CONTENTS

February 2015

I. EXECUTIVE ORDERS

BJ 15-01 BESE's Duty to Uphold the Accountability System and Offer Alternatives to the PARCC Test 299
BJ 15-02 Carry-Forward Bond Allocation 2014 300

II. EMERGENCY RULES

Education

Student Financial Assistance Commission, Office of Student Financial Assistance
Scholarship/Grant Programs—TOPS Core Curriculum Equivalents: Art Media I-IV (LAC 28:IV.703) 301

Governor

Crime Victims Reparations Board—Eligibility and Application Process (LAC 22:XIII.303 and 503) 301
Division of Administration, Office of Group Benefits—General Provisions, Prior Authorization
Requirements, Benefit Limits, Pharmacy Benefits Formulary (LAC 32:I.1701) 302

Health and Hospitals

Bureau of Health Services Financing—Coordinated Care Network—Physician Services
Reimbursement Methodology (LAC 50:I.3307 and 3509) 304
Coordinated Care Network—Recipient Participation (LAC 50:I.3103) 305
Facility Need Review (LAC 48:I.12501 and 12525) 306
Home and Community-Based Services Providers—Licensing Standards (LAC 48:I.Chapters 50 and 51) 306
Home and Community-Based Services Waivers—Community Choices Waiver
(LAC 50:XXI.8329 and 8601) 311
Inpatient Hospital Services—Children's Specialty Hospitals—Supplemental Payments for
New Orleans Area Hospitals (LAC 50:V.969) 312
Inpatient Hospital Services—Non-Rural, Non-State Hospitals—Supplemental Payments for
Baton Rouge Area Hospitals (LAC 50:V.973) 313
Inpatient Hospital Services—Non-Rural, Non-State Hospitals—Supplemental Payments for
Monroe Area Hospitals (LAC 50:V.971) 314
Inpatient Hospital Services—Public-Private Partnerships—Reimbursement Methodology
(LAC 50:V.1703) 315
Inpatient Hospital Services—Public-Private Partnerships—Supplemental Payments
(LAC 50:V.Chapter 17) 315
Nursing Facilities—Per Diem Rate Reduction (LAC 50:II.20005) 316
Nursing Facilities—Per Diem Rate Reduction (LAC 50:II.20005) 317
Nursing Facilities—Standards for Payment—Level of Care Determinations (LAC 50:II.10156) 318
Outpatient Hospital Services—Children's Specialty Hospitals—Supplemental Payments for
New Orleans Area Hospitals (LAC 50:V.6121) 320
Outpatient Hospital Services—Non-Rural, Non-State Hospitals—Supplemental Payments for
Baton Rouge Area Hospitals (LAC 50:V.6905) 320
Outpatient Hospital Services—Non-Rural, Non-State Hospitals—Supplemental Payments for
Monroe Area Hospitals (LAC 50:V.6903) 319
Outpatient Hospital Services—Public-Private Partnerships—Supplemental Payments
(LAC 50:V.Chapter 67) 321
Recovery Audit Contractor Program (LAC 50:I.Chapter 85) 322
Targeted Case Management—Reimbursement Methodology (LAC 50:XV.10701) 325
Therapeutic Group Homes—Licensing Standards (LAC 48:I.Chapter 62) 325
Office for Citizens with Developmental Disabilities—Certification of Medication Attendants
(LAC 48:IX.Chapter 9) 328
Office of Aging and Adult Services—Home and Community-Based Services Waivers
Community Choices Waiver (LAC 50:XXI.8329 and 8601) 311
Nursing Facilities—Standards for Payment—Level of Care Determinations (LAC 50:II.10156) 318
Office of Public Health—Added Controlled Dangerous Substances (LAC 46:LIII.2704) 329

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Public Safety and Corrections
Office of State Fire Marshal—Door-to-Door Solicitations (LAC 55:V.3239) 330
Wildlife and Fisheries
Wildlife and Fisheries Commission—Shrimp Season Closures 330

III. RULES
Agriculture and Forestry
Beef Industry Council—Beef Promotion and Research Program (LAC 7:V.Chapter 27) 332
Office of Agricultural and Environmental Sciences, Structural Pest Control Commission
Hydraulic Injection (LAC 7:XXV.141) 333
Education
Board of Elementary and Secondary Education—Bulletin 131—Alternative Education Schools/Programs
Standards (LAC 28:CXLIX.Chapter 21) 370
Bulletin 135—Health and Safety (LAC 28:CLVII.309) 371
Bulletin 138—Jump Start Program (LAC 28:CLXIII.501 and 503) 371
Bulletin 741—Louisiana Handbook for School Administrators—Emergency Planning and Attendance
(LAC 28:CXV.339 and 1103) 372
Student Financial Assistance Commission, Office of Student Financial Assistance—Scholarship/Grant
Programs—TOPS Core Curriculum Equivalent (LAC 28:IV.703) 373
Scholarship/Grant Programs—TOPS Tech Early Start Award
(LAC 28:IV.1001, 1003, 1005, 1007, 1009, 1011, 1013, 1015, 1017, and 1901) 374
Environmental Quality
Office of the Secretary, Legal Division—Minor Source Permit Requirements
(LAC 33:III.503 and 519)(AQ266) 376
Governor
Board of Examiners of Certified Shorthand Reporters—Certification of Transcript (LAC 46:XXI.1103) 334
Code of Ethics (LAC 46:XXI.1303) 335
Division of Administration, Office of Facility Planning and Control—Uniform Public Work Bid Form
(LAC 34:III.313) 336
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) 338
Real Estate Appraisers Board—Real Estate (LAC 46:LXVII.Chapters 103 and 104) 368
Health and Hospitals
Bureau of Health Services Financing—Adult Behavioral Health Services
(LAC 50:XXXIII.6103, 6301, 6303, and Chapter 65) 377
Family Planning Services (LAC 50:XV.Chapters 251-255) 378
Home and Community-Based Services Waivers—Adult Day Health Care (LAC 50:XXI.Chapter 29) 379
School Based Behavioral Health Services (LAC 50:XXXIII.4303 and 4501) 384
Office of Aging and Adult Services—Home and Community-Based Services Waivers
Adult Day Health Care (LAC 50:XXI.Chapter 29) 379
State Personal Assistance Services Program (LAC 48:I.Chapter 191 and LAC 67:VII.Chapter 11) 385
Office of Behavioral Health—Adult Behavioral Health Services
(LAC 50:XXXIII.6103, 6301, 6303, and Chapter 65) 377
School Based Behavioral Health Services (LAC 50:XXXIII.4303 and 4501) 384
Office of Public Health—Plumbing Fixtures and Water Supply and Distribution (LAC 51:XIV.411 and 609) 389
Public Safety and Corrections
Liquefied Petroleum Gas Commission—Classes of Permits (LAC 55:IX.113) 394
Liquefied Petroleum Gas (LAC 55:IX.107, 159, 163, 166, 201, 203, 205, 1507 and 1543) 395
Treasury
Board of Trustees of the Teachers' Retirement System of Louisiana—Defined Benefit Plan
(LAC 58:III.Chapter 17) 397
Louisiana Housing Corporation—Workforce Housing Initiative Program (LAC 16:II.Chapter 9) 401

