval.

a. Continuing education undertaken by the ARCP does not require the department's approval.

8. If a provider, organization, entity, or individual, with an approved curriculum, ceases to provide training, the department shall be notified in writing within 30 days of cessation of training. Prior to resuming the training program, the provider, organization, entity, or individual shall reapply to the department for approval to resume the program.

9. Disqualification of Training Programs and Sanctions. The department may disqualify a training curriculum offered by a provider, organization, entity, or individual that has demonstrated substantial noncompliance with training requirements including, but not limited to:

- a. the qualifications of training coordinators; or
- b. training curriculum requirements.

10. Compliance with Training Requirements

a. The review of compliance with training requirements will include, at a minimum, a review of:

- i. the documented use of an approved training curriculum; and
- ii. the provider's adherence to established training requirements.

b. The department may impose applicable sanctions for failure to adhere to the training requirements outlined in this Section.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6869. Record Keeping

A. Administrative Records. The ARCP shall have an administrative record that includes:

- 1. the articles of incorporation or certified copies thereof, if incorporated, by-laws, operating agreements, or partnership documents, if applicable;
- 2. the written policies and procedures approved annually by the owner/governing body that address the requirements listed in this Subchapter;
- 3. the minutes of formal governing body meetings;
- 4. the organizational chart of the ARCP;
- 5. all leases, contracts, and purchase of service agreements to which the ARCP is a party, which includes all appropriate credentials;
- 6. insurance policies; and
- 7. copies of incident/accident reports.

B. Personnel Records. An ARCP shall maintain a personnel record for each employee. At a minimum, this file shall contain the following:

- 1. the application for employment, including the resume of education, training, and experience, if applicable;
- 2. a criminal history check, prior to an offer of employment, in accordance with state law;

3. evidence of applicable professional or paraprofessional credentials/certifications according to state law, rule or regulation;

4. documentation of any state or federally required medical examinations or medical testing;

5. employee's hire and termination dates;

6. documentation of orientation and annual training of staff;

7. documentation of a valid driver's license, documentation of a valid chauffeur's or commercial driver's license with passenger endorsement, if applicable, and Louisiana DMV record for any employee that transports residents;

8. documentation of reference checks; and

9. annual performance evaluations. An employee's annual performance evaluation shall include his/her interaction with residents, family, and other providers.

C. Resident Records. An ARCP shall maintain a separate record for each resident. Such record shall be current and complete and shall be maintained in the ARCP in which the resident resides and readily available to ARCP staff and department staff. Each record shall contain the information below including but not limited to:

1. resident's name, marital status, date of birth, sex, Social Security number, and previous home address;

2. date of initial residency and date of termination of residency;

3. location of new residence following move-out;

4. name, address and telephone number of the resident's representative;

5. names, addresses, and telephone numbers of individuals to be notified in case of accident, death, or other emergency;

6. name, address, and telephone number of a physician to be called in an emergency;

7. ability to ambulate;

8. resident's plan/authorization for routine and emergency medical care;

9. the pre-residency assessment and service agreement;

10. assessment and any special problems or precautions;

11. individual PCSP, updates, and quarterly reviews;

12. continuing record of any illness, injury, or medical or dental care when it impacts the resident's ability to function without assistance with ADLs and IADLs or impacts the services the resident requires, including but not limited to all orders received from licensed medical practitioners;

13. a record of all personal property and funds which the resident has entrusted to the ARCP;

14. written and signed acknowledgment that the resident has been informed and received verbal explanation and copies of his/her rights, the house rules, written procedures for safekeeping of his/her valuable personal possessions, written statement explaining his/her rights regarding personal funds, and the right to examine his/her record;

15. advance directives and requirements for assistance in emergency evacuation; and

16. documentation of any third party services provided and documentation of any notifications provided to the resident's representative regarding services.

D. Maintenance and Storage of Records. All records shall be maintained in an accessible, standardized order and format and shall be retained and disposed of in accordance with state laws. An ARCP shall have sufficient space, facilities, and supplies for providing effective storage of records. The ARCP shall maintain the resident's records in the following manner.

1. Each resident and/or resident's legal representative, if applicable, upon written or oral request, shall have the right to inspect and/or copy his or her records during normal business hours in accordance with state and federal law.

a. After receipt of his/her records for inspection, the ARCP shall provide, upon request and two working days' notice, at a cost consistent with the provisions of applicable state law, photocopies of the records or any portions thereof.

2. The ARCP shall not disclose any resident records maintained by the ARCP to any person or agency other than the ARCP personnel, law enforcement, the department, or the attorney general's office, except upon expressed written consent of the resident or his or her legal representative, or when disclosure is required by state or federal law or regulations.

3. The ARCP shall maintain the original records in an accessible manner for a period of five years following a resident's death or vacating the ARCP.

4. The original resident records, while the resident maintains legal residence at the ARCP, shall be kept on the ARCP premises at all times, unless removed pursuant to subpoena.

5. In the event of a change of ownership, the resident records shall remain with the ARCP.

6. An ARCP which is closing shall notify the department of the plan for the disposition of residents' records in writing within 30 days prior to closure. The plan shall include where the records will be stored and the name, address and phone number of the person responsible for the resident and personnel records.

7. If the ARCP closes, the ARCP owner(s) shall store the resident records for five years from the date of closure within the state of Louisiana.

E. Confidentiality and Security of Records

1. The ARCP shall have written procedures for the maintenance and security of records specifying:

a. who shall supervise the maintenance of records;
b. who shall have custody of records; and
c. to whom records may be released. Release shall be made in accordance with any and all federal and state laws.

2. The ARCP shall have a written procedure for protecting clinical record information against loss, destruction, or unauthorized use.

3. The ARCP shall ensure the confidentiality of all 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 contractor, or the resident. Information from, or copies of, records may be released only to authorized individuals, and the ARCP shall ensure that unauthorized individuals cannot gain access to or alter resident records.

4. Employees of the ARCP shall not disclose or knowingly permit the disclosure of any information concerning the resident or his/her family, directly or indirectly, to any unauthorized person.

5. The ARCP shall obtain the resident's, and if applicable, the resident's representative's written, informed permission prior to releasing any information from which the resident or his/her family might be identified, except to the department. Identification information may be given to appropriate authorities in case of an emergency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6871. Incident and Accident Reports

A. An ARCP shall have written procedures for the reporting and documentation of accidents, incidents and other situations or circumstances affecting the health, safety or well-being of a resident or residents. The procedures shall include:

1. a provision that the director or his/her designee shall be immediately verbally notified of accidents, incidents and other situations or circumstances affecting the health, safety or well-being of a resident or residents; and

2. a provision that staff shall be trained on the reporting requirements.

B. An ARCP shall report to HSS any incidents suspected of involving:

1. abuse;
2. neglect;
3. misappropriation of personal property regardless of monetary value; or
4. injuries of unknown origin. Injuries of unknown origin are defined as:

a. the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; or

b. the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma).

C. The initial report of the incident or accident is due within 24 hours of occurrence or discovery of the incident.

D. After submission of the initial 24-hour report, a final report shall be submitted within five business days regardless of the outcome.

E. Report Contents. The information contained in the incident report shall include, but is not limited to the following:

1. circumstances under which the incident occurred;
2. date and time the incident occurred;
3. where the incident occurred (bathroom, apartment, room, street, lawn, etc.);
4. immediate treatment and follow-up care;
5. name and address of witnesses;
6. date and time family or representative was notified;
7. symptoms of pain and injury discussed with the physician; and
8. signatures of the director, or designee, and the staff person completing the report.

F. When an incident results in death of a resident, involves abuse or neglect of a resident, or entails any serious threat to the resident's health, safety or well-being, an ARCP director or designee shall:

1. immediately report verbally to the director and submit a preliminary written report within 24 hours of the incident to the department;

2. notify HSS and any other appropriate authorities, according to state law and submit a written notification to the above agencies within 24 hours of the suspected incident;

3. immediately notify the family or the resident's representative and submit a written notification within 24 hours;

4. immediately notify the appropriate law enforcement authority in accordance with state law;

5. take appropriate corrective action to prevent future incidents and provide follow-up written report to all the above persons and agencies as per reporting requirements; and

6. document its compliance with all of the above procedures for each incident and keep such documentation (including any written reports or notifications) in the resident's file. A separate copy of all such documentation shall be kept in the provider's administrative file.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter G. Emergency Preparedness

§6875. Emergency Preparedness Plan

A. The ARCP shall have an emergency preparedness plan designed to manage the consequences of all hazards, declared disasters or other emergencies that have the potential to disrupt the ARCP's ability to provide care and treatment and/or threatens the lives or safety of the residents. The ARCP shall follow and execute its emergency preparedness plan in the event or occurrence of a disaster or emergency.

1. Emergency events include, but are not limited to hurricanes, floods, fires, chemical or biological hazards, power outages, tornados, tropical storms and severe weather.

B. The ARCP will work in concert with the local parish Office of Emergency Preparedness (OEP) in developing plans.

C. Upon the department's request, an ARCP shall present its plan for review. At a minimum, the plan shall include and address the elements listed below.

1. The plan shall be individualized and site specific. All information contained in the plan shall be current and correct. The ARCP's plan shall follow all current applicable laws, standards, rules or regulations.

2. Upon request, the plan shall be made available to representatives of the following offices:

- a. OSFM;
- b. OPH; and
- c. local Office of Homeland Security.

3. The plan shall contain census information, including transportation needs for current census and available capacity.

4. The plan shall contain a clearly labeled and legible master floor plan(s) that indicates the following:

a. the areas in the ARCP, either in the resident's apartment or the other areas of the ARCP, that are to be used by residents as shelter or safe zones during emergencies;

b. the location of emergency power outlets, if available (if none are powered or all are powered, this shall be stated as such on the plan); and

c. the locations of posted, accessible, emergency information.

5. The plan shall provide for floor plans or diagrams to be posted and those plans or diagrams shall clearly indicate:

a. that specific room or apartment's location, the fire exits, the fire evacuation routes, locations of alarm boxes and fire extinguishers, and written fire evacuation procedures shall be included on one plan; and

b. a separate floor plan or diagram with safe zones or sheltering areas for non-fire emergencies shall indicate areas of building, apartments, or rooms that are designated as safe or sheltering areas.

6. The plan shall include a detailed list of what will be powered by emergency generator(s), if the ARCP has a generator.

7. The plan shall be viable and promote the health, safety and welfare of the residents.

8. The plan shall include a procedure for monitoring weather warnings and watches and evacuation orders from local and state emergency preparedness officials. This procedure will include:

- a. who will monitor;
- b. what equipment will be used; and
- c. procedures for notifying the director or responsible persons.

9. The plan shall provide for the delivery of essential care and services to meet the needs of the residents during emergencies, who are housed in the ARCP or by the ARCP at another location, during an emergency.

10. The plan shall contain information about staffing when the ARCP is sheltering in place or when there is an evacuation of the ARCP. Planning shall include documentation of staff that have agreed to work during an emergency and contact information for such staff. The plan shall include provisions for adequate, qualified staff as well as provisions for the assignment of responsibilities and duties to staff.

11. The plan shall include procedures to notify each resident's family or responsible representative whether the ARCP is sheltering in place or evacuating to another site. The plan shall include which staff is responsible for providing this notification. If the ARCP evacuates, notification shall include:

- a. the date and approximate time that the ARCP is evacuating;
- b. the place or location to which the ARCP is evacuating, including the:
 - i. name;
 - ii. address; and
 - iii. telephone number.

12. The plan shall include the procedure or method whereby each ARCP resident has a manner of identification that is provided to them to be attached to his/her person. Residents shall be instructed to keep the identification on their person at all times in the event of sheltering in place or evacuation. The following minimum information shall be included with the resident:

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

13. The plan shall include an evaluation of the building and necessary systems to determine the ability to withstand wind, flood, and other local hazards that may affect the ARCP. If applicable, the plan shall also include an evaluation of each generator's fuel source(s), including refueling plans and fuel consumption.

14. The plan shall include an evaluation of the ARCP's surroundings to determine lay-down hazards, objects that could fall on the ARCP, and hazardous materials in or around the ARCP, such as:

- a. trees;
- b. towers;
- c. storage tanks;
- d. other buildings;
- e. pipe lines;
- f. chemicals;
- g. fuels; or
- h. biologics.

15. For ARCPs that are geographically located south of Interstate 10 or Interstate 12, the plan shall include the determinations of when the ARCP will shelter in place and when the ARCP will evacuate for a storm or hurricane and the conditions that guide these determinations.

16. If the ARCP shelters in place, the ARCP's plan shall include provisions for seven days of necessary supplies to be provided by the ARCP prior to the emergency event, to include:

- a. drinking water or fluids;
- b. non-perishable food; and
- c. other provisions as needed to meet the contractual obligations and current level of care requirements of each resident.

17. The plan shall include a posted communications plan for contacting emergency services and monitoring emergency broadcasts and whose duty and responsibility this will be. The communications plan will include a secondary plan in the event primary communications fail.

18. The plan shall include how the ARCP will notify the local Office of Emergency Preparedness and the department when the decision is made to shelter in place or evacuate and whose responsibility it is to provide this notification.

D. The ARCP shall have transportation or arrangements for transportation for evacuation, hospitalization, or any other services which are appropriate and to meet the contractual obligations and current level of care requirements of each resident.

1. Transportation or arrangements for transportation shall be adequate for the current census and meet the ambulatory needs of the residents.

2. Transportation or arrangements for transportation shall be for the evacuation from and return to the ARCP or as needed to meet the contractual obligations or current level of care requirements of each resident.

E. The ARCP director, or designee, shall make the decision to evacuate or shelter in place after reviewing all available and required information on the storm, the ARCP, the ARCP's surroundings, and in consultation with the local Office of Emergency Preparedness. In making the decision to shelter in place or evacuate, the ARCP shall consider the following:

- 1. under what conditions the ARCP will shelter in place;
- 2. under what conditions the ARCP will close or evacuate; and
- 3. when will these decisions be made.

F. The ARCP accepts all responsibility for the health and well-being of all residents that shelter with the ARCP before, during, and after the storm.

G. The ARCP shall have a plan for an on-going safety program to include:

- 1. inspection of the ARCP for possible hazards with documentation;
- 2. monitoring of safety equipment and maintenance or repair when needed and/or according to the recommendations of the equipment manufacturer, with documentation;
- 3. investigation and documentation of all accidents or emergencies;
- 4. fire control and evacuation planning with documentation of all emergency drills; and
- 5. all aspects of the ARCP's plan, planning, and drills which shall meet the requirements of the OSFM.

H. The ARCP shall inform the resident and/or the resident's representative of the ARCP's emergency plan and ongoing safety plan and the actions to be taken. Current emergency preparedness plan information shall be available for review by the resident or the resident's representative.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6877. Emergency Plan Activation, Review and Summary

A. Following an event or occurrence of a disaster or emergency, whether the ARCP shelters in place or evacuates, upon request by the department the ARCP shall submit a written summary attesting how the ARCP's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

- 1. pertinent plan provisions and how the plan was followed and executed;
- 2. plan provisions that were not followed;
- 3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;
- 4. contingency arrangements made for those plan provisions not followed; and
- 5. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of these injuries and deaths.

B. The ARCP's emergency plan(s) shall be activated at least annually, either in response to an emergency or in a planned drill. All staff shall be trained and have knowledge of the emergency plan.

C. All ARCPs must conduct egress and relocation drills in accordance with the requirements of the OSFM.

1. All staff shall participate in at least one drill annually.

2. Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance.

D. In addition to the exercises for emergencies due to fire, the ARCP plan shall be activated at least once per year for emergencies due to a disaster other than fire, such as storm, flood, and other natural disasters. The activation(s) shall include an exercise for shelter-in-place and an exercise for evacuation. The ARCP shall document the exercise for shelter-in-place and the exercise for evacuation.

E. The ARCP's performance during the activation of the plan shall be evaluated annually by the ARCP and the findings shall be documented in the plan. Records shall be kept to document the evacuation times and participation. Such records shall be maintained at the ARCP and shall be readily available to the OSFM upon request.

F. The plan shall be revised if indicated by the ARCP's performance during the emergency event or the planned drill.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41: §6879. **Notification**

A. The emergency preparedness plan shall specify the following:

1. list of all persons, agencies, authorities to be notified and routinely updated contact information;
2. process of notification;
3. verification or documentation of attempted notification; and
4. back-up communication plans and procedures.

B. An ARCP shall immediately notify the HSS program desk and other appropriate agencies of any fire, disaster or other emergency that may present a danger to residents or require their evacuation from the ARCP.

C. In the event that an ARCP evacuates, temporarily relocates or temporarily ceases operations at its licensed location as a result of an evacuation order issued by the state, local or parish Office of Homeland Security Emergency Preparedness (OHSEP), the ARCP must immediately give notice to the HSS and Governor's Office of Homeland Security Emergency Preparedness (GOHSEP) by facsimile or e-mail of the following:

1. the date and approximate time of the evacuation; and
2. the locations of where the residents have been placed, whether this location is a host site for one or more of the ARCP residents.

D. In the event that an ARCP evacuates, temporarily relocates or temporarily ceases operations at its licensed location for any reason other than an evacuation order, the ARCP must immediately give notice to the HSS by facsimile or e-mail of the following:

1. the date and approximate time of the evacuation; and

2. the location of where the residents have been placed, whether this location is a host site for one or more of the ARCP residents.

E. If there are any deviations or changes made to the locations of the residents that was given to the HSS and the local OEP, then both HSS and the local OEP shall be notified of the changes within 48 hours of their occurrence.

F. Effective immediately upon notification of an emergency declared by the secretary, all ARCPs licensed in Louisiana shall file an electronic report with the ESF-8 portal and its applications during a declared emergency, disaster, or a public health emergency.

1. The electronic report shall be filed as prescribed by the department throughout the duration of the disaster or emergency event.

2. The electronic report shall include but not be limited to the following:

- a. status of operation;
- b. availability of beds;
- c. generator status, if applicable;
- d. evacuation destination(s) and status;
- e. shelter in place status;
- f. current census;
- g. emergency evacuation transportation needs

categorized by the following types:

i. *red*—high risk patients that need to be transported by advanced life support ambulance due to dependency on mechanical or electrical life sustaining devices or very critical medical condition;

ii. *yellow*—residents who are not dependent on mechanical or electrical life sustaining devices, but cannot be transported using normal means (buses, vans, cars), may need to be transported by an ambulance; however, in the event of inaccessibility of medical transport, buses, vans or cars may be used as a last resort; or

iii. *green*—residents who need no specialized transportation may be transported by car, van, bus or wheelchair accessible transportation; and

h. any other information as requested by the department.

3. There shall be a plan and procedures to file the report if primary communications fail.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6881. Authority to Re-open After an Evacuation, Temporary Relocation or Temporary Cessation of Operation

A. The following applies to any ARCP that evacuates, temporarily relocates or temporarily ceases operation at its licensed location due to an emergency.

1. The ARCP must immediately give written notice to HSS by hand delivery, facsimile or e-mail of the following information:

- a. the date and approximate time of the evacuation;
- b. the sheltering host site(s) to which the ARCP is evacuating; and
- c. a list of residents being evacuated, which shall indicate the evacuation site for each resident.

2. Within 48 hours, the ARCP must notify HSS of any deviations from the intended sheltering host site(s) and must provide HSS with a list of all residents and their locations.

3. If there was no damage to the licensed location due to the emergency event, and there was no power outage of more than 48 hours at the licensed location due to the emergency event, the ARCP may reopen at its licensed location and shall notify HSS within 24 hours of reopening. For all other evacuations, temporary relocations, or temporary cessation of operations due to an emergency event, an ARCP must submit to HSS a written request to reopen, prior to reopening at the licensed location. The request to reopen shall include:

- a. a damage report;
- b. the extent and duration of any power outages;
- c. the re-entry census;
- d. staffing availability;
- e. access to emergency or hospital services; and
- f. availability and/or access to food, water, medications and supplies.

B. Upon receipt of a reopening request, the department shall review and determine if reopening will be approved. The department may request additional information from the ARCP as necessary to make determinations regarding reopening.

C. After review of all documentation, in order to assure that the ARCP is in compliance with the licensing standards including, but not limited to, the structural soundness of the building, the sanitation code, staffing requirements and the execution of emergency plans, the department shall issue a notice of one of the following determinations:

1. approval of reopening without survey;
2. surveys required before approval to reopen will be granted. Surveys may include OPH, fire marshall and health standards; or
3. denial of reopening.

D. The HSS, in coordination with state and parish OHSEP, will determine the ARCP's access to the community service infrastructure, such as hospitals, transportation, physicians, professional services and necessary supplies.

E. The HSS will give priority to reopening surveys.

F. Upon request by the department, the ARCP shall submit a written summary attesting how the ARCP's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

1. pertinent plan provisions and how the plan was followed and executed;
2. plan provisions that were not followed;
3. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;
4. contingency arrangements made for those plan provisions not followed;
5. a list of all injuries and deaths of residents that occurred during execution of the plan, evacuation and temporary relocation including the date, time, causes and circumstances of the injuries and deaths; and

6. a summary of all request for assistance made and any assistance received from the local, state, or federal government.

G. Sheltering in Place. If an ARCP shelters in place at its licensed location during an emergency event, the following will apply.

1. The ARCP must immediately give written notice to the HSS by hand delivery, facsimile or e-mail that the ARCP will shelter in place.

2. Upon request by the department, the ARCP shall submit a written summary attesting how the ARCP's emergency preparedness plan was followed and executed. The initial summary shall contain, at a minimum:

- a. pertinent plan provisions and how the plan was followed and executed;
- b. plan provisions that were not followed;
- c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;
- d. contingency arrangements made for those plan provisions not followed;
- e. a list of all injuries and deaths of residents that occurred during the execution of the plan, including the date, time, causes and circumstances of these injuries and deaths; and
- f. a summary of all request for assistance made and any assistance received from the local, state, or federal government.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter H. Physical Environment

§6885. General Requirements and Authority

A. The standards in this Subchapter shall apply to any ARCP constructed after the effective date of this rule, alterations, additions or substantial rehabilitation to an existing ARCP, or adaptation of an existing building to create an ARCP. Cosmetic changes to the ARCP such as painting, flooring replacement or minor repairs shall not be considered an alteration or substantial rehabilitation.

B. An ARCP shall submit architectural plans and construction documents to the OSFM. The regulations and codes governing new ARCPs also apply if and when the ARCP proposes to begin operation in a building not previously and continuously used as an ARCP licensed under these regulations.

C. Design Criteria. The project shall be designed in accordance with the following criteria:

1. the requirements of the OSFM;
2. Part XIV (Plumbing) of the *Sanitary Code* (LAC 51), state of Louisiana;
3. the 2010 Americans with Disabilities Act and Architectural Barriers Act Accessibility Guidelines; and
4. the current department licensing regulations for adult residential care providers.

D. Life Safety Code Occupancy Requirements. Any ARCP that provides services to four or more residents who are not capable of taking action for self-preservation under emergency conditions without the assistance of others shall meet the construction requirements established for limited care health care occupancies and codes adopted by the OSFM. All level 4 ARCPs shall meet limited care health care occupancies and codes adopted by the OSFM.

E. During power outages or other emergencies, Level 4 ARCPs shall have the ability to generate power for emergency lighting, designated power outlets and temperature control.

F. Waivers. The secretary may, within his or her sole discretion, grant waivers to physical environment requirements insofar as they do not conflict with the requirements of the OSFM or OPH. Requests for waivers are considered on the following basis.

1. The ARCP must demonstrate how resident health and safety and the maintenance of a homelike environment are not compromised.

2. No waiver shall be approved that results in an ARCP that is not physically distinct from any residential care facility, nursing home or hospital.

3. No waiver shall be approved which results in a living environment that does not provide all required physical features and/or does not provide sufficient space to permit residents to carry out, with or without assistance, all the functions necessary for independent living.

4. The ARCP shall demonstrate its ability to completely fulfill all other requirements of the service.

5. The department shall make a written determination of the request.

6. Waivers are not transferable in an CHOW and are subject to review or revocation upon any change in circumstances to the waiver.

G. All ARCPs licensed under these regulations shall be designed and constructed to substantially comply with pertinent local and state laws, codes, ordinances and standards. All new construction shall be in accordance with Louisiana Uniform Construction Code in effect at the time of original licensure.

H. Practices that create an increased risk of fire are prohibited. This includes, but is not limited to:

1. space heaters;
2. the accumulation or storage within the ARCP of combustible materials such as rags, paper items, gasoline, kerosene, paint or paint thinners; or
3. the use of extension cords or multi-plug adapters for electrical outlets, except ARCPs may utilize transient voltage surge protectors or surge suppressors with microprocessor electronic equipment such as computers or CD/DVD recorders or players. Any transient voltage surge protectors or surge suppressors shall have a maximum UL rating of 330v and shall have a functioning protection indicator light. ARCPs may not use transient voltage surge protectors or surge suppressors that do not function completely or for which the protection indicator light does not work.

I. Safety Standards for Smoking

1. Adult residential care providers may elect to prohibit smoking in the ARCP or on the grounds or both. If an ARCP elects to permit smoking in the ARCP or on the grounds, the ARCP shall include the following minimal provisions, and the ARCP shall ensure the following.

a. In ARCPs equipped with sprinkler systems, the ARCP may designate a smoking area or areas within the ARCP. The designated area or areas shall have a ventilation system that is separate from the ventilation system for non-smoking areas of the ARCP. ARCPs lacking a sprinkler system are prohibited from designating smoking areas within the ARCP.

b. Smoking shall be prohibited in any room or compartment where flammable liquids, combustible gases or oxygen is used or stored, and any general use/common areas

of the ARCP. Such areas shall be posted with "no smoking" signs.

c. Smoking by residents assessed as not capable of doing so without assistance shall be prohibited unless the resident is under direct supervision.

d. Ashtrays of noncombustible material and safe design shall be placed in all areas where smoking is permitted.

e. Metal containers with self-closing cover devices into which ashtrays may be emptied shall be placed in all areas where smoking is permitted.

J. Kitchen/Food Service

1. Each ARCP shall comply with all applicable regulations relating to food service for sanitation, safety and health as set forth by state, parish and local health departments.

2. The ARCP shall have a central or a warming kitchen.

3. The kitchen of an ACRP shall be in compliance with the requirements of Part XXIII of the Louisiana *Sanitary Code* (LAC 51).

4. Level 3 and 4 ARCPs may opt out of having a central kitchen if meals are prepared in an off-site location.

a. ARCPs opting out shall have a kitchen area to hold, warm and serve food prepared at the off-site location. This kitchen area shall meet the Louisiana *Sanitary Code* requirements for food safety and handling.

b. Meals and snacks provided by the ARCP but not prepared on-site shall be obtained from or provided by an entity that meets the standards of state and local health regulations concerning the preparation and serving of food.

c. Opting out does not exempt ARCPs from meeting dining room space that is separate and distinct as referenced above in physical separation standards.

5. In ARCPs that have commercial kitchens with automatic extinguishers in the range hood, the manufacturer's recommendations regarding portable fire extinguishers shall be followed.

6. The kitchen and food preparation area shall be well lit, ventilated, and located apart from other areas to prevent food contamination in accordance with the state *Sanitary Code*.

7. An adequate supply of eating utensils (e.g., cups, saucers, plates, glasses, bowls, and flatware) will be maintained in the ARCP's kitchen to meet the needs of the communal dining program. Eating utensils shall be free of chips or cracks.

8. An adequate number of pots and pans shall be provided for preparing meals.

9. Each ARCP shall have adequate storage space. All storage space shall be constructed and maintained to prevent the invasion of rodents, insects, sewage, water leakage or any other contamination. Shelving shall be of sufficient height from the floor to allow cleaning of the area underneath the bottom shelf. All items shall be stored in accordance with state *Sanitary Code*.

10. Food waste shall be placed in garbage cans with airtight fitting lids and bag liners. Garbage cans shall be emptied daily.

K. Laundry

1. Each ARCP shall have laundering facilities unless commercial laundries are used.

a. The laundry shall be located in a specifically designed area that is physically separate and distinct from residents' rooms and from areas used for dining and food preparation and service.

b. There shall be adequate rooms and spaces for sorting, processing and storage of soiled material.

c. Laundry rooms shall not open directly into a resident's personal living area or food service area.

2. Domestic washers and dryers for the use by residents may be provided in resident areas provided they are installed and maintained in such a manner that they do not cause a sanitation problem, offensive odors, or fire hazard.

3. Supplies and equipment used for housekeeping and laundry will be stored in a separate locked room. All hazardous chemicals will be stored in compliance with OPH requirements.

L. Lighting

1. All in-door areas of an ARCP shall be well lighted to ensure residents' safety and to accommodate need.

2. Night-lights for corridors, emergency situations and the exterior shall be provided as needed for security and safety.

3. All rooms shall have working light switches at the entrance to each room.

4. Light fixtures in resident general use or common areas shall be equipped with covers to prevent glare and hazards to the residents.

M. HVAC/Ventilation

1. The ARCP shall provide safe HVAC systems capable of maintaining a temperature range of 71-81 degrees Fahrenheit.

2. Filters for heaters and air conditioners shall be provided as needed and maintained in accordance with manufacturer's specifications.

N. If the ARCP uses live-in staff, staff shall be provided with adequate, separate living space with a private bathroom. This private bathroom is not to be counted as available to residents.

O. An ARCP shall have space that is distinct from residents' living areas to accommodate administrative and record-keeping functions.

P. An ARCP shall have a designated space to allow private discussions with individual residents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6887. Physical Appearance and Conditions

A. The ARCP shall be constructed, equipped, and maintained in good repair and free of hazards.

1. Potentially hazardous areas include, but are not limited to:

- a. steep grades;
- b. cliffs;
- c. open pits;
- d. swimming pools;
- e. high voltage boosters; or
- f. high speed roads.

2. Potentially hazardous areas shall be fenced off or have natural barriers to protect residents.

B. An accessible outdoor recreation area is required and shall be made available to all residents and include

walkways suitable for walking and benches for resting. Lighting of the area shall be equal to a minimum of five foot-candles.

C. ARCPs shall have an entry and exit drive to and from the main building entrance that will allow for picking up and dropping off residents and for mail deliveries. ARCPs licensed after the effective date of this Rule shall have a covered area at the entrance to the building to afford residents protection from the weather.

D. If the ARCP maintains a generator on the grounds of the ARCP, it shall be fenced off or have natural barriers to protect residents.

E. Waste Removal and Pest Control

1. Garbage and rubbish that is stored outside shall be stored securely in covered containers and shall be removed on a regular basis.

2. Trash collection receptacles and incinerators shall be separate from outdoor recreational space and located as to avoid being a nuisance to neighbors.

3. The ARCP shall have an effective pest control program through a pest control contract.

F. Signage. The ARCP's address shall be displayed so as to be easily visible from the street.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6889. Resident Dining and Common Areas

A. The ARCP shall provide common areas to allow residents the opportunity for socialization. Common areas shall not be confined to a single room.

B. The ARCP shall meet the following requirements for resident dining and common areas.

1. The common areas shall be maintained to provide a clean, safe and attractive environment for the residents.

2. Each ARCP shall have dining room and common areas easily accessible to all residents.

3. Dining rooms and common areas shall be available for use by residents at appropriate times to provide periods of social diversion and individual or group activities.

4. Common areas and dining rooms shall not be used as bedrooms.

C. Square Footage. Square footage requirements for common areas and dining room(s) are as follows.

1. Common areas shall be separate from the dining room with a combined total square footage of at least 60 square feet per resident as based on licensed capacity. Common areas do not include corridors and lobby areas for the purposes of calculation.

2. The ARCP shall have at least 20 square feet of designated dining space per resident if dining will be conducted in one seating. If dining will be conducted in two seatings, 10 square feet per resident will be required. ARCPs will document their dining seating plan, and maintain the documentation for review by the department.

D. Residents of the ARCP shall have access to the outdoors for recreational use. The parking lot shall not double as recreational space.

E. If the ARCP accepts residents that have dementia or cognitive impairments that make it unsafe for them to leave the building or grounds without supervision, an enclosed area shall be provided adjacent to the ARCP so that such residents may go outside safely.

F. With the exception of level 1 ARCPs, the ARCP shall provide public restrooms of sufficient number and location to serve residents and visitors. Public restrooms shall be located close enough to common areas to allow residents to participate comfortably in activities and social opportunities.

G. For every 40 residents, there shall be, at a minimum, one dedicated telephone available for use in common areas when a telephone line is not provided in each apartment.

1. The telephone shall allow unlimited local calling without charge.

2. Long distance calling shall be possible at the expense of the resident or the resident's representative via personal calling card, pre-paid telephone card, or similar methods.

3. The telephone shall be located away from frequently used areas so that residents shall be able to make telephone calls in an at least auditory privacy.

H. In ARCPs housing residents in more than one building, covered walkways with accessible ramps are required for buildings that house residents and areas intended for resident use, such as laundry facilities, dining rooms or common areas.

I. An ARCP shall not share common living, or dining space with another entity licensed to care for individuals on a 24-hour basis.

J. Space used for administration, sleeping, or passage shall not be considered as dining or common areas.

K. Adult Residential Care Providers in Shared Businesses

1. Physical and Programmatic Separation. If more than one business occupies the same building, premises, or physical location, the ARCP shall be both physically and programmatically distinct from the business to which it is attached or of which it is a part. ARCPs shall comply with R.S. 40:2007.

2. Entrance. If more than one business occupies the same building, premises, or physical location, the ARCP shall have its own entrance. This separate entrance shall not be accessed solely through another business or health care provider. This separate entrance shall have appropriate signage and shall be clearly identifiable as belonging to the ARCP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6891. Resident Personal Space

A. Level 1 ARCP Bedroom Requirements

1. A level 1 ARCP shall ensure that each single occupancy bedroom space has a floor area of at least 100 net square feet and that each multiple occupancy bedroom space has a floor area of at least 70 net square feet for each resident. Bathrooms and closets/wardrobes shall not be included in the calculation of square footage.

2. There shall be no more than two residents per bedroom. All shared living arrangements shall be agreed to in writing by both parties.

3. A room where access is through a bathroom or another bedroom shall not be approved or used as a resident's bedroom.

4. Privacy of residents shall be maintained in residents' personal space.

B. Level 2 ARCP Bedroom Requirements

1. A level 2 ARCP shall ensure that each single occupancy bedroom space has a floor area of at least 100 net square feet and that each multiple occupancy bedroom space has a floor area of at least 70 net square feet for each resident. Bathrooms and closets/wardrobes shall not be included in the calculation of square footage.

2. There shall be no more than two residents per bedroom. All shared living arrangements shall be agreed to in writing by both parties.

3. A room where access is through a bathroom or another bedroom shall not be approved or used as a resident's bedroom.

4. Privacy of residents shall be maintained in resident's personal space.

C. Requirements for Resident Bathrooms in Level 1 and 2 ARCPs

1. There shall be at least one bathroom for every four residents.

2. Bathrooms shall be equipped with one toilet, bathtub or shower, and a washbasin.

3. Grab bars and non-skid surfacing or strips shall be installed in all showers and bath areas.

4. Bathrooms shall have floors and walls of impermeable, cleanable, and easily sanitized materials.

5. Resident bathrooms shall not be utilized for storage or purposes other than those indicated by this Subsection.

6. Hot and cold-water faucets shall be easily identifiable and be equipped with scald control.

a. Hot water temperatures shall not exceed 120 degrees Fahrenheit.

7. Each bathroom shall be supplied with toilet paper, soap and towels.

8. Mirrors shall be provided and secured to the wall at convenient heights to allow residents to meet basic personal hygiene and grooming needs.

9. Bathrooms shall be located so that they open into the hallway, common area, or directly into the bedroom. If the bathroom opens directly into a bedroom, it shall be for the use of the occupants of that bedroom only.

D. Requirements for Resident Apartments in Levels 3 and 4

1. All apartments in levels 3 and 4 shall be independent and shall contain at a minimum the following areas:

a. a bedroom/sleeping area that can be distinguished by sight from other areas in the apartment;

b. a bathroom;

c. a kitchenette that can be distinguished by sight from other areas in the apartment;

d. a dining/living area; and

e. a closet/wardrobe.

2. Square Footage in Level 3 and 4 ARCPs

a. Efficiency/studio apartments shall have a minimum of 250 net square feet of floor space, excluding bathrooms and closets and/or wardrobes.

b. Resident apartments with separate bedrooms shall be at minimum 190 square feet in living area excluding bathrooms and 100 square feet for each bedroom excluding closets and/or wardrobes.

3. Privacy of residents shall be maintained in all apartments.

4. Each apartment shall have an individual lockable entrance and exit. All apartments shall be accessible by means of a master key or similar system that is available at all times in the ARCP and for use by designated staff.

5. No apartment shall be occupied by more than two residents regardless of square footage. All shared living arrangements shall be agreed to in writing by both residents.

a. It is recognized that there may be more individuals in an ARCP due to husbands and wives sharing a living unit than is listed as the total licensed capacity.

6. Each apartment shall contain an outside window. Skylights are not acceptable to meet this requirement.

7. In new ARCPs licensed after the effective date of these regulations, the ARCP shall provide HVAC thermostats that can be individually controlled by the resident, with a locking mechanism provided, if required, to prevent harm to a resident.

8. Each apartment shall have a call system, either wired or wireless, monitored 24 hours a day by the ARCP staff.

9. Each apartment shall be equipped for telephone and television cable or central television antenna system.

10. Each apartment shall have access to common areas and dining room(s).

11. Kitchenettes

a. Each apartment shall contain, at a minimum, a small refrigerator, a wall cabinet for food storage, a small bar-type sink, and a counter with workspace and electrical outlets, a small cooking appliance, for example, a microwave or a two-burner cook top.

b. If the resident's assessment indicates that having a cooking appliance in the apartment endangers the resident, no cooking appliance shall be provided or allowed in the apartment or the cooking appliance may be disconnected.

12. Bathrooms. Each apartment shall have a separate and complete bathroom with a toilet, bathtub or shower, and sink. The bathrooms shall be ADA accessible.

a. Entrance to a bathroom from one bedroom shall not be through another bedroom.

b. Grab bars and non-skid surfacing or strips shall be installed in all showers and bath areas.

c. Bathrooms shall have floors and walls of impermeable, cleanable, and easily sanitized materials.

d. Resident bathrooms shall not be utilized for storage or purposes other than those indicated by this Subsection.

e. Hot and cold-water faucets shall be easily identifiable and be equipped with scald control.

i. Hot water temperatures shall not exceed 120 degrees Fahrenheit.

f. Each bathroom shall be equipped with an emergency call system that is monitored 24 hours a day by the ARCP staff.

13. Storage. The ARCP shall provide adequate portable or permanent closet(s) in the apartment for clothing and personal belongings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§6893. Furnishings and Equipment

A. Common Areas

1. Furniture for shared living rooms and sitting areas shall include comfortable chairs, tables, and lamps.

2. All furnishings and equipment shall be durable, clean, and appropriate to its function. Furnishings shall be tested in accordance with the provisions of the applicable edition of the NFPA 101 Life Safety Code.

3. Windows shall be kept clean and in good repair and supplied with curtains, shades or drapes. Each window that can be opened shall have a screen that is clean and in good repair.

4. All fans located within seven feet of the floor shall be protected by screen guards.

5. Throw or scatter rugs, or bath rugs or mats shall have a non-skid backing.

6. Wastepaper baskets and trash containers used in the common areas shall be metal or approved washable plastic baskets.

B. Furnishings and Supplies

1. Each Facility shall strive to maintain a residential environment and encourage residents to use their own furnishings and supplies. However, if the resident does not bring their own furniture, the ARCP shall assist in planning and making arrangements for obtaining:

a. a bed, including a frame and a clean mattress and pillow;

b. basic furnishings, such as a private dresser or similar storage area for personal belongings that is readily accessible to the resident;

c. a closet, permanent or portable, to store clothing and aids to physical functioning, if any, which is readily accessible to the resident;

d. a minimum of two chairs;

e. blankets and linens appropriate in number and type for the season and the individual resident's comfort;

f. towels and washcloths; and

g. provisions for dining in the living unit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2166.1-2166.8.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Chapter 88. Adult Residential Care Home

§8801. Authority; Purpose/Intent; Policy

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2326 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8803. Licensing Procedure

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau

of Licensing, LR 24:2327 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8805. License and Other Fees

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2328 (December 1998), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 26:2632 (November 2000), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8807. Denial, Revocation or Nonrenewal of License, Appeal Procedure

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2328 (December 1998), amended by the Department of Social Services, Office of Family Support, LR 36:831 (April 2010), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8809. Operating Without a License or in Violation of Departmental Regulations; Penalty; Injunctive Relief

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2329 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8811. General Authority and Regulations

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2329 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8813. Definitions

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2329 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8815. Organization and Administration

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2331 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8817. Management Responsibilities

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2331 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8819. Required Staffing

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2333 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8821. Resident Protection

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2334 (December 1998), LR 30:92 (January 2004), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8823. Admission

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2336 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8825. Discharge

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau

of Licensing, LR 24:2337 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8827. Services

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2338 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8829. Environment

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2340 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8831. Assisted Living

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2341 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8833. Personal Care Home

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2343 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§8835. Shelter Care Facility

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 14:27 (January 1988), amended by the Department of Social Services, Office of the Secretary, Bureau of Licensing, LR 24:2344 (December 1998), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a positive impact on family functioning, stability and autonomy as described in R.S. 49:972 by assuring the safe operation of facilities that render adult residential care services.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual and community asset development as described in R.S. 49:973.