IV. NOTICE OF INTENT
Children and Family Services
Economic Stability Section—TANF Initiatives (LAC 67:III.5541 and 5579) 403
Economic Development
Office of Business Development—Quality Jobs Program (LAC 13:I.1107) 404
Education
Board of Elementary and Secondary Education—Bulletin 741—Louisiana Handbook for School
Administrators (LAC 28:CXV.2318) 406
Bulletin 741—Nonpublic Louisiana Handbook for Nonpublic School Administrators
(LAC 28:LXXIX.2109) 407
Bulletin 746—Louisiana Standards for State Certification of School Personnel
(LAC 28:CXXXI.204, 243, 341, 344, 604, and 605) 408

Bulletin 996—Standards for Approval of Teacher and/or Educational Leader Preparation Programs (LAC 28:XLV.501) 412
Student Financial Assistance Commission, Office of Student Financial Assistance
Scholarship/Grant Programs—TOPS Core Curriculum Equivalents—Art Media I-IV (LAC 28:IV.703) 414
Governor
Crime Victims Reparations Board—Compensation to Victims (LAC 22:XIII.303 and 503) 414
Eligibility for Sexual Assault Victims (LAC 22:XIII.301) 416
Health and Hospitals
Behavior Analyst Board—Continuing Education (LAC 46:VIII.Chapter 8) 417
Board of Examiners of Psychologists—Continuing Education (LAC 46:LXIII.811) 419
Provisional Licensure of Psychologists (LAC 46:LXIII.Chapter 1-21) 420
Provisional Licensure of Psychologists (LAC 46:LXIII.102, 105, 601, 603, 701, 705, 709, 901, 902, 1101, 1301, 1503, 1901, and 2103) 427
Board of Medical Examiners—Physician Assistants, Licensure and Certification; Practice (LAC 46:XLV.1521, 4505, 4506, 4511, and 4512) 431
Board of Veterinary Medicine—License Procedures (LAC 46:LXXXV.303) 434
Bureau of Health Services Financing—Applied Behavior Analysis-Based Therapy Services (LAC 50:XV.Chapters 1-7) 436
Behavioral Health Service Providers—Licensing Standards (LAC 48:I.Chapters 56 and 74 and LAC 48.III.Chapter 5) 439
Hospital Licensing Standards—Therapeutic Recreational Therapists (LAC 48:I.9501) 481
Medicaid Eligibility—Children Supplemental Security Income (SSI) 482
Medicaid Eligibility—Modified Adjusted Gross Income (LAC 50:III.2327, 2529, 10307, and 10705) 483
Nursing Facilities—Per Diem Rate Reduction (LAC 50:II.20005) 489
Emergency Response Network—LERN Destination Protocol: TRAUMA (LAC 48:I.19119) 490
Public Safety and Corrections
Office of State Fire Marshal—Fire Protection (LAC 55:V.3239) 492
Wildlife and Fisheries
Wildlife and Fisheries Commission—Deer Management Assistance Program (DMAP) (LAC 76:V.111) 493

V. POTPOURRI
Agriculture and Forestry
Office of Forestry—Adopted Severance Tax Values for 2015 495
Office of the Commissioner—Annual Listing of Agritourism Activities 495
Governor
Division of Administration, Office of Technology Services—OTS IT Bulletin 495
Health and Hospitals
Bureau of Health Services Financing—Substantive Changes and Public Hearing Notification
Managed Care for Physical and Basic Behavioral Health (LAC 50:I.Chapters 31-40) 495
Natural Resources
Office of Conservation—Financial Security, Utility Review Status (LAC 43:XIX.Chapter 1) 499
Office of Conservation, Environmental Division—Ecoserv Environmental Services—Hearing Notice 498
Public Hearing—Substantive Changes to Proposed Rule—Plug and Abandonment of Oil and Gas Wells,
Wildlife and Fisheries
Wildlife and Fisheries Commission—Public Hearing—Substantive Changes to Louisiana Fisheries Forward Program (LAC 76:VII.347) 500

VI. INDEX 502

Executive Orders

EXECUTIVE ORDER BJ 15-01

BESE's Duty to Uphold the Accountability System
and Offer Alternatives to the PARCC Test

WHEREAS, the Preamble to Article VIII (Education) of the Louisiana Constitution provides: The goal of the public educational system is to provide learning environments and experiences, at all stages of human development, that are humane, just, and designed to promote excellence in order that every individual may be afforded an equal opportunity to develop to his full potential.

WHEREAS, Article VIII of the Louisiana Constitution vests the legislature with the overall responsibility *"to provide for the education of the people of the state"* and establishes the State Board of Elementary and Secondary Education (BESE) as the state body responsible for the *"supervision and control of public elementary and secondary schools ... in accordance with law";*

WHEREAS, the State of Louisiana recognizes the vital interest of parents in the education of their children and the importance of fostering involvement between parents and schools;

WHEREAS, the legislature, in the performance of its overall constitutional responsibility for public education, has passed clear laws designed to facilitate parental involvement, assist student achievement, evaluate teachers based on value-added data, and establish an accountability system for schools and school districts, including:

- La. R.S. 17:406 et seq. (Family-School Partnership Act) to increase the collaboration of parents and schools,
- Act 54 of the 2010 Legislative Session (teacher evaluations) provides that 50% of teacher evaluations must be based on student achievement data,
- La. R.S. 17:10.1 (school and district accountability system) "which requires and supports student achievement in each public school" and "provide[s] clear standards and expectations for schools and schools systems so that assessment of their effectiveness will be understood", and
- La. R.S. 17:24.4 (…statewide standards for required subjects…) which requires BESE to implement standards-based assessments based on nationally-based content standards but does not specify any specific or particular assessment to utilize;

WHEREAS, BESE has chosen to utilize Common Core standards-based assessments developed by the Partnership for Assessment of Readiness for College and Careers ("PARCC");

WHEREAS, beginning in March of this year, students statewide will be tested for the first time utilizing Partnership for Assessment of Readiness for College and Careers, ("PARCC") standardized tests developed for Common Core;

WHEREAS, increasing numbers of Louisiana parents, teachers, and school districts are voicing concerns over Common Core and PARCC testing, and parents are exploring alternatives that are in the best interest of their children, including opting out of the PARCC test completely;

WHEREAS, BESE policy currently provides that students who do not take the PARCC test will receive a score of zero, impacting their own personal achievement, teacher evaluations, and school and district performance scores;

WHEREAS, nationally norm-referenced or other comparable assessments utilized by other states, and compliant with La. R.S. 17:24.4, are readily available in the marketplace and offer complete and abbreviated versions for the purpose of benchmarking, either of which can easily be administered as alternatives to the PARCC test;

WHEREAS, it is inherent upon BESE, pursuant to the clear statutory findings of law provided by the legislature, to avert the growing disruption to this year's assessments by offering alternative means of testing readily available in the marketplace and currently utilized by other states, in order to avoid the negative impacts to student achievement, the teacher evaluation system, and the school and district accountability system.