Small Business Statement

In compliance with Act 820 of the 2008 Regular Session of the Louisiana Legislature, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule may have an adverse impact on small businesses, as described in R.S. 49:965.2 et seq if the requirements of these licensing changes increases the financial burden on providers. With the resources available to the department, a regulatory flexibility analysis has been prepared in order to consider methods to minimize the potential adverse impact on small businesses. The department has determined that there is no less intrusive or less costly alternative methods of achieving the intended purpose since the changes result from legislative mandates.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule may have an adverse impact on the staffing level requirements or qualifications required to provide the same level of service if the provider elects to provide medication administration, and may increase the direct or indirect cost to the provider to provide the same level of service. This proposed Rule may negatively impact the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to Cecile Castello, Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821 or by email to MedicaidPolicy@la.gov. Ms. Castello is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

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

**RULE TITLE: Adult Residential Care Providers
Licensing Standards**

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

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than

the cost of promulgation for FY 14-15. It is anticipated that \$14,104 (SGF) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

It is anticipated that the implementation of this proposed rule will not affect revenue collections since the licensing fees, in the same amounts, will continue to be collected.

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

This Rule is being promulgated to repeal and replace the provisions governing the licensing standards for adult residential care providers and adult residential care homes in order to incorporate these provisions under a single comprehensive Rule in the *Louisiana Administrative Code*.

It is anticipated that implementation of this proposed rule will not have economic costs or benefits to adult residential care providers for FY 14-15, FY 15-16, and FY 16-17 since the required licensing fees have not changed.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Cecile Castello
Director
1411#075

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Behavioral Health**

Behavioral Health Services
Statewide Management Organization
(LAC 50:XXXIII.101, 103, 301, 305, 501 and 901)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII. 101, §103, §301, §305 §501, and §901 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health promulgated an Emergency Rule which amended the provisions governing the statewide management organization in order to include the administration of behavioral health services covered under the LaCHIP Affordable Plan (phase 5) (*Louisiana Register*, Volume 38, Number 12). LaCHIP Affordable Plan benefits, including behavioral health services, were administered by the Office of Group Benefits. The administration of these services was transferred to the statewide management organization under the Louisiana Behavioral Health Partnership. The department promulgated an Emergency Rule which amended the provisions of the January 1, 2013 Emergency Rule in order to revise recipient coverage under the LaCHIP Affordable Plan (*Louisiana Register*, Volume 40, Number 7). The department now proposes to amend the provisions

governing behavioral health services coordinated by the statewide management organization to: 1) include the provisions of the August 1, 2014 Emergency Rule; 2) revise the recipient participation criteria and the reimbursement methodology; 3) exclude the medically needy spend-down population; and 4) update the participant eligibility criteria.

Title 50

**PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services**

Subpart 1. Statewide Management Organization

Chapter 1. General Provisions

§101. Introduction

A. - D.4. ...

E. Effective for dates of service on or after March 1, 2015, the PIHP/SMO shall be paid on a risk basis for adult and children/youth services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§103. Recipient Participation

A. - A.5. ...

6. children who receive foster care or adoption assistance (Title IV-E), or who are in foster care or who are otherwise in an out-of-home placement;

7. Title XXI SCHIP populations, including:

a. LaCHIP phases 1-4; and

b. LaCHIP Affordable Plan (phase 5);

8. persons dually enrolled in Medicare and full Medicaid; and

9. recipients enrolled in the LaMOMS program.

B. ...

C. Notwithstanding the provisions of §103.A above, the following Medicaid recipients are excluded from enrollment in the PIHP/SMO:

1. recipients enrolled in the Medicare beneficiary programs (Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, Qualified Individuals and Qualified Disabled Working Individuals);

2. adults who reside in an intermediate care facility for persons with intellectual disabilities (ICF/ID);

3. recipients of refugee cash assistance;

4. recipients enrolled in the Regular Medically Needy Program;

5. recipients enrolled in the Spend-Down Medically Needy Program;

6. - 7. ...

8. recipients who receive services through the Program of All-Inclusive Care for the Elderly (PACE);

9. recipients enrolled in the Low Income Subsidy Program;

10. recipients who receive services through the Take Charge Plus Program under the family planning eligibility option;

11. participants enrolled under the section 1115 Greater New Orleans community health connections waiver;

12. recipients who receive coverage under the long-term care Medicare co-insurance program;

13. any Medicaid eligible individual during a period of incarceration;

14. Non-Medicaid adult on the eligibility file who is eligible for a low-income subsidy program administered by the Social Security Administration; and

15. members enrolled in a managed care organization for long-term supports and services.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:361 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 3. Statewide Management Organization Participation

§301. Participation Requirements and Responsibilities

A. ...

B. A PIHP/SMO shall:

1. manage behavioral health services for adults with substance use disorders as well as adults with functional behavioral health needs;

2. manage mental health and substance use care for all eligible children and youth in need of behavioral health care;

3. implement and maintain a coordinated system of care for a subset of children and youth who are in, or at risk of, out-of-home placement;

a. Repealed.

4. - 12.c. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:362 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§305. Service Delivery

A. - B. ...

C. The PIHP/SMO shall be required to contract with at least one federally qualified health center (FQHC) in each medical practice region of the state (according to the practice patterns within the state) if there is an FQHC which can provide substance use or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 5. Reimbursement

§501. Reimbursement Methodology

A. ...

B. Effective for dates of service on or after July 1, 2012, the monthly capitation payments to the PIHP/SMO for adult behavioral health services shall be reduced by 1.927 percent of the monthly capitation payments on file as of June 30, 2012.

C. Effective for dates of service on or after March 1, 2015, the PIHP/SMO shall be paid on a risk basis for children and adult behavioral health services.

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

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

38:363 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 39:317 (February 2013), LR 41:

Chapter 9. Monitoring Activities

§901. General Provisions

A. The contracted PIHP/SMO shall be accredited by an accrediting body that is designated in the contract, or agrees to submit an application for accreditation at the earliest possible date as allowed by the accrediting body. Once accreditation is achieved, it shall be maintained through the life of this agreement.

B. - G. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:363 (February 2012).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. Interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

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

**RULE TITLE: Behavioral Health Services
Statewide Management Organization**

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

In FY 14-15, it is anticipated that implementation of this proposed rule will result in an indeterminable decrease in programmatic expenditures in the Medicaid program. The decrease reflects a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16 and FY 16-17, it is anticipated that implementation of this proposed rule will result in an indeterminable increase in programmatic expenditures in the Medicaid program. In FY 15-16, the increase reflects the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the State Management Organization (SMO). In FY 16-17, the increase reflects the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. The increase in programmatic expenditures is at no net cost to the state because premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$738 (\$369 SGF and \$369 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

In FY 14-15, it is anticipated that the implementation of this proposed rule will decrease revenue collections for the federal share of programmatic expenditures reflecting a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16, it is anticipated that the implementation of this proposed rule will increase revenue collections for the federal share of programmatic expenditures for the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, it is anticipated that the implementation of this proposed rule will increase revenue collections for the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. Premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$369 will be collected in FY 14-15 for the federal share of the administrative expense for promulgation of this proposed rule and the final rule.

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

This proposed Rule continues the provisions of the August 1, 2014 Emergency Rule which amended the provisions governing behavioral health services coordinated by the SMO to revise the recipient participation criteria and the reimbursement methodology, and proposes to amend the provisions governing the reimbursement methodology for children's services, exclude the medically needy spend-down population, and update the participant eligibility criteria. It is anticipated that implementation of this proposed rule will not have economic cost or benefits to behavioral health providers or recipients in FY 14-15, FY 15-16, and FY 16-17. The decrease in programmatic expenditures in FY 14-15, reflecting one time savings from a change in the timing of capitation payments made to the SMO, will have no impact on providers

as requirements for timely claims payment by the SMO are unchanged.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)**

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#076

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Behavioral Health**

Behavioral Health Services
Substance Use Services
(LAC 50:XXXIII.Chapters 141-147)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.Chapters 141-147 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health currently provide substance abuse services for children and adults through a coordinated behavioral health services system under the Medicaid Program.

The department now proposes to amend the provisions governing substance abuse services in order to clarify these provisions, replace references to substance abuse with substance use, and revise the reimbursement methodology.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE

Part XXXIII. Behavioral Health Services

Subpart 15. Substance Use Services

Chapter 141. General Provisions

§14101. Introduction

A. The Medicaid Program hereby adopts provisions to provide coverage under the Medicaid state plan for substance use services rendered to children and adults. These services shall be administered under the authority of the Department of Health and Hospitals, Office of Behavioral Health, in collaboration with a statewide management organization (SMO) which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. The substance use services rendered shall be those services which are medically necessary to reduce the disability resulting from the illness and to restore the individual to his/her best possible functioning level in the community.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and

Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§14103. Recipient Qualifications

A. Children and adults who meet Medicaid eligibility and clinical criteria shall qualify to receive medically necessary substance use services.

B. Qualifying children and adults with an identified substance use diagnosis shall be eligible to receive substance use services covered under the Medicaid state plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 143. Services

§14301. General Provisions

A. ...

B. Substance use services are subject to prior approval by the SMO.

C. - D.1. ...

E. Children who are in need of substance use services shall be served within the context of the family and not as an isolated unit. Services shall be appropriate for:

E.1. - F. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§14303. Covered Services

A. The following substance use services shall be reimbursed under the Medicaid Program:

A.1. - B.2. ...

3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving substance use services;

4. - 5. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:426 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 145. Provider Participation

§14501. Provider Responsibilities

A. Each provider of substance use services shall enter into a contract with the statewide management organization in order to receive reimbursement for Medicaid covered services.

B. ...

C. Providers of substance use services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial authorization are approved for re-authorization prior to service delivery.

D. Anyone providing substance use services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of

this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. Substance use providers shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be reported to the SMO in writing within the time limit established by the department.

F. - F.6. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health LR 41:

Chapter 147. Reimbursement

§14701. Reimbursement Methodology

A. Effective for dates of service on or after March 1, 2015, the department, or its fiscal intermediary, shall make monthly capitated payments to the SMO. Payments shall be developed and based upon the fee-for-service reimbursement methodology currently established for the covered services.

B. The capitated rates paid to the SMO shall be actuarially sound rates and the SMO will determine the rates paid to its contracted providers.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:427 (February 2012), amended LR 39:3301 (December 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

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

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Behavioral Health Services Substance Use Services

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

In FY 14-15, it is anticipated that implementation of this proposed rule will result in an indeterminable decrease in programmatic expenditures in the Medicaid program. The decrease reflects a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16 and FY 16-17, it is anticipated that implementation of this proposed rule will result in an indeterminable increase in programmatic expenditures in the Medicaid program. In FY 15-16, the increase reflects the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, the increase reflects the 2.25 percent state premium tax applicable to capitation rates paid to the State Management Organization (SMO). The increase in programmatic expenditures is at no net cost to the state because premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$656 (\$328 SGF and \$328 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

In FY 14-15, it is anticipated that the implementation of this proposed rule will decrease revenue collections for the federal share of programmatic expenditures reflecting a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16, it is anticipated that the implementation of this proposed rule will increase revenue collections for the federal share of programmatic expenditures for the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, it is anticipated that the implementation of this proposed rule will increase revenue collections for the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. Premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It

is anticipated that \$328 will be expended in FY 14-15 for the federal administrative expenses for promulgation of this proposed rule and the final rule.

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

This proposed Rule is being promulgated to amend the provisions governing substance abuse services in order to clarify these provisions, replace references to substance abuse with substance use, and revise the reimbursement methodology. It is anticipated that implementation of this proposed rule will not have economic cost or benefits to behavioral health providers or recipients in FY 14-15, FY 15-16, and FY 16-17. The decrease in programmatic expenditures in FY 14-15, reflecting one time savings from a change in the timing of capitation payments made to the SMO, will have no impact on providers as requirements for timely claims payment by the SMO are unchanged.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#077

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing and Office of Behavioral Health

Children's Behavioral Health Services
(LAC 50:XXXIII.2501 and 2701)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.2501 and §2701 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health currently provides behavioral health services to children and youth through a coordinated behavioral health system under the Medicaid Program. The department now proposes to amend the provisions governing children's behavioral health services to adopt a capitated rate methodology and to allow an Office of Behavioral Health appointed designee to certify providers.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXXIII. Behavioral Health Services

Subpart 3. Children's Mental Health Services

Chapter 25. Provider Participation

§2501. Provider Responsibilities

A. - C. ...

D. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of

this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. - E.6. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 27. Reimbursement

§2701. Reimbursement Methodology

A. Effective for dates of service on or after July 1, 2012, the reimbursement rates for the following behavioral health services provided to children/adolescents shall be reduced by 1.44 percent of the rates in effect on June 30, 2012:

1. therapeutic services;
2. rehabilitation services; and
3. crisis intervention services.

B. Effective for dates of service on or after March 1, 2015, the department, or its fiscal intermediary, shall make monthly capitated payments to the SMO. Payments shall be developed and based upon the fee-for-service reimbursement methodology currently established for the covered services.

1. - 3. Repealed.

C. The capitated rates paid to the SMO shall be actuarially sound rates, and the SMO will determine the rates paid to its contracted providers.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:365 (February 2012), amended LR 39:317 (February 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same

level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Children's Behavioral Health Services

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

In FY 14-15, it is anticipated that implementation of this proposed rule will result in an indeterminable decrease in programmatic expenditures in the Medicaid program. The decrease reflects a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16 and FY 16-17, it is anticipated that implementation of this proposed rule will result in an indeterminable increase in programmatic expenditures in the Medicaid program. In FY 15-16, the increase reflects the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the State Management Organization (SMO). In FY 16-17, the increase reflects the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. The increase in programmatic expenditures is at no net cost to the state because premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$410 (\$205 SGF and \$205 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

In FY 14-15, it is anticipated that the implementation of this proposed rule will decrease revenue collections for the federal share of programmatic expenditures reflecting a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16, it is anticipated that the implementation of this proposed rule will increase revenue collections for the federal share of programmatic expenditures for the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, it is anticipated that the implementation of this proposed rule will increase revenue collections for the 2.25 percent state premium tax applicable to capitation rates paid to the SMO.

Premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$205 will be collected in FY 14-15 for the federal share of the administrative expense for promulgation of this proposed rule and the final rule.

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

This proposed Rule amends the provisions governing children's behavioral health services to adopt a capitated rate methodology, and to allow an Office of Behavioral Health appointed designee to certify providers. It is anticipated that implementation of this proposed rule will not have economic cost or benefits to behavioral health providers or recipients in FY 14-15, FY 15-16, and FY 16-17. The decrease in programmatic expenditures in FY 14-15, reflecting one time savings from a change in the timing of capitation payments made to the SMO, will have no impact on providers as requirements for timely claims payment by the SMO are unchanged.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#078

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing**

**Family Planning Services
(LAC 50:XV.Chapters 251-255)**

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:XV.Chapters 251-255 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions to establish a new optional eligibility group under the Medicaid state plan to provide coverage for family planning services and supplies (*Louisiana Register*, Volume 40, Number 6).

The department promulgated an Emergency Rule which amended the provisions governing family planning services to revise and clarify the provisions of the June 20, 2014 Rule (*Louisiana Register*, Volume 40, Number 6). The department subsequently promulgated an Emergency Rule which amended the provisions of the June 20, 2014 Emergency Rule in order to revise the formatting of these provisions to ensure that the provisions are appropriately incorporated into the *Louisiana Administrative Code* (*Louisiana Register*, Volume 40, Number 9). This proposed Rule is being promulgated to continue the provisions of the September 20, 2014 Emergency Rule.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XV. Services for Special Populations

Subpart 17. Family Planning Services

Chapter 251. General Provisions

§25101. Purpose

A. Effective July 1, 2014, the Medicaid Program shall provide coverage of family planning services and supplies under the Medicaid state plan, to a new targeted group of individuals who are otherwise ineligible for Medicaid. This new optional coverage group may also include individuals receiving family planning services through the Section 1115 demonstration waiver, Take Charge Program, if it is determined that they meet the eligibility requirements for the state plan family planning services.

B. The primary goals of family planning services are to:

1. increase access to services which will allow improved reproductive and physical health;
2. improve perinatal outcomes; and
3. reduce the number of unintended pregnancies.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1097 (June 2014), amended LR 41:

Chapter 253. Eligibility Criteria

§25301. Recipient Qualifications

A. Recipients who qualify for family planning services in the new categorically needy group include individuals of child bearing age who meet the following criteria:

1. women who are not pregnant and have income at or below 138 percent of the federal poverty level; and
2. men who have income at or below 138 percent of the federal poverty level.
3. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1097 (June 2014), amended LR 41:

Chapter 255. Services

§25501. Covered Services

A. Medicaid covered family planning services include:

1. seven office visits per year for physical examinations or necessary re-visits as it relates to family planning or family planning-related services;
2. contraceptive counseling (including natural family planning), education, follow-ups and referrals;
3. laboratory examinations and tests for the purposes of family planning and management of sexual health;
4. pharmaceutical supplies and devices to prevent conception, including all methods of contraception approved by the Federal Food and Drug Administration; and
- a. - c. Repealed.

5. male and female sterilization procedures and follow-up tests provided in accordance with 42 CFR 441, subpart F.

B. Family planning-related services include the diagnosis and treatment of sexually transmitted diseases or

infections, regardless of the purpose of the visit at which the disease or infection was discovered. Medicaid covered family planning-related services include:

1. diagnostic procedures, drugs and follow-up visits to treat a sexually transmitted disease, infection or disorder identified or diagnosed at a family planning visit (other than HIV/AIDS or hepatitis);
2. annual family planning visits for individuals, both males and females of child bearing age, which may include:
 - a. a comprehensive patient history;
 - b. physical, including breast exam;
 - c. laboratory tests; and
 - d. contraceptive counseling;
3. vaccine to prevent cervical cancer;
4. treatment of major complications from certain family planning procedures; and
5. transportation services.

C. - C.3. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:1098 (June 2014), amended LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct and indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge,

LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Family Planning Services

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

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 14-15. It is anticipated that \$574(\$287 SGF and \$287 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

It is anticipated that the implementation of this proposed rule will not affect revenue collections other than the federal share of the promulgation costs for FY 14-15. It is anticipated that \$287 will be collected in FY 14-15 for the federal share of the expense for promulgation of this proposed rule and the final rule.

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

This proposed Rule continues the provisions of the September 20, 2014 Emergency Rule which amended the provisions governing family planning services to revise and clarify the provisions of the June 20, 2014 Final Rule, and to ensure the provisions are adopted in a clear and concise manner in the Louisiana Administrative Code. It is anticipated that implementation of this proposed rule will not have economic costs or benefits to family planning providers for FY 14-15, FY 15-16, and FY 16-17.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#079

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing and Office of Behavioral Health

Home and Community-Based
Behavioral Health Services Waiver
(LAC 50:XXXIII.8103, 8305, 8501 and 8701)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.8103, §8305, §8501, and §8701 in the Medical Assistance Program, as

authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health currently provide behavioral health services to Medicaid eligible children diagnosed with mental illness or a serious emotional disturbance through the home and community-based services (HCBS) waiver as part of the coordinated behavioral health services system under the Medicaid Program.

The department now proposes to amend the provisions governing the HCBS waiver for children's behavioral health services in order to revise these provisions and the reimbursement methodology.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXXIII. Behavioral Health Services

Subpart 9. Home and Community-Based Services

Waiver

Chapter 81. General Provisions

§8103. Recipient Qualifications

A. The target population for the Home and Community-Based Behavioral Health Services Waiver Program shall be Medicaid recipients who:

1. ...
2. have a qualifying mental health diagnosis;

A.3. - B. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:366 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 83. Services

§8305. Covered Services

A. The following behavioral health services shall be provided in the HCBS waiver program:

1. short-term respite care;
2. independent living/skills building;
3. youth support and training;
4. parent support and training; and
5. crisis stabilization.
6. - 7. Repealed.

B. - C.5. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:367 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 85. Provider Participation

§8501. Provider Responsibilities

A. - C. ...

D. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. - E.6. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:368 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 87. Reimbursement

§8701. Reimbursement Methodology

A. The department, or its fiscal intermediary, shall make monthly capitated payments to the SMO. Payments shall be developed and based upon the fee-for-service reimbursement methodology currently established for the covered services.

B. The capitated rates paid to the SMO shall be actuarially sound rates and the SMO will determine the rates paid to its contracted providers.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:368 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

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

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Home and Community-Based Behavioral Health Services Waiver

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

In FY 14-15, it is anticipated that implementation of this proposed rule will result in an indeterminable decrease in programmatic expenditures in the Medicaid program. The decrease reflects a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16 and FY 16-17, it is anticipated that implementation of this proposed rule will result in an indeterminable increase in programmatic expenditures in the Medicaid program. In FY 15-16, the increase reflects the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the State Management Organization (SMO). In FY 16-17, the increase reflects the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. The increase in programmatic expenditures is at no net cost to the state because premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$492 (\$246 SGF and \$246 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

In FY 14-15, it is anticipated that the implementation of this proposed rule will decrease revenue collections for the federal share of programmatic expenditures reflecting a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16, it is anticipated that the implementation of this proposed rule will increase revenue collections for the federal share of programmatic expenditures for the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, it is anticipated that the implementation of this proposed rule will increase revenue collections for the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. Premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$246 will be expended in FY 14-15 for the federal administrative expenses for promulgation of this proposed rule and the final rule.

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

This proposed Rule is being promulgated to amend the provisions governing the HCBS waiver for children's

behavioral health services in order to revise these provisions and the reimbursement methodology. It is anticipated that implementation of this proposed rule will not have economic cost or benefits to behavioral health providers or recipients in FY 14-15, FY 15-16, and FY 16-17. The decrease in programmatic expenditures in FY 14-15, reflecting one time savings from a change in the timing of capitation payments made to the SMO, will have no impact on providers as requirements for timely claims payment by the SMO are unchanged.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#081

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing and Office of Aging and Adult Services

Home and Community-Based Services Waivers
Adult Day Health Care
(LAC 50:XXI.Chapter 29)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services propose to amend LAC 50:XXI.Chapter 29 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services (OAAS) amended the provisions governing the adult day health care (ADHC) waiver to revise the provisions governing: 1) the program description; 2) the allocation of waiver opportunities; 3) the provision of services and discharge criteria; 4) the reimbursement methodology to implement a quarter hour pay rate and a provider specific transportation component, and to reduce the direct care floor (*Louisiana Register*, Volume 37, Number 9).

The department now proposes to amend the provisions governing the ADHC waiver in order to clarify the cost reporting requirements for ADHC facility reimbursements.

Title 50

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

Subpart 3. Adult Day Health Care

Chapter 29. Reimbursement

§2903. Cost Reporting

A. Cost Centers Components

1. Direct Care Costs. This component reimburses for in-house and contractual direct care staffing, social services and activities (excluding the activities director) and fringe benefits and direct care supplies.

2. Care Related Costs. This component reimburses for in-house and contractual salaries and fringe benefits for supervisory and dietary staff, raw food costs and care related supplies.

3. Administrative and Operating Costs. This component reimburses for in-house or contractual salaries and related benefits for administrative, housekeeping, laundry and maintenance staff. Also included are:

- a. utilities;
- b. accounting;
- c. dietary supplies;
- d. housekeeping and maintenance supplies; and
- e. all other administrative and operating type expenditures.

4. Property. This component reimburses for depreciation, interest on capital assets, lease expenses, property taxes and other expenses related to capital assets, excluding property costs related to patient transportation.

5. Transportation. This component reimburses for in-house and contractual driver salaries and related benefits, non-emergency medical transportation, vehicle maintenance and supply expense, motor vehicle depreciation, interest expense related to vehicles, vehicle insurance, and auto leases.

B. Providers of ADHC services are required to file acceptable annual cost reports of all reasonable and allowable costs. An acceptable cost report is one that is prepared in accordance with the requirements of this Section and for which the provider has supporting documentation necessary for completion of a desk review or audit. The annual cost reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the center for no less than five years following the date cost reports are submitted to the bureau. A chart of accounts and an accounting system on the accrual basis or converted to the accrual basis at year end are required in the cost report preparation process. The bureau or its designee will perform desk reviews of the cost reports. In addition to the desk review, a representative number of the facilities shall be subject to a full-scope, annual on-site audit. All ADHC cost reports shall be filed with a fiscal year from July 1 through June 30.

1. When a provider ceases to participate in the ADHC Waiver Program, the provider must file a cost report covering a period under the program up to the effective date of cessation of participation in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than one month or not more than 13 months.

C. ...

D. Annual Reporting. Cost reports are to be filed on or before the last day of September following the close of the cost reporting period. Should the due date fall on a Saturday, Sunday, or an official state or federal holiday, the due date shall be the following business day. The cost report forms and schedules must be filed with one copy of the following documents:

1. a cost report grouping schedule. This schedule should include all trial balance accounts grouped by cost report line item. All subtotals should agree to a specific line

item on the cost report. This grouping schedule should be done for the balance sheet, income statement and expenses;

2. a depreciation schedule. The depreciation schedule which reconciles to the depreciation expense reported on the cost report must be submitted. If the center files a home office cost report, copies of the home office depreciation schedules must also be submitted with the home office cost report. All hospital based facilities must submit a copy of a depreciation schedule that clearly shows and totals assets that are hospital only, ADHC only and shared assets;

3. - 5. ...

6. For management services provided by a related party or home office, a description of the basis used to allocate the costs to providers in the group and to non-provider activities and copies of the cost allocation worksheet, if applicable. Costs of related management/home offices must be reported on a separate cost report that includes an allocation schedule; and

D.7. - F. ...

G. Accounting Basis. The cost report must be prepared on the accrual basis of accounting. If a center is on a cash basis, it will be necessary to convert from a cash basis to an accrual basis for cost reporting purposes. Particular attention must be given to an accurate accrual of all costs at the year-end for appropriate recordation of costs in the applicable cost reporting period. Care must be given to the proper allocation of costs for contracts to the period covered by such contracts. Amounts earned although not actually received and amounts owed to creditors but not paid must be included in the appropriate cost reporting period.

H. ...

I. Attendance Records

1. Attendance data reported on the cost report must be supportable by daily attendance records. Such information must be adequate and available for auditing.

a. - b. Repealed.

2. Daily attendance records should include the time of each client's arrival and departure from the facility. The attendance records should document the presence or absence of each client on each day the facility is open. The facility's attendance records should document all admissions and discharges on the attendance records. Attendance records should be kept for all clients that attend the adult day facility. This includes Medicaid, Veteran's Administration, insurance, private, waiver and other clients. The attendance of all clients should be documented regardless of whether a payment is received on behalf of the client. Supporting documentation such as admission documents, discharge summaries, nurse's progress notes, sign-in/out logs, etc. should be maintained to support services provided to each client.

3. - 4. Repealed.

J. Employee record:

1. the provider shall retain written verification of hours worked by individual employees:

a. records may be sign-in sheets or time cards, but shall indicate the date and hours worked;

b. records shall include all employees even on a contractual or consultant basis;

c. - d. Repealed.

2. verification of employee orientation and in-service training;

3. verification of the employee's communicable disease screening.

K. Billing Records

1. The provider shall maintain billing records in accordance with recognized fiscal and accounting procedures. Individual records shall be maintained for each client. These records shall meet the following criteria.

a. Records shall clearly detail each charge and each payment made on behalf of the client.

b. Records shall be current and shall clearly reveal to whom charges were made and for whom payments were received.

c. Records shall itemize each billing entry.

d. Records shall show the amount of each payment received and the date received.

2. The provider shall maintain supporting fiscal documents and other records necessary to ensure that claims are made in accordance with federal and state requirements.

L. Non-acceptable Descriptions. "Miscellaneous", "other" and "various", without further detailed explanation, are not acceptable descriptions for cost reporting purposes. If any of these are used as descriptions in the cost report, a request for information will not be made and the related line item expense will be automatically disallowed. The provider will not be allowed to submit the proper detail of the expense at a later date, and an appeal of the disallowance of the costs may not be made.

1. - 2. Repealed.

M. Exceptions. Limited exceptions to the cost report filing requirements will be considered on an individual provider basis upon written request from the provider to the Bureau of Health Services Financing, Rate and Audit Review Section. If an exception is allowed, the provider must attach a statement describing fully the nature of the exception for which prior written permission was requested and granted. Exceptions which may be allowed with written approval are as follows.

1. If the center has been purchased or established during the reporting period, a partial year cost report may be filed in lieu of the required 12-month report.

2. If the center experiences unavoidable difficulties in preparing the cost report by the prescribed due date, an extension may be requested prior to the due date. Requests for exception must contain a full statement of the cause of the difficulties that rendered timely preparation of the cost report impossible.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2569 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and Office of Aging and Adult Services, LR 37:3626 (September 2011), LR 41:

§2905. Cost Categories Included in the Cost Report

A. Direct Care (DC) Costs

1. - 13. ...

14. Drugs, Over-the-Counter and Non-Legend—cost of over-the-counter and non-legend drugs provided by the center to its residents. This is for drugs not covered by Medicaid.

15. - 16. ...

17. Recreational Supplies, DC—cost of items used in the recreational activities of the center.

18. Other Supplies, DC—cost of items used in the direct care of residents which are not patient-specific such as prep supplies, alcohol pads, betadine solution in bulk, tongue depressors, cotton balls, thermometers, blood pressure cuffs and under-pads and diapers (reusable and disposable).

19. Allocated Costs, Hospital Based—the amount of costs that have been allocated through the step-down process from a hospital or state institution as direct care costs when those costs include allocated overhead.

20. Miscellaneous, DC—costs incurred in providing direct care services that cannot be assigned to any other direct care line item on the cost report.

21. Total Direct Care Costs—sum of the above line items.

B. Care Related (CR) Costs

1. - 7. ...

8. Contract, Dietary—cost of dietary services and personnel hired through contract that are not employees of the center.

9. - 15. ...

16. Supplies, CR—the costs of supplies used for rendering care related services to the clients of the center. All personal care related items such as shampoo and soap administered by all staff must be included on this line.

17. ...

18. Miscellaneous, CR—costs incurred in providing care related care services that cannot be assigned to any other care related line item on the cost report.

19. Total Care Related Costs—the sum of the care related cost line items.

C. Administrative and Operating Costs (AOC)

1. - 24. ...

25. Interest Expense, Non-Capital interest paid on short term borrowing for center operations.

26. ...

27. Legal Fees—only actual and reasonable attorney fees incurred for non-litigation legal services related to client care are allowed.

28. Linen Supplies—cost of sheets, blankets, pillows, and gowns.

29. Management Fees and Home Office Costs—the cost of purchased management services or home office costs incurred that are allocable to the provider. Costs for related management/home office must also be reported on a separate cost report that includes an allocation schedule.

30. Office Supplies and Subscriptions—cost of consumable goods used in the business office such as:

a. pencils, paper and computer supplies;

b. cost of printing forms and stationery including, but not limited to, nursing and medical forms, accounting and census forms, charge tickets, center letterhead and billing forms;

c. cost of subscribing to newspapers, magazines and periodicals.

31. Postage—cost of postage, including stamps, metered postage, freight charges, and courier services.

a. - c. Repealed.

32. Repairs and Maintenance—supplies and services, including electricians, plumbers, extended service

agreements, etc., used to repair and maintain the center building, furniture and equipment except vehicles. This includes computer software maintenance.

33. Taxes and Licenses—the cost of taxes and licenses paid that are not included on any other line of the cost report. This includes tags for vehicles, licenses for center staff (including nurse aide re-certifications) and buildings.

34. Telephone and Communications—cost of telephone services, internet and fax services.

35. Travel—cost of travel (airfare, lodging, meals, etc.) by the administrator and other authorized personnel to attend professional and continuing educational seminars and meetings or to conduct center business. Commuting expenses and travel allowances are not allowable.

36. Utilities—cost of water, sewer, gas, electric, cable TV and garbage collection services.

37. Allocated Costs, Hospital Based—costs that have been allocated through the step-down process from a hospital as administrative and operating costs.

38. Advertising—costs of employment advertising and soliciting bids. Costs related to promotional advertising are not allowable.

39. Maintenance Supplies—supplies used to repair and maintain the center building, furniture and equipment except vehicles.

40. Miscellaneous—costs incurred in providing center services that cannot be assigned to any other line item on the cost report. Examples of miscellaneous expenses are small equipment purchases, all employees' physicals and shots, nominal gifts to all employees, such as a turkey or ham at Christmas, and flowers purchased for the enjoyment of the clients. Items reported on this line must be specifically identified.

41. Total administrative and operating costs.

D. Property and Equipment

1. - 2. ...

3. Interest Expense, Capital—interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase the center's land, buildings and/or furniture, and equipment, excluding vehicles.

4. Property Insurance—cost of fire and casualty insurance on center buildings, and equipment, excluding vehicles. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

5. Property Taxes—taxes levied on the center's buildings and equipment. Hospital-based facilities and state-owned facilities must allocate property insurance based on the number of square feet.

6. - 8. ...

9. Miscellaneous, Property—any capital costs related to the facility that cannot be assigned to any other property and equipment line item on the cost report.

10. Total property and equipment.

E. - E.5. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2164 (October 2008), repromulgated LR 34:2571 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:3626 (September 2011), amended LR 41:

§2909. Nonallowable Costs

A. - C.5. ...

D. Specific nonallowable costs (this is not an all-inclusive listing):

1. - 17. ...

18. penalties and sanctions—penalties and sanctions assessed by the Centers for Medicare and Medicaid Services, DHH, the Internal Revenue Service or the state Tax Commission; insufficient funds charges;

19. - 20. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2169 (October 2008), repromulgated LR 34:2573 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 41:

§2915. Provider Reimbursement

A. Cost Determination Definitions

Adjustment Factor—Repealed.

Base Rate Components—Repealed.

a. - e. Repealed.

Index Factor—computed by dividing the value of the index for December of the year preceding the rate year by the value of the index one year earlier (December of the second preceding year).

Rate Component—the rate is the summation of the following:

- a. direct care;
- b. care related costs;
- c. administrative and operating costs;
- d. property costs; and
- e. transportation costs.

B. Rate Determination

1. The base rate is calculated based on the most recent audited or desk reviewed cost for all ADHC providers filing acceptable full year cost reports. The rates are based on cost components appropriate for an economic and efficient ADHC providing quality service. The client per quarter hour rates represent the best judgment of the state to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ADHC.

2. For rate periods between rebasing, the rates will be trended forward using the index factor contingent upon appropriation by the legislature.

3. The median costs for each component are multiplied in accordance with §2915.B.4 then by the appropriate index factors for each successive year to determine base rate components. For subsequent years, the components thus computed become the base rate components to be multiplied by the appropriate index factors, unless they are adjusted as provided in §2915.B.6 below. Application of an inflationary adjustment to reimbursement rates in non-rebasing years shall apply only when the state legislature allocates funds for this purpose. The inflationary adjustment shall be made prorating allocated funds based on the weight of the rate components.

4. - 5. ...

6. Formulae. Each median cost component shall be calculated as follows.

a. Direct Care Cost Component. Direct care allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the Consumer Price Index-medical services (south region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The direct care rate component shall be set at 115 percent of the inflated median.

b. Care Related Cost Component. Care related allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the center at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by the value of the Consumer Price Index-all items (south region) index for December of the year preceding the rate year by the value of the index for the December of the year preceding the cost report year. The care related rate component shall be set at 105 percent of the inflated median.

c. Administrative and Operating Cost Component. Administrative and operating allowable quarter hour cost from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost of the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. The median cost shall be trended forward by dividing the value of the CPI-all items (south region) index for December of the year preceding the base rate year by the value of the index for the December of the year preceding the cost report year. The administrative and operating rate component shall be set at 105 percent of the inflated median.

d. Property Cost Component. The property allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. This will be the rate component. Inflation will not be added to property costs.

e. Transportation Cost Component. The transportation allowable quarter hour costs from all acceptable full year cost reports, except those for which an audit disclaimer has been issued, will be calculated on a provider by provider basis. Should a provider not have filed an acceptable full year cost report, the provider's transportation cost will be reimbursed as follows.

i. New provider, as described in §2915.E.1, will be reimbursed in an amount equal to the statewide allowable quarter hour median transportation costs.

(a). In order to calculate the statewide allowable quarter hour median transportation costs, all acceptable full year cost reports, except those for which an audit disclaimer

has been issued, shall be arrayed from lowest to highest. The cost at the midpoint of the array shall be the median cost. Should there be an even number of arrayed cost, an average of the two midpoint centers shall be the median cost. This will be the rate component. Inflation will not be added to transportation costs.

ii. Providers that have gone through a change of ownership (CHOW), as described in §2915.E.2, will be reimbursed for transportation costs based upon the previous owner's specific allowable quarter hour transportation costs for the period of time between the effective date of the CHOW and the first succeeding base year in which the new owner could possibly file an allowable 12-month cost report. Thereafter, the new owner's data will be used to determine the provider's rate following the procedures specified in this Rule.

iii. Providers that have been issued an audit disclaimer, or have a non-filer status, as described in §2915.E.3, will be reimbursed for transportation costs at a rate equal to the lowest allowable quarter hour transportation cost (excluding providers with no transportation costs) in the state as of the most recent audited and/or desk reviewed rate database.

iv. For rate periods between rebasing years, if a provider discontinues transportation services and reported no transportation costs on the most recently audited or desk reviewed cost report, no facility specific transportation rate will be added to the facility's total rate for the rate year.

7. Budgetary Constraint Rate Adjustment. Effective for the rate period July 1, 2011 to July 1, 2012, the allowable quarter hour rate components for direct care, care related, administrative and operating, property, and transportation shall be reduced by 10.8563 percent.

a. - e.iii. Repealed.

8. Interim Adjustments to Rates. If an unanticipated change in conditions occurs that affects the cost of at least 50 percent of the enrolled ADHC providers by an average of five percent or more, the rate may be changed. The Department will determine whether or not the rates should be changed when requested to do so by 25 percent or more of the enrolled providers, or an organization representing at least 25 percent of the enrolled providers. The burden of proof as to the extent and cost effect of the unanticipated change will rest with the entities requesting the change. The Department may initiate a rate change without a request to do so. Changes to the rates may be temporary adjustments or base rate adjustments as described below.

a. Temporary Adjustments. Temporary adjustments do not affect the base rate used to calculate new rates.

i. Changes Reflected in the Economic Indices. Temporary adjustments may be made when changes which will eventually be reflected in the economic indices, such as a change in the minimum wage, a change in FICA or a utility rate change, occur after the end of the period covered by the indices, i.e., after the December preceding the rate calculation. Temporary adjustments are effective only until the next annual base rate calculation.

ii. Lump Sum Adjustments. Lump sum adjustments may be made when the event causing the adjustment requires a substantial financial outlay, such as a change in certification standards mandating additional equipment or furnishings. Such adjustments shall be subject

to the bureau's review and approval of costs prior to reimbursement.

b. Base Rate Adjustment. A base rate adjustment will result in a new base rate component value that will be used to calculate the new rate for the next fiscal year. A base rate adjustment may be made when the event causing the adjustment is not one that would be reflected in the indices.

9. Provider Specific Adjustment. When services required by these provisions are not made available to the recipient by the provider, the Department may adjust the prospective payment rate of that specific provider by an amount that is proportional to the cost of providing the service. This adjustment to the rate will be retroactive to the date that is determined by the Department that the provider last provided the service and shall remain in effect until the Department validates, and accepts in writing, an affidavit that the provider is then providing the service and will continue to provide that service

9.a. - 10. Repealed.