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: BESE is directed to adhere to the legislative findings in La. R.S. 17:406.1 regarding parental involvement, including "it has been clearly demonstrated that parental involvement in the schools is directly related to better student achievement, attitudes, and performance in school."

SECTION 2: BESE is directed to adhere to the legislative purposes delineated in La. R.S. 17:10.1 regarding a school and district accountability system, including its purposes to "require and support student achievement in each public school" and to "provide clear standards and expectations for schools and school systems so that assessment of their effectiveness will be understood", in order to avoid student achievement being negatively impacted by a score of zero (0) as a result of non-participation.

SECTION 3: BESE is directed to uphold the state accountability system established by La. R.S. 17:10.1 so that it accurately reflects student achievement, teacher quality, and school performance, and allows parents to act on their beliefs for the best interests of their children.

SECTION 4: **As a viable and necessary action, BESE is urged to grant districts the ability to offer nationally norm-referenced or other comparable assessment appropriate for Louisiana as an alternative to the PARCC test, including abbreviated versions for the purpose of benchmarking, rather than penalizing**

students, teachers and schools and jeopardizing our statewide accountability system.

SECTION 5: All departments, commissions, boards, agencies, and political subdivisions of the state are authorized and directed to cooperate with the implementations of the provisions of this Order.

SECTION 6: This Order is effective upon signature and shall remain in effect until amended, modified, terminated or rescinded.

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 30th day of January, 2015.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1502#083

EXECUTIVE ORDER BJ 15-02

Carry-Forward Bond Allocation 2014

WHEREAS, pursuant to the Tax Reform Act of 1986 and Act 51 of the 1986 Regular Session of the Louisiana Legislature (hereafter "Act"), Executive Order No. BJ 2008-47 was issued to establish a method for allocating bonds subject to private activity bond volume limits, including

(1) the method of allocating bonds subject to the private activity bond volume limits for the calendar year 2008 and subsequent calendar years;

(2) the procedure for obtaining an allocation of bonds under the ceiling; and

(3) a system of central record keeping for such allocations;

WHEREAS, Section 4(H) of No. BJ 2008-47 provides that if the ceiling for a calendar year exceeds the aggregate amount of bonds subject to the private activity bond volume limit issued during the year by all issuers, by executive order, the Governor may allocate the excess amount to issuers or an issuer for use as a carry-forward for one or more carry-forward projects permitted under the Act;

WHEREAS, the sum of four hundred sixty-two million five hundred forty-seven thousand dollars ($462,547,000) represents the amount of the ceiling determined by the staff of the Louisiana State Bond Commission ("SBC") for private activity bond volume limits for the year 2014 ("2014 Ceiling");

WHEREAS, Executive Order No. BJ 2014-15, issued on October 24, 2014, allocated eleven million dollars ($11,000,000) from the 2014 ceiling to the Louisiana Community Development Authority to be used by the Fairview Crossing Apartments Project 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, and $1,000,000 was returned unused to the ceiling;

WHEREAS, four hundred fifty-one million five hundred forty-seven thousand dollars ($451,547,000) of the 2014 Ceiling was not allocated during the 2014 calendar year; and one million dollars ($1,000,000) of the 2014 Ceiling was returned; and

WHEREAS, The SBC has determined that four hundred fifty-two million five hundred forty-seven thousand dollars ($452,547,000) of the excess 2014 Ceiling is eligible as carry-forward and the Governor desires to allocate this amount as carry-forward for projects which are permitted and eligible under the Act;

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: Pursuant to and in accordance with the provisions of Section 146(f) of the Internal Revenue Code of 1986, as amended, and in accordance with the request for carry-forward filed by the designated issuer, the excess private activity bond volume limit under the 2014 Ceiling is hereby allocated to the following issuer(s), for the following carry-forward project(s), and in the following amount(s):

Issuer	Carry-Forward Project	Carry-Forward Amount
Louisiana Public Facilities Authority	Lafayette Parish Senior Living Facility Project	$20,000,000
Louisiana Public Facilities Authority	Highland Senior Living Facility Project	$20,000,000
Louisiana Public Facilities Authority	Southwest Louisiana Bioenergy Project	$90,000,000
Louisiana Housing Corporation	Multifamily Bond Program	$200,000,000
Louisiana Housing Corporation	Single Family Bond Program	$100,000,000
Louisiana Public Facilities Authority	Qualified Residential Rental Property	$22,547,000

SECTION 2: All references in this Order to the singular shall include the plural, and all plural references shall include the singular.

SECTION 3: 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 the State of Louisiana, at the Capitol, in the City of Baton Rouge, on this 9th day of February, 2015.

Bobby Jindal
Governor

ATTEST BY
THE GOVERNOR
Tom Schedler
Secretary of State
1502#084

Emergency Rules

DECLARATION OF EMERGENCY

Student Financial Assistance Commission
Office of Student Financial Assistance

Scholarship/Grant Programs—TOPS Core Curriculum Equivalents: Art Media I-IV
(LAC 28:IV.703)

The Louisiana Student Financial Assistance Commission (LASFAC) is exercising the emergency provisions of the Administrative Procedure Act [R.S. 49:953(B)] to amend and re-promulgate the rules of the scholarship/grant programs (R.S. 17:3021-3025, R.S. 3041.10-3041.15, and R.S. 17:3042.1.1-3042.8, R.S. 17:3048.1, R.S. 56:797.D(2)).

This rulemaking adds media arts I–IV as course equivalents to art in the TOPS core curriculum for students who graduate from high school beginning in the 2017-2018 academic year (high school).

This Emergency Rule is necessary to implement changes to the scholarship/grant programs to allow the Louisiana Office of Student Financial Assistance and state educational institutions to effectively administer these programs. A delay in promulgating rules would have an adverse impact on the financial welfare of the eligible students and the financial condition of their families. LASFAC has determined that these emergency rules are necessary in order to prevent imminent financial peril to the welfare of the affected students.

This Declaration of Emergency is effective January 27, 2015, and shall remain in effect for the maximum period allowed under the Administrative Procedure Act. (SG15161E)

Title 28
EDUCATION
Part IV. Student Financial Assistance—Higher Education Scholarship and Grant Programs
Chapter 7. Taylor Opportunity Program for Students (TOPS) Opportunity, Performance, and Honors Awards
§703. Establishing Eligibility

A. - A.5.a.ii.(d). …

* * *

(e). For students graduating in academic year (high school) 2017-2018 and after, for purposes of satisfying the requirements of §703.A.5.a.i above, or §803.A.6.a, the following courses shall be considered equivalent to the identified core courses and may be substituted to satisfy corresponding core courses.