C. Cost Settlement. The direct care cost component shall be subject to cost settlement. The direct care floor shall be equal to 70 percent of the median direct care rate component trended forward for direct care services (plus 70 percent of any direct care incentive added to the rate). The Medicaid Program will recover the difference between the direct care floor and the actual direct care amount expended. If a provider receives an audit disclaimer, the cost settlement for that year will be based on the difference between the direct care floor and the lowest direct care per diem of all facilities in the most recent audited and/or desk reviewed database. If the lowest direct care per diem of all facilities in the most recent audited and/or desk reviewed database is lower than 50 percent of the direct care rate paid for that year, 50 percent of the direct care rate paid will be used as the provider's direct care per diem for settlement purposes.

D. ...

E. New Facilities, Changes of Ownership of Existing Facilities, and Existing Facilities with Disclaimer or Non-Filer Status

1. New Facilities are those entities whose beds have not previously been certified to participate, or otherwise have participated, in the Medicaid program. New facilities will be reimbursed in accordance with this Rule and receiving the direct care, care related, administrative and operating, property rate components as determined in §2915.B.1-§2915.B.6. These new facilities will also receive the state-wide average transportation rate component, as calculated in §2915.B.6.e.i.(a), effective the preceding July 1.

2. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise have participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the rate paid to the previous owner for all rate components. Thereafter, the new owner's data will be used to determine the facility's rate following the procedures in this Rule.

3. Existing providers that have been issued an audit disclaimer, or are a provider who has failed to file a complete cost report in accordance with §2903, will be reimbursed based upon the statewide allowable quarter hour

median costs for the direct care, care related, administrative and operating, and property rate components as determined in §2915.B.1-§2915.B.7. No inflation or median adjustment factor will be included in these components. The transportation component will be reimbursed as described in §2915.B.6.e.iii.

F. Effective for dates of service on or after July 1, 2012, the reimbursement rates for ADHC services shall be reduced by 1.5 percent of the rates in effect on June 30, 2012.

1. The provider-specific transportation component shall be excluded from this rate reduction.

F.2. - G.1. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 34:2170 (October 2008), repromulgated LR 34:2575 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:2157 (July 2011), LR 37:2627 (September 2011), repromulgated LR 38:1594 (July 2012), amended LR 39:507 (March 2013), LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

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

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118,

Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

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

**RULE TITLE: Home and Community-Based
Services Waivers—Adult Day Health Care**

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

It is anticipated that implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 14-15. It is anticipated that \$2,132 (\$1,066 SGF and \$1,066 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

It is anticipated that the implementation of this proposed rule will not affect revenue collections other than the federal share of the promulgation costs for FY 14-15. It is anticipated that \$1,066 will be expended in FY 14-15 for the federal administrative expenses for promulgation of this proposed rule and the final rule.

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

This proposed Rule is being promulgated to amend the provisions governing the ADHC Waiver to clarify the cost reporting requirements for ADHC facility reimbursements. It is anticipated that implementation of this proposed rule will not have economic cost or benefits to ADHC providers for FY 14-15, FY 15-16, and FY 16-17.

**IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT
(Summary)**

It is anticipated that the implementation of this proposed rule will not have an effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#080

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Behavioral Health**

Medicaid Eligibility
Behavioral Health Services
Medically Needy Program
(LAC 50:III.2314)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt LAC 50:III.2314 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgated a Rule in order to reinstate the Title XIX Medically Needy Program (MNP) and to establish coverage restrictions (*Louisiana Register*, Volume 24, Number 5). All Behavioral health services are restricted from coverage under the Medically Needy Program.

In February 2012, the department adopted provisions in the Medicaid Program to restructure the existing behavioral health services delivery system into a comprehensive service delivery model called the Louisiana Behavioral Health Partnership (LBHP). Certain recipients enrolled in the Medically Needy Program, whose Medicaid eligibility is based solely on the provisions of §1915(i) of Title XIX of the Social Security Act, are eligible to only receive behavioral health services. The department now proposes to amend the provisions governing the Medically Needy Program in order to establish provisions in the *Louisiana Administrative Code* for the coverage of recipients who qualify for behavioral health services under §1915(i) of the Social Security Act.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part III. Eligibility

Subpart 3. Eligibility Groups and Factors

**Chapter 23. Eligibility Groups and Medicaid
Programs**

**§2314. Louisiana Behavioral Health Partnership
Medically Needy Program**

A. The Louisiana Behavioral Health Partnership (LBHP) Medically Needy Program (MNP) is considered only for the individuals who meet the level of need requirements of §1915 of Title XIX of the Social Security Act, and who have been determined to be ineligible for other full Medicaid programs, including regular MNP.

1. Effective for dates of service on or after March 1, 2015, recipients who receive spend-down MNP shall not be eligible for 1915(i) behavioral health services.

B. LBHP 1915(i) MNP recipients are only eligible to receive behavioral health services through the LBHP. They do not qualify for other Medicaid covered services.

C. The certification period for LBHP 1915(i) MNP recipients cannot exceed six months.

D. The following behavioral health services are covered for LBHP 1915(i) MNP recipients:

1. inpatient and outpatient hospital services;
2. emergency medical services;
3. physician/psychiatrist services;
4. treatment by a licensed mental health professional;
5. community psychiatric support and treatment;
6. psychosocial rehabilitation;
7. crisis intervention;
8. case conference [1915(b) services];
9. treatment planning [1915(b) services]; and
10. prescription drugs.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of

Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 173, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Medicaid Eligibility Behavioral Health Services Medically Needy Program

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

It is anticipated that implementation of this proposed rule will have no net programmatic fiscal impact to the state other than the cost of promulgation for FY 14-15 since any reduction in expenditures will be directly offset by a correlating increase in programmatic expenditures in legacy Medicaid or Bayou

Health (managed care). It is anticipated that \$820(\$410 SGF and \$410 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

It is anticipated that the implementation of this proposed rule will not affect revenue collections other than the federal share of the promulgation costs for FY 14-15. It is anticipated that \$410 will be collected in FY 14-15 for the federal share of the expense for promulgation of this proposed rule and the final rule.

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

This proposed Rule amends the provisions governing the Medically Needy Program in order to establish provisions in the Louisiana Administrative Code for the coverage of recipients who qualify under §1915(i) of the Social Security Act. It is anticipated that implementation of this proposed rule will have no fiscal impact to the Medicaid Program for FY 14-15, FY 15-16, and FY 16-17 since any reduction in expenditures for behavioral health services coordinated by the SMO will be directly offset by a correlating increase in expenditures for Legacy Medicaid or Bayou Health (managed care).

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#082

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Bureau of Health Services Financing and Office of Behavioral Health

Psychiatric Residential Treatment Facilities
(LAC 50:XXXIII.10303, 10501, and Chapter 107)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.10303, §10501, and Chapter 107 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions governing the reimbursement methodology for psychiatric residential treatment (PRTF) facilities (*Louisiana Register*, Volume 38, Number 2). The department now proposes to amend the provisions governing the reimbursement methodology for PRTFs to establish capitated payments, and to allow an Office of Behavioral Health appointed designee to certify providers.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXXIII. Behavioral Health Services

Subpart 11. Psychiatric Residential Treatment Facility Services

Chapter 103. Services

§10303. Covered Services

A. - A.10. ...

B. Service Exclusions. The following services shall be excluded from Medicaid reimbursement:

1. ...
2. group education, including elementary and secondary education; and
3. activities not on the inpatient psychiatric active treatment plan.
4. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 105. Provider Participation

§10501. Provider Responsibilities

A. - C. ...

D. Anyone providing PRTF services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:369 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 107. Reimbursement

§10701. Reimbursement Methodology

A. Effective for dates of service on or after March 1, 2015, the department, or its fiscal intermediary, shall make monthly capitated payments to the SMO. Payments shall be developed and based upon the reimbursement methodology established through February 28, 2015 for PRTF covered services.

1. - 4. Repealed.

B. The capitated rates paid to the SMO shall be actuarially sound rates, and the SMO will determine the rates paid to all contracted PRTF providers.

C. Covered inpatient, physician-directed PRTF services rendered to children and youth shall be reimbursed according to the following criteria.

1. A free-standing PRTF facility shall be reimbursed at the SMO established rate within their contract for the following services when provided by, and in, the facility when included on the active treatment plan:

- a. occupational therapy;
- b. physical therapy;
- c. speech therapy;
- d. laboratory services; and

e. transportation services.

2. A free-standing PRTF shall arrange through contract(s) with outside (non-facility) providers to furnish dental, vision, and diagnostic/radiology treatment activities as listed on the treatment plan. Reimbursement shall be based on the established Medicaid fee schedule for the covered service, excluded from the SMO contracted rates for the facility.

3. A hospital-based PRTF facility shall be reimbursed at the SMO established rate within their contract for covered services. The rate shall also include reimbursement for the following services when provided by, and in, the facility when included on the active treatment plan:

- a. dental services;
- b. vision services;
- c. diagnostic testing; and
- d. radiology services.

4. Pharmacy and physician services shall be reimbursed when included on the recipient's active treatment plan of care and are components of the Medicaid covered PRTF services. Payment shall be made directly to the treating pharmacy or physician. These payments shall be excluded from the PRTF's contracted rates for the facility.

D. All in-state Medicaid participating PRTF providers are required to file an annual Medicaid cost report according to the department's specifications and departmental guides and manuals. Cost reports must be prepared in advance in accordance with Medicare/Medicaid definitions of allowable and non-allowable cost.

1. Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end. Separate cost reports must be filed for the facilities central/home office when costs of that entity are reported on the facilities cost report.

2. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension must be submitted to Medicaid prior to the cost report due date. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

3. When a PRTF fails to submit a cost report by the prescribed due date, a penalty of 5 percent of the total monthly payment for the first month may be levied and withheld from the payment.

E. Services provided outside of the facility and/or not on the active plan of care shall not be reimbursed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:370 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§10703. In-State Publicly Owned and Operated

Psychiatric Residential Treatment Facilities

A. In-state publicly owned and operated PRTFs shall be reimbursed for all reasonable and necessary costs of operation. These facilities shall be reimbursed at the SMO established rate within their contract for services provided in, and by, the facility on the active treatment plan.

B. ...

C. Cost settlements occur outside of the financial and administrative responsibility of the SMO, and shall be handled directly by the department.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:370 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§10705. In-State Privately Owned and Operated Psychiatric Residential Treatment Facilities

A. In-state privately owned and operated PRTFs shall be reimbursed for covered PRTF services at the SMO established rate within their contract with the provisions of §10703 above. The rate paid to the provider will be determined by the SMO and should take into consideration the following ownership and service criteria:

1. ...
2. free-standing privately owned and operated PRTF specializing in substance use treatment programs;
3. free-standing privately owned and operated PRTF specializing in behavioral health treatment;
4. hospital-based privately owned or operated PRTF specializing in behavioral health treatment;
5. hospital-based privately owned or operated PRTF specializing in sexually-based treatment programs; and
6. hospital-based privately owned or operated PRTF specializing in substance use treatment programs.

B. ...

C. Risk Sharing. In-state privately owned and operated PRTF covered services provided during the time period from January 1, 2012 through June 30, 2013 shall also receive risk-sharing payments. These payments shall be made as part of a transitional plan to include these services within the Medicaid Program.

1. The department will make no risk sharing payments for services rendered on or after July 1, 2013.

D. Beginning March 1, 2015, all covered PRTF services rendered by private facilities contracted with the SMO will be reimbursed based upon the rate set by the SMO and evidenced in the PRTF's individual contract with the SMO.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:370 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§10707. Out-of-State Psychiatric Residential Treatment Facilities

A. Effective for dates of service on or after March 1, 2015, out-of-state PRTFs shall be reimbursed in accordance with the SMO established rate within their contract. Any publically owned and operated PRTFs outside of Louisiana will not receive cost settlements.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:370 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Psychiatric Residential Treatment Facilities

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

In FY 14-15, it is anticipated that implementation of this proposed rule will result in an indeterminable decrease in programmatic expenditures in the Medicaid program. The decrease reflects a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Behavioral Health

School Based Behavioral Health Services
(LAC 50:XXXIII.4303 and 4501)

2015. In FY 15-16 and FY 16-17, it is anticipated that implementation of this proposed rule will result in an indeterminable increase in programmatic expenditures in the Medicaid program. In FY 15-16, the increase reflects the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the State Management Organization (SMO). In FY 16-17, the increase reflects the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. The increase in programmatic expenditures is at no net cost to the state because premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$738 (\$369 SGF and \$369 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

In FY 14-15, it is anticipated that the implementation of this proposed rule will decrease revenue collections for the federal share of programmatic expenditures reflecting a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16, it is anticipated that the implementation of this proposed rule will increase revenue collections for the federal share of programmatic expenditures for the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, it is anticipated that the implementation of this proposed rule will increase revenue collections for the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. Premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$369 will be collected in FY 14-15 for the federal share of the administrative expense for promulgation of this proposed rule and the final rule.

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

This proposed Rule amends the provisions governing the reimbursement methodology for psychiatric residential treatment facilities to establish capitated payments, and to allow an Office of Behavioral Health appointed designee to certify providers. It is anticipated that implementation of this proposed rule will not have economic cost or benefits to behavioral health providers or recipients in FY 14-15, FY 15-16, and FY 16-17. The decrease in programmatic expenditures in FY 14-15, reflecting one time savings from a change in the timing of capitation payments made to the SMO, will have no impact on providers as requirements for timely claims payment by the SMO are unchanged.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#083

Evan Brasseaux
Staff Director
Legislative Fiscal Office

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.4301 and §4501 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health currently provide school based behavioral health services to children and youth through a coordinated behavioral health services system under the Louisiana Medicaid Program. The department now proposes to amend the provisions governing school based health services in order to revise these provisions, and to allow an Office of Behavioral Health appointed designee to certify providers.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services

Subpart 5. School Based Behavioral Health Services

Chapter 43. Services

§4303. Covered Services

A. ...

B. The following school based behavioral health services shall be reimbursed under the Medicaid Program:

- 1. therapeutic services, including diagnosis and treatment;
2. rehabilitation services, including community psychiatric support and treatment (CPST); and
3. addiction services.

C. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:400 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 45. Provider Participation

§4501. Local Education Agency Responsibilities

A. - B. ...

C. Each provider of behavioral health services shall enter into a contract with the statewide management organization in order to receive reimbursement for Medicaid covered services.

D. All services shall be delivered in accordance with federal and state laws and regulations, the provisions of this

Rule, the provider manual, and other notices or directives issued by the department.

E. Providers of behavioral health services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial authorization are approved for re-authorization prior to service delivery.

F. Anyone providing behavioral health services must be certified by the department, or its designee, in addition to operating within their scope of practice license. To be certified or recertified, providers shall meet the provisions of this Rule, the provider manual and the appropriate statutes. The provider shall create and maintain documents to substantiate that all requirements are met.

G. Providers shall maintain case records that include, at a minimum:

1. a copy of the treatment plan,;
 2. the name of the individual;
 3. the dates of service;
 4. the nature, content and units of services provided;
 5. the progress made toward functional improvement;
- and
6. the goals of the treatment plan.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:401 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

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

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to

MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: School Based Behavioral Health Services

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

In FY 14-15, it is anticipated that implementation of this proposed rule will result in an indeterminable decrease in programmatic expenditures in the Medicaid program. The decrease reflects a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16 and FY 16-17, it is anticipated that implementation of this proposed rule will result in an indeterminable increase in programmatic expenditures in the Medicaid program. In FY 15-16, the increase reflects the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, the increase reflects the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. The increase in programmatic expenditures is at no net cost to the state because premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$410 (\$205 SGF and \$205 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

In FY 14-15, it is anticipated that the implementation of this proposed rule will decrease revenue collections for the federal share of programmatic expenditures reflecting a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16, it is anticipated that the implementation of this proposed rule will increase revenue collections for the federal share of programmatic expenditures for the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, it is anticipated that the implementation of this proposed rule will increase revenue collections for the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. Premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$205 will be expended in FY 14-15 for the federal administrative expenses for promulgation of this proposed rule and the final rule.

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

This proposed Rule is being promulgated to amend the provisions governing school based health services in order to revise these provisions, and to allow an Office of Behavioral Health appointed designee to certify providers. It is anticipated that implementation of this proposed rule will not have economic cost or benefits to the school based behavioral health service providers for FY 14-15, FY 15-16, and FY 16-17. The decrease in programmatic expenditures in FY 14-15, reflecting one time savings from a change in the timing of capitation payments made to the SMO, will have no impact on providers as requirements for timely claims payment by the SMO are unchanged.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is anticipated that the implementation of this proposed rule will not have an effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#084

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Health and Hospitals
Bureau of Health Services Financing
and
Office of Behavioral Health**

Therapeutic Group Homes
(LAC 50:XXXIII.12103, 12303, 12501 and Chapter 127)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health propose to amend LAC 50:XXXIII.12103, §12303, §12501 and Chapter 127 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health adopted provisions to implement a coordinated behavioral health services system under the Medicaid Program to provide behavioral health services to children with emotional/behavioral disorders in therapeutic group homes (TGHs) (*Louisiana Register*, Volume 38, Number 2).

The department now proposes to amend the provisions governing TGHs in order to revise these provisions and the reimbursement methodology.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part XXXIII. Behavioral Health Services

Subpart 13. Therapeutic Group Homes

Chapter 121. General Provisions

§12103. Recipient Qualifications

A. ...

B. Qualifying children and adolescents with an identified mental health or substance use diagnosis shall be eligible to receive behavioral health services rendered by a TGH.

C. - C.3. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:427 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 123. Services

§12303. Covered Services

A. - A.4. ...

B. Service Exclusions. The following services/components shall be excluded from Medicaid reimbursement:

1. - 2. ...

3. any services or components in which the basic nature of which are to supplant housekeeping, homemaking, or basic services for the convenience of an individual receiving substance use services;

4. - 6. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 125. Provider Participation

§12501. Provider Responsibilities

A. - C. ...

D. Anyone providing TGH services must be certified by the department, or its designee, in addition to operating within their scope of practice license.

E. ...

F. Providers of TGH services shall be required to perform screening and assessment services upon admission and within the timeframe established by the department thereafter to track progress and revise the treatment plan to address any lack of progress and to monitor for current medical problems and concomitant substance use issues.

G. ...

1. - 2. Reserved.

H. For TGH facilities that provide care for sexually deviant behaviors, substance use, or dually diagnosed individuals, the facility shall submit documentation regarding the appropriateness of the research-based, trauma-informed programming and training, as well as compliance with ASAM level of care being provided.

I. - J. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:428 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Chapter 127. Reimbursement

§12701. Reimbursement Methodology

A. Effective March 1, 2015, the department, or its fiscal intermediary, shall make monthly capitated payments to the SMO. Payments shall be developed and based upon the reimbursement methodology established through February 28, 2015 for TGH covered services.

1. - 2. Repealed.

B. The capitated rates paid to the SMO shall be actuarially sound rates and the SMO will determine the rates paid to all contracted TGH providers.

C. Reimbursement for covered TGH services shall be inclusive of, but not be limited to:

1. allowable cost of clinical and related services;
2. psychiatric support services;
3. allowable cost of integration with community resources; and
4. skill-building services provided by unlicensed practitioners.

D. Allowable and non-allowable costs components, as defined by the department, shall be outlined in the TGH provider manual and other departmental guides.

E. All in-state Medicaid participating TGH providers are required to file an annual Medicaid cost report according to the department's specifications and departmental guides and manuals. Cost reports must be prepared in advance in accordance with Medicare/Medicaid definitions of allowable and non-allowable cost.

1. Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end. Separate cost reports must be filed for the facilities central/home office when costs of that entity are reported on the facilities cost report.

2. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension must be submitted to Medicaid prior to the cost report due date. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

3. When a TGH fails to submit a cost report by the prescribed due date, a penalty of five percent of the total monthly payment for the first month maybe levied and withheld from the payment.

F. Services provided by psychologists and licensed mental health practitioners shall be billed separately and reimbursed according to the SMO established rates within the treating provider's individual contract with the SMO.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§12703. In-State Privately Owned and Operated Therapeutic Group Homes

Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:429 (February 2012), repealed by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§12705. In-State Publicly Owned and Operated Therapeutic Group Homes

A. Effective March 1, 2015, in-state publicly owned and operated therapeutic group homes shall be reimbursed according to the SMO established rate within their contract.

B. Payments to in-state publicly owned and operated TGH facilities will be subject to retroactive cost settlement for all reasonable and necessary cost of operation in accordance with Medicare allowable cost principles outlined

in the Centers for Medicare and Medicaid Service's Provider Reimbursement Manual Publication 15-1.