Core Curriculum Course(s)	Equivalent (Substitute) Course
Algebra I, Geometry and Algebra II	Integrated Mathematics I, II and III
Art	Media Arts I-IV
Any listed core course or its equivalent.	Any core curriculum course taken by a student who has been deemed to be gifted and talented pursuant to R.S. 17:1941 et seq., as implemented in State Board of Elementary and Secondary Education policy and in fulfillment of the student's Individualized Education Program shall be considered a gifted and talented course and shall fulfill the core curriculum requirement in its given subject area.

A.5.a.ii.(f). - J.4.b.ii. …

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

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:338 (May 1996), repromulgated LR 24:636 (April 1998), amended LR 24:1902 (October 1998), LR 24:2237 (December 1998), LR 25:257 (February 1999), LR 25:655 (April 1999), LR 25:1794 (October 1999), LR 26:64, 67 (January 2000), LR 26:689 (April 2000), LR 26:1262 (June 2000), LR 26:1602 (August 2000), LR 26:1996, 1999, 2001 (September 2000), LR 26:2268 (October 2000), LR 26:2753 (December 2000), LR 27:36 (January 2001), LR 27:702 (May 2001), LR 27:1219, 1219 (August 2001), repromulgated LR 27:1850 (November 2001), amended LR 28:772 (April 2002), LR 28:2330, 2332 (November 2002), LR 29:125 (February 2003), LR 29:2372 (November 2003), LR 30:1162 (June 2004), LR 30:1471 (July 2004), LR 30:2019 (September 2004), LR 31:37 (January 2005), LR 31:2213 (September 2005), LR 31:3112 (December 2005), LR 32:2239 (December 2006), LR 33:435 (March 2007), LR 33:2357 (November 2007), LR 33:2612 (December 2007), LR 34:1389 (July 2008), LR 35:228 (February 2009), LR 36:312 (February 2010), LR 36:490 (March 2010), LR 36:2269 (October 2010), LR 36:2855 (December 2010), LR 37:2987 (October 2011), LR 38:354 (February 2012), LR 38:3158 (December 2012), LR 39:481 (March 2013), LR 39:2485 (September 2013), LR 40:54 (January 2014), LR 41:

George Badge Eldredge
General Counsel

1502#017

DECLARATION OF EMERGENCY

Office of the Governor
Crime Victims Reparations Board

Eligibility and Application Process
(LAC 22:XIII.303 and 503)

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 January 13, 2015, 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
§303. Application Process

A. Claimant Responsibility

1. ...

2. Applications:

a. must be signed and dated by the victim/claimant. Only original signatures, no copies, will be accepted. If the victim is a minor, the parent or guardian is the claimant and must sign. If the victim is deceased, the person responsible for the bill is the claimant and must sign the application;

b. the application is only valid if the crime resulting in the personal injury, death, or catastrophic property loss was reported to the appropriate law enforcement officers within seventy-two hours after the date of the crime or within such longer period as the board determines is justified by the circumstances. Victims of sexual assault may take up to one year to meet the reporting requirements in this Part;

c. victims of sexual assault may assign their right to collect medical expenses associated with the sexual assault to a hospital/health care facility; however, the cost of the forensic medical examination is not reimbursable by the board as provided in §503.M.2. The hospital/health care facility may then apply for reparations.

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

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Commission on Law Enforcement and Administration of Criminal Justice, Crime Victims Reparations Board, LR 20:539 (May 1994), amended LR 22:710 (August 1996), amended by the Office of the Governor, Crime Victims Reparations Board, LR 41:

Chapter 5. Awards
§503. Limits on Awards

A. - L.1. ...

M. Crime Scene Evidence

1. - 1.c. ...

2. Medical Examination of Sexual Assault Victims

a. Costs of the forensic medical examination are the responsibility of the coroner or his designee as provided by law and are not reimbursable by the Crime Victims Reparations Board (CVR Board) under this Section. All other expenses related to victims of sexual assault are reimbursable by the board at 100 percent, subject to the provisions of the Crime Victims Reparations Act and its administrative rules.

b. In instances where the sexual assault victim assigns his or her rights to collect reparations for reimbursable medical expenses beyond those associated with the forensic medical examination to the hospital/health care facility, the hospital/health care facility must submit the following items directly to the CVR Board within one year of the date of service in order to receive reimbursement:

i. victim of sexual assault assignment of rights form, signed by the victim;

ii. hospital/health care facility application;

iii. itemized bill for services rendered.

c. The sexual assault victim may submit these expenses to his or her private insurance or other third party payor. If these expenses are paid by insurance or other third party payor, the hospital/health care facility shall not file an application with the CVR Board.

d. Nothing in this Section shall preclude a sexual assault victim or claimant from filing a regular or emergency application for additional benefits.

M.3. - O.3.b. ...

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 20:539 (May 1994), amended LR 22:710 (August 1996), LR 24:328 (February 1998), LR 25:26 (January 1999), LR 26:1019 (May 2000), LR 29:577 (April 2003), LR 31:1330 (June 2005), LR 32:242 (February 2006), LR 35:65 (January 2009), LR 37:1605 (June 2011, LR 41:

Lamarr Davis
Chairman

1502#001

DECLARATION OF EMERGENCY

Office of the Governor
Division of Administration
Office of Group Benefits

General Provisions, Prior Authorization Requirements, Benefit Limits, Pharmacy Benefits Formulary
(LAC 32:I.1701)

Pursuant to the authority granted by R.S. 42:801(C) and 802(B)(6), vesting the Office of Group Benefits (OGB) with the responsibility for administration of the programs of benefits authorized and provided pursuant to chapter 12 of title 42 of the *Louisiana Revised Statutes*, and granting the power to adopt and promulgate rules with respect thereto, OGB, hereby invokes the Emergency Rule provisions of R.S. 49:953(B).

OGB finds that imminent peril to the public health, safety, or welfare requires it to revise and amend certain of its general provisions including to prior authorization requirements, benefit limits, and the pharmacy benefits. R.S. 42:803(B) grants authority to OGB to establish a self-funded health benefits program and establish plan(s) of benefits for employees under the direction of the commissioner of administration. The plan documents in effect for OGB self-funded plans (PPO, HMO, and CDHP) and the LAC Part III, §423 (PPO) state that changes shall be made from "time to time" to the plans and "such modifications will be promulgated subject to the applicable provisions of law." While no applicable law expressly requires promulgation for such changes to be effective between enrollees and OGB, this Rule is being promulgated due to the imminent peril of financial exposure of the state, OGB, its plan enrollees, and other state programs resulting from a threat of litigation that rules are required to be

promulgated by law. According to the OGB, the OGB fund balance will be as low as $8 million by July 2015 if these and other changes are not implemented. The OGB fund, in the absence of these changes through December 2014, will be depleted by $194,300 per day and $231,819 per day from January to June 2015. This daily loss causes an imminent peril by accelerating the need to impose increases of 18 percent or greater in premiums according to the LFO. These and other resulting costs to enrollees could become so burdensome for enrollees that they drop their health coverage. The fund is now facing the imminent peril of becoming actuarially unsound and unstable. Moreover, if the OGB fund goes into a deficit, then taxpayers are statutorily required to pay the costs of any increase in premiums to enrollees. Consequently, other state programs will be impacted through the resulting budget cuts to higher education and health care which will result in a reduction in critical services for all citizens of the state. Accordingly, the following Emergency Rule, effective September 30, 2014, is being extended beyond the initial 120-day period and will remain in effect until the final Rule becomes effective.

Title 32

EMPLOYEE BENEFITS

Part I. General Provisions

Chapter 17. Emergency Provisions

§1701. Prior Authorization Requirements, Benefit Limits, Pharmacy Benefits Formulary

A. Changes for the PPO, HMO, and CDHP 2014 plans of benefits have been adopted which affect medical and pharmacy benefits and drug utilization.

B. Medical Benefits

1. A prior authorization is a process used to determine the necessity of a proposed service or procedure and is a standard means used by health plans to manage health care utilization. To avoid extra costs, enrollees should always ensure that their health care providers obtain a prior authorization when necessary for a covered benefit.

2. In addition to any services previously identified in the 2014 plan documents or these rules, services that will now require prior authorization, include, but are not limited to:

a. cardiac rehabilitation;

b. CT scans;

c. genetic testing;

d. home health care;

e. hospice;

f. MRI/MRA;

g. orthotic devices;

h. outpatient pain rehabilitation/pain control programs;

i. physical /occupational therapy;

j. residential treatment centers;

k. inpatient hospital admissions (except routine maternity stays).

3. An updated summary of benefits and coverage (SBC) with a complete list of services and procedures requiring prior authorizations shall be available to OGB enrollees through its third-party administrator (TPA) and the OGB website.

4. In addition to any limits previously identified in 2014 plan documents or these rules, OGB self-funded plans will follow the pharmacy benefit formulary's standard for number of visits allowed per benefit period for skilled nursing facilities, home health care services and hospice care services. An updated summary of benefits and coverage (SBC) shall be made available to enrollees through the OGB TPA and through the OGB website.

C. Pharmacy Benefits Formulary. OGB shall have discretion to adopt its PBM pharmacy benefits formulary or other drug formulary. 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 a generic, preferred brand, non-preferred brand name, or specialty drug is obtained. Formulary changes for members with Medicare as their primary coverage shall be effective January 1, 2015. For maintenance medication, 90-day prescriptions may be filled at retail pharmacies for two and a half times the cost of the co-pay. Medications available over-the-counter in the same prescribed strength, are no longer covered under the pharmacy plan. The pharmacy co-payment threshold is changed from $1,200 to $1,500. Additional changes include:

	Prior Benefit	New Benefit
Before co-payment threshold satisfied:		
Generic	50% up to $50	50% up to $30
Preferred	50% up to $50	50% up to $55
Non-Preferred	50% up to $50	65% up to $80
Specialty	50% up to $50	50% up to $80
After co-payment threshold satisfied:		
Generic	$0 co-pay	$0 co-pay
Preferred	$15 co-pay	$20 co-pay
Non-Preferred	$15 co-pay	$40 co-pay
Specialty	$15 co-pay	$40 co-pay

D. Drug Utilization Management

1. Clinical utilization management through prior authorizations for certain medications, the use of step therapy and quantity limitations to promote appropriate utilization of prescription medications and use of generic medications.

2. High cost compound management to promote the use of commercially available, lower cost, individual compound medications instead of high cost compound medications.

3. Medical foods exclusion as the FDA does not currently have safety or efficacy evaluation standards for them as they are not regulated as drugs.

4. Review the usage of narcotic medications such as opiates and acetaminophen to prevent their over and/or improper usage.

5. Polypharmacy management identification and case management for members receiving multiple prescriptions to ascertain and implement appropriate consolidation of medication therapy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 42:801(C) and 802(B)(6).

HISTORICAL NOTE: Promulgated by the Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:

Susan T. West
Chief Executive Officer
Office of Group Benefits
and
Ruth Johnson
Deputy Commissioner of Administration

1502#005

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 promulgated an Emergency Rule which amended the provisions of the August 20, 2014 Emergency Rule to correct an error in the formatting of these provisions (*Louisiana Register*, Volume 40, Number 11). This Emergency Rule is being promulgated to continue the provision of the November 20, 2014 Emergency Rule. This action is being taken to avoid federal sanctions and to secure enhanced federal funding.

Effective March 21, 2015 the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions 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.l. ...

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 40:311 (February 2014), LR 41:

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 40:311 (February 2014), LR 41:

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

1502#053

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Coordinated Care Network
Recipient Participation
(LAC 50:I.3103)

The Department of Health and Hospitals, Bureau of Health Services Financing amends 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 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 coordinated care networks (CCNs) to permit certain individuals who receive waiver services authorized under the provisions of 1915(b) and 1915(c) of the Social Security Act, and Medicaid eligible children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* class action litigation (hereafter referred to as *Chisholm* class members) to have the option of voluntarily enrolling into a participating health plan under the BAYOU HEALTH Program (*Louisiana Register*, Volume 40, Number 6).

The department promulgated an Emergency Rule which amended the provisions governing the June 20, 2014 Rule to exclude *Chisholm* class member participation in CCNs to allow sufficient time for CCNs to amend the current contracts to meet the requirements of the *Chisholm* judgment (*Louisiana Register,* Volume 40, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 20, 2014 Emergency Rule. This action is being taken to promote the health and welfare of recipients participating in the BAYOU HEALTH program.

Effective March 19, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing CCNs to clarify recipient participation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Medicaid Coordinated Care
Chapter 31. Coordinated Care Network
§3103. Recipient Participation

A. - A.3. ...

B. Voluntary Participants

1. Participation in a CCN is voluntary for:

a. - b.iv. ...

v. enrolled in the Family Opportunity Act Medicaid Buy-In Program; and

c. individuals who receive home and community-based waiver services.

d. - 2. Repealed.

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. - e. ...

f. are eligible through the Tuberculosis Infected Individual Program;

g. are enrolled in the Louisiana Health Insurance Premium Payment (LaHIPP) Program; or

h. are under 21 years of age and are listed on the New Opportunities Waiver Request for Services Registry (*Chisholm* class members).

i. For purposes of these provisions, *Chisholm* class members shall be defined as those children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* (or her successor) class action litigation.

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), 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 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

1502#054

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 promulgated an Emergency Rule which amended 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 (*Louisiana Register*, Volume 40, Number 11). This Emergency Rule is being promulgated to continue the provisions of the November 20, 2014 Emergency Rule.

This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation in the FNR Program.