C. Cost settlements occur outside of the financial and administrative responsibility of the SMO, and shall be handled directly by the department.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:429 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

§12707. Out-of-State Therapeutic Group Homes

A. Effective March 1, 2015, out-of-state therapeutic group homes shall be reimbursed the lesser of their specific in-state TGH Medicaid per diem reimbursement rate, or 95 percent of the reimbursement rate established by the SMO for their services.

B. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:429 (February 2012), Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this Emergency Rule has been considered. It is anticipated that this Emergency Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to J. Ruth Kennedy, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030 or by email to MedicaidPolicy@la.gov. Ms. Kennedy is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 9:30 a.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested persons will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Therapeutic Group Homes

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

In FY 14-15, it is anticipated that implementation of this proposed rule will result in an indeterminable decrease in programmatic expenditures in the Medicaid program. The decrease reflects a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16 and FY 16-17, it is anticipated that implementation of this proposed rule will result in an indeterminable increase in programmatic expenditures in the Medicaid program. In FY 15-16, the increase reflects the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the State Management Organization (SMO). In FY 16-17, the increase reflects the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. The increase in programmatic expenditures is at no net cost to the state because premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$820 (\$410 SGF and \$410 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule.

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

In FY 14-15, it is anticipated that the implementation of this proposed rule will decrease revenue collections for the federal share of programmatic expenditures reflecting a one-time savings from moving per member per month capitation rate payments from the month of enrollment to the month following enrollment effective March 2015. In FY 15-16, it is anticipated that the implementation of this proposed rule will increase revenue collections for the federal share of programmatic expenditures for the non-recurring of the one-time savings in FY 14-15 and the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. In FY 16-17, it is anticipated that the implementation of this proposed rule will increase revenue collections for the 2.25 percent state premium tax applicable to capitation rates paid to the SMO. Premium tax revenues collected from the SMO by the Department of Insurance are transferred to the Medical Assistance Trust Fund for support of the Medicaid program. It is anticipated that \$410 will be collected in FY 15-16 for the federal share of the expense for promulgation of this proposed rule and the final rule.

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

This proposed Rule amends the provisions governing TGHs in order to revise these provisions and the reimbursement methodology. It is anticipated that implementation of this proposed rule will not have economic cost or benefits to behavioral health providers or recipients in

FY 14-15, FY 15-16, and FY 16-17. The decrease in programmatic expenditures in FY 14-15, reflecting one time savings from a change in the timing of capitation payments made to the SMO, will have no impact on providers as requirements for timely claims payment by the SMO are unchanged.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy
Medicaid Director
1411#085

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Office of Aging and Adult Services Division of Adult Protective Services

Adult Protective Services Agency (LAC 48:I.Chapter 171)

The Department of Health and Hospitals, Office of Aging and Adult Services, Division of Adult Protective Services proposes to amend LAC 48:XIII.17101-17125 under the Adult Protective Services Program as authorized by R.S. 15:1501-1511. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. Pursuant to Act 13 of the 2012 Regular Session, the operation of the Adult Protective Services (APS) program for persons age 60 and older, commonly referred to as elderly protective services (EPS), was transferred to the Department of Health and Hospital (DHH), Office of Aging and Adult Services (OAAS). Since July 1, 2012, OAAS was charged with operating an adult protective services program under a memorandum of understanding between the Department of Health and Hospitals and the Governor's Office Community Programs.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 13. Protective Services Agency

Chapter 171. Division of Adult Protective Services §17105. Definitions

A. ...

Adult—any individual 18 years of age or older or an emancipated minor who, due to a physical, mental, or developmental disability is unable to manage his own resources, carry out the activities of daily living, or protect himself from abuse, neglect or exploitation.

Adult Protective Services (APS)—that division within the Department of Health and Hospitals' Office of Aging and Adult Services determined by the department as the protective services agency for any individual 18 years and older in need of adult protective services, pursuant to the provisions of R.S. 14:403.2 and R.S. 15:1501-15:1511, to provide protection to adults with disabilities as defined herein.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services, LR 20:435 (April 1994), amended LR 27:313 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:760 (April 2010), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, Division of Adult Protective Services, LR 37:904 (March 2011), LR 37:904 (March 2011), LR 41:

§17107. Eligibility for Services

A. The protection of this Rule extends to any adult as defined by law, 18 years of age and older or emancipated minors, living in unlicensed community settings, either independently or with the help of others, who is alleged to be abused, neglected, exploited, or extorted.

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:436 (April 1994), amended LR 27:313 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:761 (April 2010), LR 41:

§17109. Reporting

A.1. - A.1.b. ...

2. Reports of abuse, neglect, exploitation and extortion shall be processed through the DHH Office of Aging and Adult Services, Division of Adult Protective Services' central intake system. Reports should be made/forwarded to: Adult Protective Services, P.O. Box 2031, Bin #14, Baton Rouge, LA 70821. The state-wide, toll-free telephone number is (800) 898-4910.

B. - E. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:436 (April 1994), amended LR 27:314 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:761 (April 2010), LR 41:

§17111. Investigation and Service Planning

A. ...

B. Service Plan. The protective service worker will be responsible for developing a service plan based upon the case determination. If, at the end of the investigation, it is determined that the individual has been abused, neglected, exploited, and/or extorted by other parties, and that the problem cannot be remedied by extrajudicial means, Adult Protective Services shall refer the matter to the local district attorney's office or the DHH Bureau of Legal Services. Evidence must be presented, together with an account of the protective services given or available to the individual, and a recommendation as to what services, if ordered, would eliminate the abuse/neglect.

C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:436 (April 1994), amended LR 27:314 (March 2001), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:762 (April 2010), LR 41:

§17115. Confidentiality

A. ...

1. Requests for copies of confidential information are to be forwarded to the APS Director, P.O. Box 2031, Bin #14, Baton Rouge, LA 70821.

A.2. - C. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:437 (April 1994), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:763 (April 2010), LR 41:

§17125. Dissemination

A. ...

B. Copies of this Rule shall be disseminated to state and local agencies which serve populations of persons with mental, physical, or emotional disabilities (including but not limited to community services offices of the Office for Citizens with Developmental Disabilities, Office of Behavioral Health, Office of Public Health and state and local law enforcement agencies, advocacy agencies, nursing homes, hospitals, private care agencies, and other related service agencies).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 14:403.2 and R.S. 15:1501-15:1511.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Protective Services LR 20:438 (April 1994), amended by the Office of Aging and Adult Services, Division of Adult Protective Services, LR 36:764 (April 2010), LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a neutral effect on the ability of the family to perform its functions since the rule only authorizes the transfer of operation to the Department of Health and Hospitals (DHH), Office of Aging and Adult Services (OAAS).

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Small Business Statement

A regulatory flexibility analysis pursuant to R. S. 49:965.6 has been conducted. It has been determined that the promulgation of this Rule will not have an adverse impact on small business.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, and will have no direct or indirect cost to the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments to Hugh Eley, Office of Aging and Adult Services, P.O. Box 2031, Baton Rouge, LA 70821-2031. He is responsible for responding to inquiries regarding this proposed Rule. The deadline for the receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 1 p.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested individuals will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Adult Protective Services Agency

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

The Adult Protective Services Act (LA R.S. 15:1501-1511) delineates the operation of an adult protective services program for individuals aged 60 years or older to the Governor's Office of Elderly Affairs (GOEA) and individuals between the ages of 18 - 59 years old to the Department of Health and Hospitals (DHH), Office of Aging and Adult Services (OAAS). However, a Memorandum of Understanding (MOU) signed in July 2012 between DHH and the Governor's Office of Community Programs has transferred the operation of the adult protective services programs for individuals age 60 years or older (commonly referred to as Elderly Protective Services - EPS) to DHH/OAAS. Although GOEA maintains the responsibility for EPS through the statutes, the operation of the EPS program by DHH/OAAS is accomplished through the MOU. This rule proposes to expand the Adult Protective Services program within DHH/OAAS to any individual 18 years and older as outlined in the MOU.

This proposed rule change does not affect current services offered through the Adult Protective Services Program and therefore are not anticipated to result in any additional savings or costs, other than the cost of promulgation of the rule in the amount of \$2,050 in FY 14-15. This cost is routinely included in the agency's annual operating budget.

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

There is no known effect on revenue collections of state or local governmental units.

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

Individuals aged 60 years or older will now receive protective services from DHH/OAAS. The proposed rule is not anticipated to impact services.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule is not anticipated to have any effect on competition and employment.

Robin Wagner
Deputy Assistant Secretary
1411#018

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Office of Aging and Adult Services

State Personal Assistance Services Program
(LAC 48:I.Chapter 191 and LAC 67:VII.Chapter 11)

The Department of Health and Hospitals, Office of Aging and Adult Services proposes to repeal LAC 67:VII.1101-1129 and promulgate LAC 48:I.19101-19121 as authorized by R.S. 46:2116.2. This proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

During the 2010 Regular Session, the Louisiana Legislature authorized the transfer of the State Personal Assistance Services Program and its functions to the Department of Health and Hospitals, Office of Aging and Adult Services (R.S. 46:2116.2). This proposed Rule is being promulgated to adopt the changes created by the new legislation.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 17. Personal Assistance Services

Chapter 191. State Personal Assistance Services Program

Editor's Note: This Chapter, formerly LAC 67:VII.Chapter 11, was moved to LAC 48:I.Chapter 191.

§19101. Mission

[Formerly LAC 67:VII.1101]

A. General Statement. The legislature of Louisiana recognizes the right of people with significant physical disabilities to lead independent and productive lives and further recognizes that persons with significant disabilities require personal assistance to meet tasks of daily living and, in many cases to avoid costly institutionalization. The creation of the State Personal Assistance Services Program, hereafter referred to as the SPAS Program, is to provide state personal assistance services to persons with significant disabilities in order to support and enhance their employability and/or to avoid inappropriate and unnecessary institutionalization. The mission of the SPAS Program is to provide for an orderly sequence of services to those persons who are determined eligible for the program.

B. Program Administration. The Department of Health and Hospitals, through Office of Aging and Adult Services (OAAS), is responsible for the administration of the SPAS Program.

C. Purpose of this Rule. This Rule sets forth the policies of OAAS in carrying out the agency's mission, specifically as this mission relates to the SPAS Program.

D. Exceptions. The secretary or secretary's designee shall have the sole responsibility for any exceptions to this policy manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), repromulgated LR 19:1436 (November 1993), amended LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19103. Enabling Legislation

[Formerly LAC 67:VII.1103]

A. House Bill Number 1198, Act 939 of the 2010 Regular Session, LAC Title 48, Chapter 191, *Revised Statute* 46:2116.2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1437 (November 1993), LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19105. Definitions

[Formerly LAC 67:VII.1105]

A. The following terms, when used in this manual, shall have the meaning, unless the context clearly indicates otherwise.

Self-Directed—the participant or legal/personal representative will direct, supervise, hire and discharge his/her personal attendant and be able to *self-direct* all goods/services needed.

Management Contractor/Fiscal Agent—contracted entity which may be responsible for day to day program activities including but not limited to eligibility requirements, etc.

Department—the Department of Health and Hospitals.

Individual with Significant Disabilities—an individual with loss of sensory or motor functions interfering with activities of daily living to the extent that the person requires assistance with non-medical personal care needs, domestic or cleaning needs, dressing and undressing, moving into and out of bed, transferring, ambulation, related services including but not limited to meal preparation, laundry, and grocery shopping, and/or other similar activities of daily living.

PA—personal assistance.

Secretary—the *secretary* of the Department of Health and Hospitals.

State Personal Assistance Services (SPAS) Program—services means goods and services which are required by a person with significant disabilities age 18 eighteen or older to increase a person's independence or substitute for a person's dependence on human assistance.

Intentional Program Violation—made a false or misleading statement, or misrepresented, concealed or withheld fact; or committed any act that constitutes a violation of the SPAS Program or SPAS policy and/or procedures.

AUTHORITY NOTE; Promulgated in accordance with 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1437 (November 1993), LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19107. General Requirements

[Formerly LAC 67:VII.1107]

A. Cost-Effective Service Provision. All services shall be provided in a cost-effective manner.

B. This program shall be considered as a source of last resort for personal assistance services after private and governmental sources have been expended.

C. Case File Documentation. All SPAS Program management contractors/fiscal agents must maintain a case file for each SPAS Program participant. The case file shall contain documentation to support the decision to provide, deny, or amend services. Documentation of the amounts and dates of each service provided to support all claims for reimbursement must also be included in the case file.

D. The department is under no obligation to perform any of the services described in R.S 46:2116 et seq., and can utilize other sources to provide these services. Additionally, funds appropriated for state plan personal assistance services may be used as match for available funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), repromulgated LR 19:1437 (November 1993), amended LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19109. Applicant and Participant Appeal Rights

[Formerly LAC 67:VII.1111]

A. Any individual whose request is denied for goods/services, denied eligibility or discharged from the program may appeal said decision in accordance with the provisions of R.S. 46:107. Such appeal shall be conducted in accordance with the Administrative Procedure Act and shall be subject to judicial review.

B. A participant's current services shall remain in place during the appeals process until a final administrative decision is reached. A decision is final when the Division of Administrative of Law renders a decision on the appeal.

AUTHORITY NOTE; Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1438 (November 1993), LR 33:1147 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19111. Eligibility Decisions

[Formerly LAC 67:VII.1113]

A. An individual can be determined eligible for services as set forth in R.S. 46:2116.2 if that individual meets all of the following criteria:

1. is an individual with significant disabilities;
2. is age 18 or older;
3. needs goods and/or personal assistance services from this program to prevent or remove the individual from inappropriate placement in an institutional setting or enhance or maintain individual's employability;
4. provides verification of the disability from the treating physician;
5. is capable or has legal/personal representation capable of self-direction. Although the participant is capable of self-directing they may chose a qualified provider agency for services; and
6. has unique economic and social needs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1147 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19113. Economic Need

[Formerly LAC 67:VII.1115]

A. In determining an individual's financial need for services, the management contractor will use a system based upon the current federal poverty guidelines. The economic need status of each participant for the SPAS Program shall be considered in the initial determination of eligibility for services and at least annually thereafter. The participant must provide verification of income.

B. The total monthly income of the SPAS applicant and/or spouse shall be considered in determining the amount of available income in the determination of eligibility for services. Current income received on a regular basis must be considered regardless of its source.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 33:1148 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19115. Plan for State Personal Assistance Services

[Formerly LAC 67:VII.1117]

A. Following a determination of eligibility for services, an appropriate individualized assessment will be completed to determine the scope of services. After a case-by-case assessment of needs, a service plan will be developed, implemented, and updated as appropriate. The service plan will be individualized and outcome oriented.

B. A state personal assistance services plan is to be developed between the participant and the management contractor to determine the specific goods/services needed. A SPAS plan shall be initiated annually or more often, if indicated. The SPAS plan and all updated plans shall be contained in the participant's case record.

C. The participant is to cooperate fully in the development of the SPAS plan, including all changes and amendments. The participant's signature is required for the personal assistance plan and any amendments.

D. Minimum content of the personal assistance plan:

1. identification of specific goods/services to be delivered;
2. the frequency of goods/services with flexibility;
3. the beginning date and service review dates.

E. Annual State Personal Assistance Services Plan Review. Every 12 months a review of the SPAS plan is mandatory and shall be reflected on the amended plan. A review can be done before 12 months, if indicated. In all cases, the participant shall be involved in any review and/or changes to his/her personal assistance plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1148 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19117. Financial

[Formerly LAC 67:VII.1119]

A. Prior Authorization. A participant shall obtain prior authorization from contract manager for goods and/or services before they can begin. Failure to obtain prior authorization will result in a denial of goods or services. If an emergency situation exists where goods or services are

needed to begin prior to the management contractor's receipt of written acceptance, management contractor may provide verbal authorization for services to begin. The management contractor must amend the SPAS plan before service can begin.

B. The participant of SPAS will invoice the management contractor bi-monthly in arrears for personal assistance services purchased and include copies of time sheets as verification of the services being provided. The invoice shall contain the following:

1. dates of services;
2. description of goods/ services provided along with the number of hours of personal assistance services per day and/or number of goods received;
3. rate of pay;
4. signature of direct service worker; and
5. signature of participant of the SPAS Program.

C. The participant of SPAS will submit receipts or invoices for the goods and/or other services purchased to the management contractor as verification of the goods and/or other services being provided.

D. All purchases must comply with state purchasing guidelines.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1148 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19119. Management Contractor Responsibilities

[Formerly LAC 67:VII.1121]

A. The management contractor shall keep a waiting list of individuals wanting to apply for the SPAS Program.

B. The management contractor shall take a pre-application on participants who will be placed on the waiting list for services and shall use criteria developed by OAAS.

C. The management contractor shall maintain a case record on each participant and applicant. The case record must include, as a minimum, the pre-application form and, if applicable, a copy of the denial of eligibility letter, personal assistance plan and all amendments to this plan, documentation from medical and/or other appropriate sources, proof of income and any other additional material which is a necessary part of the application and/or reconsideration for the SPAS Program.

D. Upon admission into the program, the management contractor shall review and have the participant sign an agreement of understanding outlining the management contractor's responsibilities as well as the participant's. A copy should be left with the individual and a signed copy shall be maintained in the participant's case record.

E. The management contractor shall reassess all SPAS Program participants at least annually or more often if their needs change. If there is a change in circumstances, a revised personal assistance plan must be completed.

F. The management contractor shall make available all required OAAS training and certifications to all participants who self direct their personal assistance under this program. Documentation of training including dates, name of trainer and names of individuals trained should be included in the case record.

G. The management contractor shall maintain copies of the time sheets and/or invoices received. Time sheets and invoices shall document the date goods/services rendered, description of the goods/services, times services rendered, name and contact information of the provider. Payments for the time worked shall be paid within a reasonable period of time after the invoice is received by the management contractor.

H. The management contractor shall investigate information brought to the management contractor's attention which causes question of continued eligibility. This could include such items as falsification of time sheets, misuse of SPAS Program funds, and any other violation of the policy stated herein. This information shall be provided to the OAAS program manager for disposition. If the information provided is substantiated, this shall be reason for denial of services or loss of eligibility.

I. The management contractor shall provide the participant with a copy of the SPAS Program policy manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1149 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§19121. Reasons for Closure and/or Termination [Formerly LAC 67:VII.1127]

A. The following may result in termination of services and/or closure:

1. the participant no longer meets eligibility criteria;
2. the participant intentionally falsified information;
3. the participant has shown consistent failure to cooperate with the service plan and management contractor;
4. the participant is unable to be contacted and/or whereabouts unknown for 90 days or more and no response after an attempted home visit and certified letter;
5. the participant made misrepresentations in the eligibility determination process;
6. the participant made misrepresentations to obtain goods and services;
7. any other reason which is contradictory to policy and procedures for the SPAS Program.

B. The management contractor should issue a "warning" to participants who commit a violation of policy. If the violation is not intentional, written notice of the violation and action to correct the violation is to be given to the participant. A copy of the warning notice to the participant is to be placed in the participants case record. The management contractor shall make a recommendation to the OAAS program manager to terminate a participant who continues to violate the policy and/or procedures of the SPAS Program after a warning has been issued. The decision to terminate will be based on the severity of the violation(s) and/or continued violation(s) and will be made by OAAS.

1. If the violation of policy by the participant was intentional, the management contractor shall immediately notify the OAAS program manager. In the case of an intentional violation of the policy by the participant, a warning does not need to be issued prior to termination from the program.

2. When a participant is terminated from this program the management contractor will send a termination letter to

the participant that explains the reason(s) and right to an appeal;

C. Recoupment

1. In lieu of termination, the management contractor can demand that a participant refund the SPAS Program for all benefits received.

2. If the management contractor rules that the participant must repay the amount in question, the management contractor will determine the repayment schedule. Participant can remain eligible as long as recoupment is made and a willingness to comply with policies and procedures set forth in the SPAS Program are shown. The management contractor shall maintain close monitoring of the participant until such time the management contractor determines participant is complying with the policies and procedures.

3. Recoupment is required from fraudulently received benefits as well; however, the participant will not be eligible for further services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 21:1251 (November 1995), amended LR 33:1149 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

Title 67 SOCIAL SERVICES Part VII. Rehabilitation Services Chapter 11. State Personal Assistance Services Program

§1101. Mission

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), repromulgated LR 19:1436 (November 1993), amended LR 33:1146 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1103. Enabling Legislation

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1437 (November 1993), LR 33:1146 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1105. Definitions

Repealed.

AUTHORITY NOTE; Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1437 (November 1993), LR 33:1146 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1107. General Requirements

Repealed.