Effective March 21, 2015, 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 41:135 (January 2015), LR 41:

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 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 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

1502#055

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 promulgated an Emergency Rule which amended the provisions governing the licensing standards for HCBS providers to clarify these provisions and to include licensing provisions for monitored in-home caregiving services (Louisiana Register, Volume 40, Number

11). This Emergency Rule is being promulgated to continue the provisions of the November 20, 2014 Emergency Rule. 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 March 21, 2015, 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 41:1007 (May 2014), LR 41:

§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 41:1007 (May 2014), LR 41:

§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 41:

§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 41:

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 41:

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 41:

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 41:

§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

l2. 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 41:

§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;

d. detection and reporting suspected abuse, neglect and exploitation, including training on the written policies and procedures of the HCBS provider regarding these areas;

e. 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;

f. confidentiality;

g. 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 41:

§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 41:

§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 41:

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

1502#056

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing
and
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 promulgated an Emergency Rule which amended the provisions governing the Community Choices Waiver in order to clarify the provisions of the April 20, 2014 Rule (*Louisiana Register*, Volume 40, Number 11). This Emergency Rule is being promulgated to continue the provisions of the November 20, 2014 Emergency Rule.This action is being taken to promote the health and welfare of waiver participants.

Effective March 21, 2015, 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 41:

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 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 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

1502#057

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Inpatient Hospital Services
Children's Specialty Hospitals
Supplemental Payments for New Orleans Area Hospitals
(LAC 50:V.969)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.969 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.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain children's specialty hospitals from state-owned and operated to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing now proposes to adopt a supplemental payment methodology for inpatient hospital services rendered by children's specialty hospitals in the New Orleans area. This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to inpatient hospital services through the maximization of federal dollars. It is estimated that implementation of this Emergency Rule will be cost neutral to the Medicaid Program in state fiscal year 2015 since these expenditures are included in the current budget.

Effective February 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing supplemental payments for inpatient hospital services rendered by children's specialty hospitals in the New Orleans area.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospital Services
Chapter 9. Non-Rural, Non-State Hospitals
Subchapter B. Reimbursement Methodology
§969. Supplemental Payments to Children's Specialty Hospitals in the New Orleans Area

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for inpatient hospital services rendered in a hospital in the New Orleans area that meets the following qualifying criteria per the as filed cost report ending in state fiscal year 2014:

1. classified by Medicare as a specialty children's hospital;

2. has a least 100 full-time equivalent interns and residents;

3. has least 70 percent Medicaid inpatient days' utilization rate;

4. has at least 25,000 Medicaid inpatient days; and

5. has a distinct part psychiatric unit.

B. Supplemental payments for inpatient hospital services will be paid quarterly up to the hospital specific upper payment limit (the difference between Medicaid inpatient charges and Medicaid inpatient payments). The payments to the qualifying hospital(s) shall not exceed:

1. the annual Medicaid hospital specific inpatient charges per 42 CFR 447.271;

2. the annual aggregate inpatient hospital upper payment limit for the classification of hospitals per 42 CFR 442.272; and

3. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement 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, 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 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

1502#021

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Inpatient Hospital Services
Non-Rural, Non-State Hospitals
Supplemental Payments for Baton Rouge Area Hospitals
(LAC 50:V.973)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.973 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.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain hospitals from state-owned and operated to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend the provisions governing inpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in the Baton Rouge area.

This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to inpatient hospital services through the maximization of federal dollars. It is estimated that implementation of this Emergency Rule will be cost neutral to the Medicaid Program in state fiscal year 2015 since these expenditures are included in the current budget.

Effective February 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing the reimbursement methodology for inpatient hospital services rendered by non-rural, non-state hospitals in the Baton Rouge area.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospital Services
Chapter 9. Non-Rural, Non-State Hospitals
Subchapter B. Reimbursement Methodology
§973. Supplemental Payments to Baton Rouge Area Hospitals

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for inpatient hospital services rendered in a hospital in the Baton Rouge area that meets the following qualifying criteria per the as filed cost report ending in state fiscal year 2014:

1. classified as a major teaching hospital;

2. has at least 3,000 Medicaid deliveries, as verified per the Medicaid data warehouse; and

3. has at least 45 percent Medicaid inpatient days utilization rate.

B. Supplemental payments for inpatient hospital services will be paid quarterly up to the hospital specific upper payment limit (the difference between Medicaid inpatient charges and Medicaid inpatient payments). The payments to the qualifying hospital(s) shall not exceed:

1. the annual Medicaid hospital specific inpatient charges per 42 CFR 447.271;

2. the annual aggregate inpatient hospital upper payment limit for the classification of hospitals per 42 CFR 442.272; and

3. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement 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, 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 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

1502#022

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Inpatient Hospital Services
Non-Rural, Non-State Hospitals
Supplemental Payments for Monroe Area Hospitals
(LAC 50:V.971)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.971 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.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain hospitals from state-owned and operated to private partners, the Department of Health and Hospitals (DHH), Bureau of Health Services Financing now proposes to amend the provisions governing the reimbursement methodology for inpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in DHH administrative region 8 in the Monroe area.

This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to inpatient hospital services through the maximization of federal dollars. It is estimated that implementation of this Emergency Rule will be cost neutral to the Medicaid Program in state fiscal year 2015 since these expenditures are included in the current budget.

Effective February 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing the reimbursement methodology for inpatient hospital services rendered by non-rural, non-state hospitals in the Monroe area.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospital Services
Chapter 9. Non-Rural, Non-State Hospitals
Subchapter B. Reimbursement Methodology
§971. Supplemental Payments to Monroe Area Hospitals

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for inpatient hospital services rendered by a hospital in the Monroe area that meets the following qualifying criteria:

1. inpatient acute hospital classified as a major teaching hospital;

2. located in DHH administrative region 8 (lowest per capita income of any region per the 2010 U.S. Census Bureau records); and

3. per the as filed fiscal year ending June 30, 2013 cost report has:

a. greater than 25 full-time equivalent interns and residents;

b. at least 40 percent Medicaid inpatient days utilization; and

c. a distinct part psychiatric unit.

B. Supplemental payments for inpatient hospital services will be paid quarterly up to the hospital specific upper payment limit (the difference between Medicaid inpatient charges and Medicaid inpatient payments). The payments to the qualifying hospital(s) shall not exceed:

1. the annual Medicaid hospital specific inpatient charges per 42 CFR 447.271;

2. the annual aggregate inpatient hospital upper payment limit for the classification of hospitals per 42 CFR 442.272; and

3. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement 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, 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 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

1502#023

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Inpatient Hospital Services
Public-Private Partnerships
Reimbursement Methodology
(LAC 50:V.1703)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:V.1703 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 inpatient 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 and operated hospitals that have terminated or reduced services. Participating non-state owned hospitals shall enter into a cooperative endeavor agreement with the department to support this public-provider partnership initiative (*Louisiana Register*, Volume 39, Number 11). The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for inpatient psychiatric hospital services provided by non-state owned hospitals participating in public-private partnerships (*Louisiana Register*, Volume 39, Number 1). In April 2013, the department promulgated an Emergency Rule to continue the provisions of the January 2, 2013 Emergency Rule (*Louisiana Register*, Volume 39, Number 4).