AUTHORITY NOTE; Promulgated in accordance with R.S. R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), repromulgated LR 19:1437 (November 1993), amended LR

33:1146 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1109. Confidentiality

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1437 (November 1993), LR 33:1147 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1111. Applicant and Consumer/Recipient Appeal Rights

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1438 (November 1993), LR 33:1147 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1113. Eligibility and Ineligibility Decisions

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1147 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1115. Economic Need

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 33:1148 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1117. Plan for State Personal Assistance Services

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1148 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1119. Financial

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1148 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1121. Contractor/fiscal Agent Responsibilities

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1439 (November 1993), LR 33:1149 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1123. Evaluation Team Responsibilities

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1440 (November 1993), LR 33:1149 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1125. Responsibilities for LRS in the Eligibility Decision

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1440 (November 1993), LR 33:1149 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1127. Violations, Penalties, and Reasons for Closure

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 21:1251 (November 1995), amended LR 33:1149 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

§1129. Procedures for Termination and/or Appeals

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 49:664.6 and R.S. 36:477.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (November 1993), amended LR 21:1252 (November 1995), LR 33:1150 (June 2007), repealed by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this proposed Rule will have a neutral effect on the ability of the family to perform its functions since the Rule only authorizes the transfer of responsibilities from the Department of Children and Family Services (DCFS) to the Department of Health and Hospitals (DHH), Office of Aging and Adult Services (OAAS).

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973.

Small Business Statement

A regulatory flexibility analysis pursuant to R.S. 49:965.6 has been conducted. It has been determined that the promulgation of this Rule will not have an adverse impact on small business.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service,

and will have no direct or indirect cost to the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments to Hugh Eley, Office of Aging and Adult Services, P.O. Box 2031, Baton Rouge, LA 70821-2031. He is responsible for responding to inquiries regarding this proposed Rule. The deadline for the receipt of all written comments is 4:30 p.m. on the next business day following the public hearing.

Public Hearing

A public hearing on this proposed Rule is scheduled for Tuesday, December 30, 2014 at 1 p.m. in Room 118, Bienville Building, 628 North Fourth Street, Baton Rouge, LA. At that time all interested individuals will be afforded an opportunity to submit data, views or arguments either orally or in writing.

Kathy Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: State Personal Assistance Services Program

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

The proposed rule enacts Louisiana Administrative Code (LAC) Title 48, Part 1, Section 13501-13521—State Personal Assistance Services Program (SPAS) (formerly LAC Title 67, Part VII, Section 1101-1129). During the 2010 Regular Session, Act 939 (HB 1198) transferred the State Personal Assistance Services Program and its functions from the Department of Children and Family Services (DCFS) to the Department of Health and Hospitals (DHH), Office of Aging and Adult Services (OAAS).

The transfer of the State Personal Assistance Services Program from LAC Title 67 (Social Services) to LAC Title 48 (Public Health—General) does not impact current services offered through the program being administered DHH/OAAS. Therefore, the proposed rule is not anticipated to result in any additional savings or costs, other than the cost of promulgation of the rule in the amount of \$2,050 (Statutory Dedication) in FY 14-15. This cost is routinely included in the agency's annual operating budget.

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

There is no known effect on revenue collections of state or local governmental units.

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

There is no known cost and/or economic benefit to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule is not anticipated to have any effect on competition and employment.

Robin Wagner
Deputy Assistant Secretary
1411#019

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals Office of Public Health

Reclassification of Failure to Obtain a Food Safety Certification as a Class A Violation (LAC 51:I.113)

Editor's Note: This Notice of Intent is being republished to correct a submission error. The original Notice of Intent may be viewed in the September 20, 2014 *Louisiana Register* on pages 1803-1804.

Under the authority of R.S. 40:4, R.S. 40:5 et seq., R.S. 40:6, and in accordance with R.S. 49:950 et seq. of the Louisiana Administrative Procedures Act, the State Health Officer, acting through Department of Health and Hospitals Office of Public Health, intends to amend Title 51, Part I, §113 (Suspension/Revocation/Civil Fines or Penalties [formerly paragraph 1:007-21]) of the *Public Health—Sanitary Code*. This Rule is being proposed to reclassify failure to have a food safety certificate from a class B violation to a class A.

The Department of Health and Hospitals (DHH), Office of Public Health (OPH) proposes two amendments to Title 51, Part I, Section 113 (Suspension/Revocation/Civil Fines or Penalties [formerly paragraph 1:007-21]) of the *Public Health—Sanitary Code*. This proposed Rule reclassifies failure to have a food safety certificate from a class B violation to a class A violation. In Section 113(i) class A, the first proposed amendment adds the following language, “failure to obtain a food safety certification in accordance with §305 of Part XXIII”, as a new violation that creates a condition or occurrence, which may result in death or serious harm to the public. In §113.A.3.a.ii, Class B, the second proposed amendment deletes the following language, “a food safety certificate”, relating to permitting, submitting of plans, or training requirements.

Title 51

PUBLIC HEALTH—SANITARY CODE

Part I. General Provisions

§113. Suspension/Revocation/Civil Fines or Penalties [Formerly Paragraph 1:007-21]

A. Pursuant to the provisions of R.S. 40:4, R.S. 40:5 and R.S. 40:6, the state health officer acting through the Office of Public Health, for violation(s) of a compliance order may:

1. suspend or revoke an existing license or permit;
2. seek injunctive relief as provided for in R.S. 40:4 and in 40:6; and/or
3. impose a civil fine:

a. these civil fines shall not exceed \$10,000 per violator per calendar year applicable to each specific establishment, facility, or property that the violator owns, manages, operates or leases. The schedule of civil fines by class of violations shall be as follows:

- i. class A. Violations that create a condition or occurrence, which may result in death or serious harm to the public. These violations include, but are not limited to: cooking, holding or storing potentially hazardous food at improper temperatures; failure to follow schedule process in

low acid canned foods or acidified food production; poor personal hygienic practices; failure to sanitize or sterilize equipment, utensils or returnable, multi-use containers; no water; unapproved water source; cross contamination of water; inadequate disinfection of water before bottling; sewage back up; sewage discharge on to the ground; sewage contamination of drinking water; failure to comply with human drug current good manufacturing practices (CGMP); inadequate labeling of foods or drugs regarding life threatening ingredients or information; failure to provide consumer advisories; non-compliant UV lamps or termination control switch on tanning equipment; the inadequate handling and disposal of potentially infectious biomedical wastes; failure to obtain food safety certification in accordance with §305 of Part XXIII; etc. Class A civil fines shall be \$100 per day per violation;

ii. class B. Violations related to permitting, submitting of plans, or training requirements. These violations include, but are not limited to: failure to submit plans or to obtain or hold: a permit to operate; a commercial body art certification; tanning equipment operator training; day care training; a license to install, maintain, or pump out sewage systems; etc. Class B civil fines shall be \$75 per day per violation;

iii. class C. Violations that create a condition or occurrence, which creates a potential for harm by indirectly threatening the health and/or safety of the public or creates a nuisance to the public. These violations include, but are not limited to, failure to: properly label food; properly protect food; properly store clean equipment; provide self-closing restroom doors; provide adequate lighting; provide hair restraints; provide soap and towels at hand-washing lavatories; clean floors, walls, ceilings and non-food contact surfaces; properly dispose of garbage; maintain onsite sewage systems; provide electrical power to onsite sewage systems; etc. Class C civil fines shall be \$50 per day per violation;

iv. class D. Violations related to administrative, ministerial, and other reporting requirements that do not directly threaten the health or safety of the public. These violations include, but are not limited to, failure to: retain oyster tags; provide Hazard Analysis Critical Control Plans (HACCP); maintain HACCP records; provide consumer information; provide written recall procedures; maintain lot tracking records; turn in onsite sewage system maintenance records or certification of installation; register product labels; etc. Class D civil fines shall be \$25 per day per violation;

b. the duration of noncompliance with a provision of the compliance order shall be determined as follows:

i. an investigation shall be conducted by staff for the purpose of determining compliance/noncompliance within five working days after the deadline date(s) specified in the compliance order. If non-compliance still exists, staff will provide a copy of the post-order investigation report to the person in charge and daily penalty assessments shall begin to accrue immediately from the date that non-compliance was determined in the post-order investigation report;

ii. the daily penalties shall accrue until such time as the agency has been notified in writing by the person in charge that compliance has been achieved and such

compliance verified by agency staff, or upon reaching the maximum penalty cap of \$10,000 per violator per calendar year. Upon written notification by the person in charge of compliance, an investigation to verify compliance shall be made within five working days of receipt of such notification;

iii. upon verification by investigation that compliance has been achieved, the penalties will cease to accrue on the date of receipt of notification by the person in charge;

c. the secretary of the Department of Health and Hospitals, upon the recommendation of the state health officer, may exercise his discretion and mitigate these civil fines or in lieu of a civil fine, require the violator or an employee designee to attend training seminars in the area of the violator's operations in cases where he is satisfied the violator has abated the violation and demonstrated a sincere intent to prevent future violations;

d. at the discretion of the state health officer, notice(s) imposing penalty assessments may be issued subsequent to either initial or continued noncompliance with any provision of the compliance order. Notice(s) imposing penalty assessments shall be served by United States Postal Service, via certified mail-return receipt requested, registered mail-return receipt requested, or express mail-return receipt requested, or hand delivered. Within the notice imposing penalty assessment, the state health officer will inform the person in charge of the ability to apply for mitigation of penalties imposed and of the opportunity to petition for administrative appeal within 20 days after said notice is served, according to the provisions of R.S. 49:992 of the Administrative Procedure Act;

e. once a penalty assessment is imposed, it shall become due and payable 20 calendar days after receipt of notice imposing the penalty unless a written application for mitigation is received by the state health officer within 20 calendar days after said notice is served or a petition for administrative appeal relative to contesting the imposition of the penalty assessment is filed with the Division of Administrative Law, P.O. Box 44033, Baton Rouge, LA 70804-4033 within 20 calendar days after said notice is served;

f. the department may institute all necessary civil action to collect fines imposed;

g. this Section shall not be construed to limit in any way the state health officer's authority to issue emergency orders pursuant to the authority granted in R.S. 40:4 and §115 of this Part;

h. the provisions of Paragraph 3 and Subparagraph a shall not apply to floating camps, including but not limited to houseboats which are classified as vessels by the United States Coast Guard in accordance with R.S. 40:6 as amended by Act 516 of the 2001 Regular Legislative Session;

4. may (in cases involving pollution of streams, rivers, lakes, bayous, or ditches which are located in public rights of way outside Lake Pontchartrain, Toledo Bend Reservoir or the Sabine River, their drainage basins or associated waterways):

a. suspend or revoke the existing license or permit; and/or

b. issue a civil compliance order and impose a fine of \$100 per day up to a maximum of \$10,000 in cases where

establishments operate without a license or permit or continue to operate after revocation or suspension of their license or permit;

5. may (in cases involving pollution of Lake Pontchartrain, Toledo Bend Reservoir, the Sabine River, their drainage basins, or associated waterways and pursuant to the provisions of R.S. 40:1152 and 40:1153):

a. issue a civil compliance order and/or suspend or revoke the existing license or permit; and/or

b. impose a fine of \$100 per day up to a maximum of \$10,000 in cases where establishments operate without a license or permit, or continue to operate after revocation or suspension of their license or permit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 27:1694 (October 2001), repromulgated LR 28:1210 (June 2002), amended LR 28:2529 (December 2002), LR 41:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. This proposed Rule will not have an adverse impact on the family.

1. The Effect on the Stability of the Family. There will be no effect on the stability of the family.

2. The Effect on the Authority and Rights of Parents Regarding the Education and Supervision of their Children. There will be no effect on the authority and rights of parents regarding the education and supervision of their children.

3. The Effect on the Functioning of the Family. There will be no effect on the functioning of the family.

4. The Effect on the Family Earnings and Family Budget. There will be no effect on the family earnings and family budget.

5. The Effect on the Behavior and Personal Responsibility of Children. There will be no effect on the behavior and personal responsibility of children.

6. The Ability of the Family or Local Government to Perform the Function as Contained in the Proposed Rule. There will be no effect on the ability of the family or a local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

This proposed Rule should not have any known or foreseeable impact on any child, individual or family as defined by R.S. 49:973(B). In particular, there should be no known or foreseeable effect on:

1. household income, assets, and financial security;
2. early childhood development and preschool through postsecondary education development;
3. employment and workforce development;
4. taxes and tax credits;
5. child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. In particular, there should be no known or foreseeable effect on the:

1. staffing level requirements or qualifications required to provide the same level of service;

2. total direct and indirect effect on the cost to the providers to provide the same level of service; or

3. overall effect on the ability of the provider to provide the same level of service.

Public Comments

Interested persons may submit written comments to Chief Sanitarian Tenney Sibley, Department of Health and Hospitals Office of Public Health Sanitarian Services, Bin 10, Post Office 4489, Baton Rouge, LA 70821. She is responsible for responding to inquiries regarding this proposed Rule. The deadline for receipt of all written comments is 4:30 p.m. on Wednesday, December 10, 2014.

Kathy H. Kliebert
Secretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES

RULE TITLE: Reclassification of Failure to Obtain a Food Safety Certification as a Class A Violation

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

The Department of Health and Hospitals (DHH), Office of Public Health (OPH) proposes two amendments to Title 51, Part I, Section 113 (Suspension/Revocation/Civil Fines or Penalties [formerly paragraph 1:007-21]) of the Public Health Sanitary Code. This proposed rule reclassifies failure to have a food safety certificate from a Class B violation to a Class A violation.

In Section 113(i) Class A, the first proposed amendment adds the following language "failure to obtain a food safety certification in accordance with §305 of Part XXIII" as a new violation that creates a condition or occurrence, which may result in death or serious harm to the public. In Section 113(ii) Class B, the second proposed amendment deletes the following language "a food safety certificate" relating to permitting, submitting of plans, or training requirements.

The proposed rule change will result in an estimated cost of \$491 to publish a notice of intent and final rule in the *Louisiana Register*. OPH has sufficient funds in its annual operating budget to publish the proposed rule. It is not anticipated that the proposed action will result in any significant implementation costs to local government units.

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

Although failure to obtain a food safety certification is being reclassified from a Class B to Class A violation and would generate additional revenue as a result of penalty fees increasing from \$75 to \$100, OPH does not anticipate any effects on revenue collections of state or local governmental units as a result of promulgating the proposed rule changes. Presently, OPH offers establishments that are issued violations several opportunities to come into compliance before assessing civil fines. The majority of violators become compliant and fines are not issued. Therefore, OPH does not anticipate any effects on revenue collections.

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

The proposed rule change is not anticipated to have an impact on retail food establishments.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There are no effects on competition and employment anticipated as a result of these proposed rule changes.

J.T. Lane
Assistant Secretary
1411#101

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

**Department of Treasury
Board of Trustees of the Teachers'
Retirement System of Louisiana**

Defined Benefit Plan (LAC 58:III.Chapter 17)

Notice is hereby given, in accordance with R.S. 49:950 et seq., of the Administrative Procedure Act and through the authority granted in R.S. 11:826, that the Board of Trustees of the Teachers' Retirement System of Louisiana has approved for advertisement the adoption of LAC 58:III.1701 through 1709 in order to provide certain *Internal Revenue Code* provisions governing qualified governmental retirement plans. A preamble to this proposed action has not been prepared.

**Title 58
RETIREMENT**

**Part III. Teachers' Retirement System of Louisiana
Chapter 17. Defined Benefit Plan *Internal Revenue Code* Provisions**

§1701. Use of Plan Assets

A. At no time shall it be possible for the plan assets to be used for, or diverted to, any person other than for the exclusive benefit of the members and their beneficiaries, except that contributions made by the employer may be returned to the employer if the contribution was made due to a mistake of fact as permitted by revenue ruling 91-4.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:826.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 41:

§1703. Heroes Earnings Assistance and Relief Tax Act of 2008

A. Effective January 1, 2007, 26 U.S.C. 401(a)(37), as enacted by the Heroes Earnings Assistance and Relief Tax Act of 2008, shall apply to the retirement system as provided herein. Effective with respect to deaths occurring on or after January 1, 2007, while a member is performing qualified military service (as defined in chapter 43 of title 38, *United States Code*), to the extent required by section 401(a)(37) of the *Internal Revenue Code*, survivors of a member in a state or local retirement or pension system, are entitled to any additional benefits that the system would provide if the member had resumed employment and then died, such as accelerated eligibility or survivor benefits that are contingent on the member's death while employed. In any event, a deceased member's period of qualified military service must be counted for eligibility purposes.

B. Effective January 1, 2009, 26 U.S.C. 3401(h)(2), as enacted by the Heroes Earnings Assistance and Relief Tax Act of 2008, shall apply to the retirement system as provided herein. Beginning January 1, 2009, to the extent required by

section 414(u)(12) of the *Internal Revenue Code*, an individual receiving differential wage payments (as defined under section 3401(h)(2) of the *Internal Revenue Code*) from an employer shall be treated as employed by that employer, and the differential wage payment shall be treated as compensation for purposes of applying the limits on annual additions under section 415(c) of the *Internal Revenue Code*. This provision shall be applied to all similarly situated individuals in a reasonably equivalent manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:826.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 41:

§1705. Domestic Relations Orders

A. If benefits are payable pursuant to a domestic relations order that meets the requirements of section 414(p) of the *Internal Revenue Code*, then the applicable requirements of section 414(p) of the *Internal Revenue Code* will be followed by the retirement system.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:826.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 41:

§1707. Limitations on Contributions and Benefits

A. Adjustments for Form of Benefit

1. If the form of benefit without regard to the automatic benefit increase feature is not a straight life annuity or a qualified joint and survivor annuity, then the adjustment under R.S. 11:784.1(B)(3)(a) is applied by either reducing the section 415(b) of the *Internal Revenue Code* limit applicable at the annuity starting date or adjusting the form of benefit to an actuarially equivalent amount [determined using the assumptions specified in treasury regulation section 1.415(b)-1(c)(2)(ii)] that takes into account the additional benefits under the form of benefit as described in Subparagraphs A.1.a and b below, as applicable.

a. For a benefit paid in a form to which section 417(e)(3) of the *Internal Revenue Code* does not apply (generally, a monthly benefit), the actuarially equivalent straight life annuity benefit that is the greater of:

i. the annual amount of the straight life annuity (if any) payable to the member under the plan commencing at the same annuity starting date as the form of benefit to the member; or

ii. the annual amount of the straight life annuity commencing at the same annuity starting date that has the same actuarial present value as the form of benefit payable to the member, computed using a 5 percent interest assumption (or the applicable statutory interest assumption) and:

(a) for years prior to January 1, 2009, the applicable mortality tables described in treasury regulation section 1.417(e)-1(d)(2) (revenue ruling 2001-62 or any subsequent revenue ruling modifying the applicable provisions of revenue rulings 2001-62); and

(b) for years after December 31, 2008, the applicable mortality tables described in section 417(e)(3)(B) of the *Internal Revenue Code* (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing section 417(e)(3)(B) of the *Internal Revenue Code*).

b. For a benefit paid in a form to which section 417(e)(3) of the *Internal Revenue Code* applies (generally, a lump sum benefit), the actuarially equivalent straight life annuity benefit that is the greatest of:

i. the annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable, computed using the interest rate and mortality table, or tabular factor, specified in the plan for actuarial experience;

ii. the annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable, computed using a five and one-half percent interest assumption (or the applicable statutory interest assumption); and

(a). for years prior to January 1, 2009, the applicable mortality tables for the distribution under treasury regulation section 1.417(e)-1(d)(2) (the mortality table specified in revenue ruling 2001-62 or any subsequent revenue ruling modifying the applicable provisions of revenue ruling 2001-62); and

(b). for years after December 31, 2008, the applicable mortality tables described in section 417(e)(3)(B) of the *Internal Revenue Code* (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing section 417(e)(3)(B) of the *Internal Revenue Code*); or

iii. the annual amount of the straight life annuity commencing at the annuity starting date that has the same actuarial present value as the particular form of benefit payable (computed using the applicable interest rate for the distribution under treasury regulation section 1.417(e)-1(d)(3) (using the rate in effect for the November prior to the one-year stabilization period, which is the limitation year); and

(a). for years prior to January 1, 2009, the applicable mortality tables for the distribution under treasury regulation section 1.417(e)-1(d)(2) (the mortality table specified in revenue ruling 2001-62 or any subsequent revenue ruling modifying the applicable provisions of revenue ruling 2001-62); and

(b). for years after December 31, 2008, the applicable mortality tables described in section 417(e)(3)(B) of the *Internal Revenue Code* (Notice 2008-85 or any subsequent Internal Revenue Service guidance implementing section 417(e)(3)(B) of the *Internal Revenue Code*), divided by 1.05.

c. The actuary may adjust the Section 415(b) of the *Internal Revenue Code* limit at the annuity starting date in accordance with Subparagraphs A.1.a and b above.

d. Benefits For Which No Adjustment of the 415(b) Limit is Required

i. For purposes of this Section, the following benefits shall not be taken into account in adjusting these limits:

(a). any ancillary benefit which is not directly related to retirement income benefits;

(b). that portion of any joint and survivor annuity that constitutes a qualified joint and survivor annuity; and

(c). any other benefit not required under section 415(b)(2) of the *Internal Revenue Code* and treasury regulations thereunder to be taken into account for purposes

of the limitation of section 415(b)(1) of the *Internal Revenue Code*.