The department amended the provisions governing the reimbursement methodology for inpatient 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 to establish an interim per diem reimbursement (*Louisiana Register*, Volume 39, Number 4). In June 2013, the department determined that it was necessary to rescind the January 2, 2013 and the May 3, 2013 Emergency Rules governing Medicaid payments to non-state owned hospitals for inpatient psychiatric hospital services (*Louisiana Register*, Volume 39, Number 6). The department promulgated an Emergency Rule which amended the provisions of the April 15, 2013 Emergency Rule in order to revise the formatting of these provisions as a result of the promulgation of the June 1, 2013 Emergency Rule to assure that these provisions are promulgated in a clear and concise manner in the *Louisiana Administrative Code* (LAC) (*Louisiana Register*, Volume 39, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 20, 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 March 17, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing Medicaid payments for inpatient hospital services provided by non-state owned hospitals participating in public-private partnerships.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospital Services
Chapter 17. Public-Private Partnerships
§1703. Reimbursement Methodology

A. Reserved.

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. The inpatient reimbursement shall be reimbursed at 95 percent of allowable Medicaid costs. The interim per diem reimbursement may be adjusted not to exceed the final reimbursement of 95 percent of allowable Medicaid costs.

C. - E.3. Reserved.

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 41:

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

1502#058

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Inpatient Hospital Services
Public-Private Partnerships
Supplemental Payments
(LAC 50:V.Chapter 17)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.Chapter 17 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 inpatient 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 and operated 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-provider partnership initiative. This Emergency Rule is being promulgated to continue the provisions of the November 1, 2012 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 February 26, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions to establish supplemental Medicaid payments for inpatient hospital services provided by non-state owned hospitals participating in public-private partnerships.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 1. Inpatient Hospital Services

Chapter 17. Public-Private Partnerships

§1701. Qualifying Hospitals

A. Non-State Privately Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall provide supplemental Medicaid payments for inpatient hospital services rendered by non-state privately owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a 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.

B. Non-State Publicly Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for inpatient hospital services rendered by non-state publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a 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.

C. Non-State Free-Standing Psychiatric Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for inpatient psychiatric hospital services rendered by non-state privately or publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state privately or 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 psychiatric 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 41:

§1703. Reimbursement Methodology

A. Payments to qualifying hospitals shall be made on a quarterly basis in accordance with 42 CFR 447.272.

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 41:

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

1502#059

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Nursing Facilities
Per Diem Rate Reduction
(LAC 50:II.20005)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:II.20005 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 amended the provisions governing the reimbursement methodology for nursing facilities to reduce the per diem rates paid to non-state nursing facilities in order to remove the rebased amount and sunset the state fiscal year (SFY) 2012-13 nursing facility rate rebasing (Louisiana Register, Volume 39, Number 5).

For SFY 2013-14, state general funds are required to continue nursing facility rates at the rebased level. Because of the fiscal crisis facing the state, the state general funds will not be available to sustain the increased rates. Consequently, the department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities to further reduce the reimbursement rates for non-state nursing facilities (Louisiana Register, Volume 39, Number 7).

The department has now determined that it is necessary to amend the provision of the July 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. This action is being taken to avoid a budget deficit in the medical assistance programs.

Effective February 20, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions of the July 1, 2013 Emergency Rule governing the reimbursement methodology for nursing facilities.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement
Chapter 200. Reimbursement Methodology
§20005. Rate Determination
[Formerly LAC 50:VII.1305]

A. - O. ...

P. Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by $18.90 of the rate in effect on June 30, 2013 until such time that the rate is rebased.

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 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:092 (March 2011), LR 37:1174 (April 2011), LR 37:2631 (September 2011), LR 38:1241 (May 2012), LR 39:1286 (May 2013), LR 39:3097 (November 2013), LR 41:

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

1502#049

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Nursing Facilities
Per Diem Rate Reduction
(LAC 50:II.20005)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:II.20005 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.

For state fiscal year 2014-15, state general funds are required to continue nursing facility rates at the rebased level. Because of the fiscal constraints on the state's budget, the state general funds will not be available to sustain the increased rate. Consequently, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities in order to reduce the per diem rates paid to non-state nursing facilities *Louisiana Register*, Volume 40, Number 5). This Emergency Rule is being promulgated to continue the provisions of the July 1, 2014 Emergency Rule. This action is being taken to avoid a budget deficit in the medical assistance programs.

Effective February 28, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities to reduce the reimbursement rates for non-state nursing facilities.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement
Chapter 200. Reimbursement Methodology
§20005. Rate Determination
[Formerly LAC 50:VII.1305]

A. - O. …

P. Reserved.

Q. Effective for dates of service on or after July 1, 2014, the per diem rate paid to non-state nursing facilities, shall be reduced by $90.26 of the rate in effect on June 30, 2014 until such time that the rate is rebased.

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 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010),

amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:092 (March 2011), LR 37:1174 (April 2011), LR 37:2631 (September 2011), LR 38:1241 (May 2012), LR 39:1286 (May 2013), LR 39:3097 (November 2013), LR 41:

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

1502#060

DECLARATION OF EMERGENCY

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

Nursing Facilities—Standards for Payment
Level of Care Determinations
(LAC 50:II.10156)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amend LAC 50:II.10156 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amended the provisions governing the standards for payment for nursing facilities to clarify level of care determinations (*Louisiana Register*, Volume 39, Number 6). The department promulgated an Emergency Rule which amended the provisions governing level of care pathways in order to clarify the provisions of the June 20, 2013 Rule (*Louisiana Register*, Volume 40, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 20, 2014 Emergency Rule. This action is being taken to promote the well-being of Louisiana citizens by clarifying the criteria for the level of care determination for nursing facility admission and continued stay.

Effective March 19, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing and Office of Aging and Adult Services amend the provisions governing the level of care pathways for nursing facilities.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Medical Assistance Program
Subpart 3. Standards for Payment
Chapter 101. Standards for Payment for Nursing Facilities
Subchapter G. Levels of Care
§10156. Level of Care Pathways

A. - B. ...

C. The level of care pathways elicit specific information, within a specified look-back period, regarding the individual's:

1. ...

2. receipt of assistance with activities of daily living (ADL);

C.3. - E.2.m. ...

F. Physician Involvement Pathway

1. - 2. ...

3. In order for an individual to be approved under the Physician Involvement Pathway, the individual must have one day of doctor visits and at least four new order changes within the last 14 days or:

a. at least two days of doctor visits and at least two new order changes within the last 14 days; and

F.3.b. - I.1.d. ...

2. In order for an individual to be approved under the behavior pathway, the individual must have:

a. exhibited any one of the following behaviors four to six days of the screening tool's seven-day look-back period, but less than daily:

i. - ii. ...

iii. physically abusive;

iv. socially inappropriate or disruptive; or

b. exhibited any one of the following behaviors daily during the screening tool's seven-day look-back period:

i. - iii. ...

iv. socially inappropriate or disruptive; or

c. experienced delusions or hallucinations within the screening tool's seven-day look-back period that impacted his/her ability to live independently in the community; or

d. exhibited any one of the following behaviors during the assessment tool's three-day look-back period and behavior(s) were not easily altered:

i. wandering;

ii. verbally abusive;

iii. physically abusive;

iv. socially inappropriate or disruptive; or

e. experienced delusions or hallucinations within the assessment tool's three-day look-back period that impacted his/her ability to live independently in the community.