B. Section 415(c) Limitations on Contributions and Other Additions

1. After-tax member contributions or other annual additions with respect to a member may not exceed the lesser of \$40,000 (as adjusted pursuant to section 415(d) of the *Internal Revenue Code*) or 100 percent of the member's compensation.

a. For the purposes of this Section, the following definition shall apply.

Annual Additions—the sum (for any year) of employer contributions to a defined contribution plan, member contributions, and forfeitures credited to a member's individual account. Member contributions are determined without regard to rollover contributions and to picked-up employee contributions that are paid to a defined benefit plan.

b. For purposes of applying section 415(c) of the *Internal Revenue Code* and for no other purpose, the definition of compensation where applicable will be compensation actually paid or made available during a limitation year, except as noted below and as permitted by treasury regulation section 1.415(c)-2, or successor regulation; provided, however, that member contributions picked up under section 414(h) of the *Internal Revenue Code* shall not be treated as compensation.

c. Compensation will be defined as wages within the meaning of section 3401(a) of the *Internal Revenue Code* and all other payments of compensation to an employee by an employer for which the employer is required to furnish the employee a written statement under sections 6041(d), 6051(a)(3) and 6052 of the *Internal Revenue Code* and will be determined without regard to any rules under section 3401(a) of the *Internal Revenue Code* that limit the remuneration included in wages based on the nature or location of the employment or the services performed (such as the exception for agricultural labor in section 3401(a)(2) of the *Internal Revenue Code*).

i. However, for limitation years beginning after December 31, 1997, compensation will also include amounts that would otherwise be included in compensation but for an election under section 125(a), 402(e)(3), 402(h)(1)(B), 402(k), or 457(b) of the *Internal Revenue Code*.

ii. For limitation years beginning after December 31, 2000, compensation shall also include any elective amounts that are not includible in the gross income of the member by reason of section 132(f)(4) of the *Internal Revenue Code*.

iii. For limitation years beginning on and after January 1, 2009, compensation for the limitation year shall also include compensation paid by the later of two and one-half months after a member's severance from employment or the end of the limitation year that includes the date of the member's severance from employment if the payment is regular compensation for services during the member's regular working hours, or compensation for services outside the member's regular working hours (such as overtime or shift differential), commissions, bonuses or other similar payments, and, absent a severance from employment, the payments would have been paid to the member while the member continued in employment with the employer.

(a). Any payments not described in Clause B.1.c.iii above are not considered compensation if paid after severance from employment, even if they are paid within two and one-half months following severance from employment, except for payments to the individual who does not currently perform services for the employer by reason of qualified military service (within the meaning of section 414(u)(1) of the *Internal Revenue Code*) to the extent these payments do not exceed the amounts the individual would have received if the individual had continued to perform services for the employer rather than entering qualified military service.

(b). An employee who is in qualified military service (within the meaning of section 414(u)(1) of the *Internal Revenue Code*) shall be treated as receiving compensation from the employer during such period of qualified military service equal to:

(i). the compensation the employee would have received during such period if the employee were not in qualified military service, determined based on the rate of pay the employee would have received from the employer but for the absence during the period of qualified military service; or

(ii). if the compensation the employee would have received during such period was not reasonably certain, the employee's average compensation from the employer during the twelve month period immediately preceding the qualified military service (or, if shorter, the period of employment immediately preceding the qualified military service).

iv. Back pay, within the meaning of treasury regulation section 1.415(c)-2(g)(8), shall be treated as compensation for the limitation year to which the back pay relates to the extent the back pay represents wages and compensation that would otherwise be included under this definition.

d. If the annual additions for any member for a plan year exceed the limitation under section 415(c) of the *Internal Revenue Code*, the excess annual addition will be corrected as permitted under the employee plans compliance resolution system (or similar IRS correction program).

e. For limitation years beginning on or after January 1, 2009, a member's compensation for purposes of this Subsection shall not exceed the annual limit under section 401(a)(17) of the *Internal Revenue Code*.

C. Service Purchases under Section 415(n)

1. Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, if a member makes one or more contributions to purchase permissive service credit under the plan, then the requirements of section 415(n) of the *Internal Revenue Code* will be treated as met only if:

a. the requirements of section 415(b) of the *Internal Revenue Code* are met, determined by treating the accrued benefit derived from all such contributions as an annual benefit for purposes of section 415(b) of the *Internal Revenue Code*; or

b. the requirements of section 415(c) of the *Internal Revenue Code* are met, determined by treating all such contributions as annual additions for purposes of section 415(c) of the *Internal Revenue Code*.

2. For purposes of applying this section, the system will not fail to meet the reduced limit under section 415(b)(2)(C) of the *Internal Revenue Code* solely by reason of this Subsection and will not fail to meet the percentage limitation under section 415(c)(1)(B) of the *Internal Revenue Code* solely by reason of this Subsection.

3. For purposes of this Subsection, the following definition shall apply.

a. *Permissive Service Credit*—service credit:

i. recognized by the system for purposes of calculating a member's benefit under the system;

ii. which such member has not received under the system; and

iii. which such member may receive only by making a voluntary additional contribution, in an amount determined under the system, which does not exceed the amount necessary to fund the benefit attributable to such service credit.

b. Effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, such term may include service credit for periods for which there is no performance of service, and, notwithstanding Clause C.3.a.ii above, may include service credited in order to provide an increased benefit for service credit which a member is receiving under the system.

4. The system will fail to meet the requirements of this Subsection if:

a. more than five years of nonqualified service credit are taken into account for purposes of this Subsection; or

b. any nonqualified service credit is taken into account under this Subsection before the member has at least five years of participation under the system.

5. For purposes of Paragraph C.4 above, effective for permissive service credit contributions made in limitation years beginning after December 31, 1997, the following definition shall apply.

a. *Nonqualified Service Credit*—permissive service credit other than that allowed with respect to:

i. service (including parental, medical, sabbatical, and similar leave) as an employee of the Government of the United States, any state or political subdivision thereof, or any agency or instrumentality of any of the foregoing (other than military service or service for credit which was obtained as a result of a repayment described in section 415(k)(3) of the *Internal Revenue Code*);

ii. service (including parental, medical, sabbatical, and similar leave) as an employee (other than as an employee described in Clause C.5.a.i above) of an education organization described in section 170(b)(1)(A)(ii) of the *Internal Revenue Code* which is a public, private, or sectarian school which provides elementary or secondary education (through grade 12), or a comparable level of education, as determined under the applicable law of the jurisdiction in which the service was performed;

iii. service as an employee of an association of employees who are described in Clause C.5.a.i above; or

iv. military service (other than qualified military service under section 414(u) of the *Internal Revenue Code*) recognized by the system.

b. In the case of service described in Clause C.5.a.i, ii or iii above, such service will be nonqualified service if recognition of such service would cause a member to receive a retirement benefit for the same service under more than one plan.

6. In the case of a trustee-to-trustee transfer after December 31, 2001, to which section 403(b)(13)(A) of the *Internal Revenue Code* or section 457(e)(17)(A) of the *Internal Revenue Code* applies (without regard to whether the transfer is made between plans maintained by the same employer):

a. the limitations of Paragraph C.4 above will not apply in determining whether the transfer is for the purchase of permissive service credit; and

b. the distribution rules applicable under federal law to the system will apply to such amounts and any benefits attributable to such amounts.

7. For an eligible member, the limitation of section 415(c)(1) of the *Internal Revenue Code* shall not be applied to reduce the amount of permissive service credit which may be purchased to an amount less than the amount which was allowed to be purchased under the terms of a Plan as in effect on August 5, 1997. For purposes of this Paragraph, an eligible member is an individual who first became a member in the system before January 1, 1998.

D. Modification of Contributions for 415(c) and 415(n) Purposes

1. Notwithstanding any other provision of law to the contrary, the system may modify a request by a member to make a contribution to the system if the amount of the contribution would exceed the limits provided in section 415 of the *Internal Revenue Code* by using the following methods.

a. If the law requires a lump sum payment for the purchase of service credit, the system may establish a periodic payment plan for the member to avoid a contribution in excess of the limits under section 415(c) or 415(n) of the *Internal Revenue Code*.

b. If payment pursuant to Subparagraph a. of this Paragraph will not avoid a contribution in excess of the limits imposed by section 415(c) or 415(n) of the *Internal Revenue Code*, the system may either reduce the member's contribution to an amount within the limits of those sections or refuse the member's contribution.

E. Repayments of Cashouts

1. Any repayment of contributions (including interest thereon) to the plan with respect to an amount previously refunded upon a forfeiture of service credit under the plan or another governmental plan maintained by the retirement system shall not be taken into account for purposes of section 415 of the *Internal Revenue Code*, in accordance with applicable treasury regulations.

F. Limitation of Benefits Priority

1. Reduction of benefits and/or contributions to all defined benefit plans sponsored by the state in which the member participated, where required, shall be accomplished by first reducing the member's benefit under the defined benefit plan in which the member most recently accrued benefits and thereafter in such priority as shall be determined by the plan and the plan administrator of such other plans. Necessary reductions may be made in a different manner and

priority pursuant to the agreement of the plan and the plan administrator of all other plans covering such member.

G. Limitation Year

1. For purposes of applying the limitations of section 415 of the *Internal Revenue Code*, the limitation year shall be the calendar year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:826.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 41:

§1709. Group Trust Participation

A. The board of trustees may, unless restricted by law, transfer assets of the plan to a collective or common group trust, as permitted under revenue ruling 81-100 and revenue ruling 2011-1 (or subsequent guidance), that is operated or maintained exclusively for the commingling and collective investment of monies, provided that the funds in the group trust consist exclusively of trust assets held under plans qualified under section 401(a) of the *Internal Revenue Code*, individual retirement accounts that are exempt under section 408(e) of the *Internal Revenue Code*, eligible governmental plans that meet the requirements of section 457(b) of the *Internal Revenue Code*, and government plans under section 401(a)(24) of the *Internal Revenue Code*. For this purpose, a trust includes a custodial account that is treated as a trust under section 401(f) or under section 457(g)(3) of the *Internal Revenue Code*.

B. For purposes of valuation, the value of the interest maintained by the plan in such group trust shall be the fair market value of the portion of the group trust held for the plan, determined in accordance with generally recognized valuation procedures.

C. The board of trustees may adopt one or more group trust(s) as part of the plan, by executing appropriate participation and/or adoption agreements with the group trust's trustee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 11:826.

HISTORICAL NOTE: Promulgated by the Department of the Treasury, Board of Trustees of the Teachers' Retirement System of Louisiana, LR 41:

Family Impact Statement

The proposed adoption of LAC 58:III.1701 through 1709 regarding the TRSL defined benefit plan and applicable *Internal Revenue Code* provisions should not have any known or foreseeable impact on any family as defined by R.S. 49:972(D) or on family formation, stability and autonomy. Specifically, there should be no known or foreseeable effect on:

1. the stability of the family;
2. the authority and rights of parents regarding the education and supervision of their children;
3. the functioning of the family;
4. family earnings and family budget;
5. the behavior and personal responsibility of children; or
6. the ability of the family or a local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

The proposed adoption of LAC 58:III.1701 through 1709 regarding the TRSL defined benefit plan and applicable

Internal Revenue Code provisions should not have any known or foreseeable impact on any child, individual or family poverty as defined in R.S. 49:973(D). Specifically, there should be no known or foreseeable effect on:

1. household income, assets, and financial security;
2. early childhood development and preschool through postsecondary education development;
3. employment and workforce development;
4. taxes and tax credits; and
5. child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Small Business Statement

The impact of the proposed Rule on small businesses as defined in the Regulatory Flexibility Act has been considered. It is estimated that the proposed action is not expected to have a significant adverse impact on small businesses. The agency, consistent with health, safety, environmental and economic welfare factors has considered and, where possible, utilized regulatory methods in the drafting of the proposed Rule that will accomplish the objectives of applicable statutes while minimizing the adverse impact on small businesses.

Provider Impact Statement

The proposed Rule should not have any known or foreseeable impact on providers as defined by HCR 170 of 2014 Regular Legislative Session. Per HCR 170, "provider" means an organization that provides services for individuals with developmental disabilities. In particular, it is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments on the proposed changes until 4:30 p.m., December 22, 2014, to Katherine Whitney, Deputy General Counsel, Board of

Trustees for the Teachers' Retirement System of Louisiana,
P.O. Box 94123, Baton Rouge, LA 70804-9123.

Maureen H. Westgard
Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: **Defined Benefit Plan**

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

The proposed rule changes will have no impact on state or local government expenditures. The rule adopts certain federal tax mandates regarding the TRSL defined benefit plan as a qualified governmental plan under Section 401(a) of the Internal Revenue Code. Rule additions include provisions consistent with federal law and regulations including the Heroes Earnings Assistance and Relief Tax Act of 2008, domestic relations orders, limitations on contributions and benefits, and group trust participation.

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

There will be no effect on revenue collections of state or local governmental units as a result of the proposed rule changes.

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

There will be no cost or economic benefit to any directly affected persons or non-governmental groups as a result of the proposed rule changes.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change will have no effect on competition or employment.

Maureen H. Westgard
Director
1411#036

Evan Brasseaux
Staff Director
Legislative Fiscal Office

Potpourri

POTPOURRI

Office of the Governor Division of Administration Office of Group Benefits

Notice of Withdrawal

This is to advise that the Office of Group Benefits' Notice of Intent originally published in the October 20, 2014, issue of the *Louisiana Register*, located on page 1968, has hereby been withdrawn. After further review of the Notice of Intent the Office of Group Benefits has revised the previously submitted Notice of Intent. The updated Notice of Intent may be found in the November 20, 2014, issue of the *Louisiana Register* in the Notice of Intent section.

Susan T. West
Chief Executive Officer

1411#094

POTPOURRI

Department of Health and Hospitals Board of Veterinary Medicine

Board Meeting Dates

The members of the Louisiana Board of Veterinary Medicine will meet at 8:30 a.m. on the following dates in 2015:

Thursday, February 5, 2015
Thursday, April 2, 2015
Thursday, June 4, 2015 (Annual Meeting)
Thursday, August 13, 2015
Thursday, October 1, 2015
Thursday, December 3, 2015

These dates are subject to change, so please contact the board office via telephone at (225) 342-2176 or email at admin@lsbvm.org to verify actual meeting dates.

Wendy D. Parrish
Executive Director

1411#033

POTPOURRI

Department of Health and Hospitals Office of Public Health

Public Hearing—Substantive Changes to Proposed Rule Amendments—Plumbing Fixtures, Water Supply and Distribution (LAC 51:XIV.411, 609, and 1403)

In the March 20, 2014 edition of the *Louisiana Register* (LR 37:3658-3675), the Louisiana Department of Health and Hospitals, Office of Public Health (DHH-OPH) published a Notice of Intent to amend LAC 51:XIV in order to provide an exception for certain small retail stores to have a drinking fountain installed and available for public use. In addition, this same Notice of Intent proposed to provide a waiver to the normal requirement calling for the installation of a containment device backflow preventer for qualifying multiple residential dwelling units served by a master meter. The proposed rule also corrected several typographical errors contained in the 2013 publication of LAC 51:XIV. The notice solicited views, arguments, information, written comments and testimony. As a result of one comment received during the public comment period, DHH-OPH proposes to amend the proposed Rule. Substantive changes are being made to Section 609 as set forth below.

In accordance with R.S. 49:968(H)(2), DHH-OPH will conduct a public hearing concerning these substantive changes at 10 a.m. on Monday, December 29, 2014, in Room 118 (first floor) of the Bienville Building, 628 North Fourth Street, Baton Rouge, LA. Persons attending the hearing may have their parking ticket validated when one parks in the 7-story Galvez Parking Garage which is located between North Sixth and North Fifth/North and Main Streets (cater-corner and across the street from the Bienville Building).

Title 51

PUBLIC HEALTH—SANITARY CODE

Part XIV. Plumbing

Chapter 4. Plumbing Fixtures

§411. Minimum Plumbing Fixtures

* * *

(Wording is to remain exactly the same in this Section as originally proposed in the March 20, 2014 NOI.)

Chapter 6. Water Supply and Distribution
§609. Protection of Potable Water Supply

A. - F.5.a. ...

Table 609.F.5 (Containment)	
	Air Gap

	Reduced Pressure Principle Backflow Prevention Assembly

8.	Metal Plating Plants

	Pressure Vacuum Breaker Assembly/ Spill Resistant Vacuum Breaker Assembly

	Double Check Valve Assembly

2.	Two residential dwelling units served by a master meter, unless both units are located on a parcel or contiguous parcels of land having the same ownership and neither unit is used for commercial purposes. As used herein, the term "commercial purposes" means any use other than residential.
3.	Three or more residential dwelling units served by a master meter
4.	Multistoried Office/Commercial Buildings (over 3 floors)
5.	Jails, Prisons, and Other Places of Detention or Incarceration

(The originally proposed wording of Clause 609.F.5.a.i in the March 20, 2014 NOI is now proposed to be deleted in its entirety; thus, there will no longer be a proposed Clause 609.F.5.a.i.)

5.b. - 9.d.iv. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:4(A)(7) and R.S. 40:5(2)(3)(7)(9)(16)(17)(20).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of Public Health, LR 38:2835 (November 2012), amended LR 41:

§1403. Referenced Standards

(The proposed change in wording in the March 20, 2014 NOI to this Section is now proposed to be deleted; thus, no changes to this Section are now proposed.)

Public Hearing

DHH-OPH will conduct a public hearing at 10 a.m. on Monday, December 29, 2014, in Room 118 of the Bienville Building, 628 North Fourth Street, Baton Rouge, LA 70802. Persons attending the hearing may have their parking ticket validated when one parks in the seven-story Galvez Parking Garage which is located between North Sixth and North Fifth/North and Main Streets (cater-corner and across the street from the Bienville Building). All interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing.

Public Comments

In addition, all interested persons are invited to submit written comments on the proposed Rule. Such comments must be received no later than Tuesday, December 30, 2014 at COB, 4:30 p.m., and should be addressed to Jake Causey,

Chief Engineer, Engineering Services Section, Center for Environmental Health Services, Office of Public Health, CEHS Mail Bin #3, P.O. Box 4489, Baton Rouge, LA 70821-4489, or faxed to (225) 342-7303. If comments are to be shipped or hand-delivered, please deliver to the Bienville Building, 628 North Fourth Street, Room 134, Baton Rouge, LA 70802.

Jimmy Guidry, M.D.
 State Health Officer
 and
 Kathy H. Kliebert
 Secretary

1411#051

POTPOURRI

**Department of Natural Resources
 Office of Conservation**

Orphaned Oilfield Sites

Office of Conservation records indicate that the oilfield sites listed in the table below have met the requirements as set forth by section 91 of Act 404, R.S. 30:80 et seq., and as such are being declared orphaned oilfield sites.

Operator	Field	District	Well Name	Well Number	Serial Number
Walter W. Wallace, Jr.	Grogan	S	W W Wallace A	001	179697
W. A. Moncrief	Bunkie	L	Bain	001	154897
P. T. Mize	Wildcat-No La Shreveport Dist	S	La Oil Refg Corp	A-2	13816
Tarver Oil Company	Caddo Pine Island	S	Huckaby	006	7893
M. A. French	Colgrade	S	Odis Jordan	001	89552
J. W. Bailey	Caddo Pine Island	S	Ark Fuel Oil	B-9	36162
Bob Bertolet	Mount Common Church	L	B L Bennett Swd	001	204120 (30)

James H. Welsh
 Commissioner

1411#021

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