J. - J.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 and the Office of Aging and Adult Services, LR 37:342 (January 2011), amended LR 39:1471 (June 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.

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

1502#061

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Outpatient Hospital Services
Non-Rural, Non-State Hospitals
Supplemental Payments for Monroe Area Hospitals
(LAC 50:V.6903)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.6903 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the 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.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain hospitals from state-owned and operated to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend the provisions governing the reimbursement methodology for outpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in DHH administrative region 8 in the Monroe area.

This action is being taken promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to outpatient hospital services through the maximization of federal dollars. It is estimated that implementation of this Emergency Rule will be cost neutral to the Medicaid Program in state fiscal year 2015 since these expenditures are included in the current budget. Effective February 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing supplemental payments for outpatient hospital services rendered by non-rural, non-state hospitals in the Monroe area.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 5. Outpatient Hospital Services
Chapter 69. Supplemental Payments
§6903. Non-Rural, Non-State Hospitals in the Monroe Area

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for outpatient hospital services rendered by a hospital in the Monroe area that meets the following qualifying criteria:

1. inpatient acute hospital classified as a major teaching hospital;

2. located in DHH administrative region 8 (lowest per capita income of any region per the 2010 U.S. Census Bureau records); and

3. per the as filed fiscal year ending June 30, 2013 cost report has:

a. greater than 25 full-time equivalent interns and residents;

b. at least 40 percent Medicaid inpatient days utilization; and

c. a distinct part psychiatric unit.

B. Supplemental payments for outpatient hospital services will be paid quarterly. The payments to the qualifying hospital(s) shall not exceed:

1. the aggregate outpatient hospital upper payment limits for the classification of hospitals pursuant to 42 CFR 447.321; and

2. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement 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, 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 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

1502#019

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Outpatient Hospital Services
Children's Specialty Hospitals
Supplemental Payments for New Orleans Area Hospitals
(LAC 50:V.6121)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.6121 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.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain children's specialty hospitals from state-owned and operated to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing now proposes to adopt a supplemental payment methodology for outpatient hospital services rendered by children's specialty hospitals in the New Orleans area. This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to inpatient hospital services through the maximization of federal dollars. It is estimated that implementation of this Emergency Rule will be cost neutral to the Medicaid Program in state fiscal year 2015 since these expenditures are included in the current budget.

Effective February 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing outpatient supplemental payments for outpatient hospital services rendered by children's specialty hospitals in the New Orleans area.

Title 50
PULIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospitals
Subpart 5. Outpatient Hospitals
Chapter 61. Other Outpatient Hospital Services
Subchapter B. Reimbursement Methodology
§6121. Supplemental Payments for Children's Specialty Hospitals in the New Orleans Area

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for outpatient hospital services rendered in a hospital in the New Orleans area that meets the following qualifying criteria per the as filed cost report in state fiscal year 2014:

1. classified by Medicare as a specialty children's hospital;
2. has at least 100 full-time equivalent interns and residents;
3. has at least 70 percent Medicaid inpatient days' utilization rate;
4. has at least 25,000 Medicaid inpatient days; and
5. has a distinct part psychiatric unit.

B. Supplemental payments for outpatient hospital services will be paid quarterly. The payments to the qualifying hospital(s) shall not exceed:

1. the aggregate outpatient hospital upper payment limits for the classification of hospitals pursuant to 42 CFR 447.321; and
2. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement 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, 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 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

1502#011

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Outpatient Hospital Services
Non-Rural, Non-State Hospitals
Supplemental Payments for Baton Rouge Area Hospitals
(LAC 50:V.6905)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.6905 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.

As a result of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services' disapproval of the state plan amendment for the financing of the transition of the management and operation of certain hospitals from state-owned and operated to private partners, the Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend the provisions governing outpatient hospital services rendered by non-rural, non-state hospitals in order to adopt a supplemental payment methodology for services provided by hospitals located in the Baton Rouge area.

This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and continued access to outpatient hospital services through the maximization of federal dollars. It is estimated that implementation of this Emergency Rule will be cost neutral to the Medicaid Program in state fiscal year 2015 since these expenditures are included in the current budget.

Effective February 12, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing adopts provisions governing the reimbursement methodology for outpatient hospital services rendered by non-rural, non-state hospitals in the Baton Rouge area.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE

Part V. Hospital Services

Subpart 5. Outpatient Hospital Services

Chapter 69. Supplemental Payments

§6905. Non-Rural, Non-State Hospitals in the Baton Rouge Area

A. Effective for dates of service on or after February 12, 2015, quarterly supplemental payments shall be made for outpatient hospital services rendered in a hospital in the Baton Rouge area that meets the following qualifying criteria per the as filed cost report ending state fiscal year 2014:

1. classified as a major teaching hospital;

2. has at least 3,000 Medicaid deliveries, as verified per the Medicaid data warehouse; and

3. has at least 45 percent Medicaid inpatient days utilization rate.

B. Supplemental payments for outpatient hospital services will be paid quarterly. The payments to the qualifying hospital(s) shall not exceed:

1. the aggregate outpatient hospital upper payment limits for the classification of hospitals pursuant to 42 CFR 447.321; and

2. the budgeted state fiscal year supplemental payment amount included in the Annual Appropriation Act as allocated to this specific program in the budget spread pursuant to the department's reimbursement 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 Service Financing, 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 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

1502#020

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Outpatient Hospital Services
Public-Private Partnerships
Supplemental Payments
(LAC 50:V.Chapter 67)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.Chapter 67 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). This Emergency Rule continues the provisions of the March 2, 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 February 26, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing supplemental 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

§6701. Qualifying Hospitals

A. Non-State Privately Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall provide supplemental Medicaid payments for outpatient hospital services rendered by non-state privately owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a 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 outpatient 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.

B. Non-State Publicly Owned Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for outpatient hospital services rendered by non-state publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a 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 outpatient 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.

C. Non-State Free-Standing Psychiatric Hospitals. Effective for dates of service on or after November 1, 2012, the department shall make supplemental Medicaid payments for outpatient psychiatric hospital services rendered by non-state privately or publicly owned hospitals that meet the following conditions.

1. Qualifying Criteria. The hospital must be a non-state privately or publicly owned and operated hospital that enters into a cooperative endeavor agreement with the Department of Health and Hospitals to increase its provision of outpatient Medicaid and uninsured psychiatric 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 41:

§6703. Reimbursement Methodology

A. Payments to qualifying hospitals shall be made on a quarterly basis in accordance with 42 CFR 447.321.

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 41:

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

1502#062

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 promulgated an Emergency Rule which adopted provisions to establish the RAC program (*Louisiana Register*, Volume 40, Number 11). This Emergency Rule is being promulgated to continue the provisions of the November 20, 2014 Emergency Rule. This action is being taken to avoid federal sanctions.

Effective March 21, 2015, 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 41:

§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 41:

§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 41:

§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 41:

§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 41:

§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 41:

§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 41:

§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 41:

§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 41:

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

1502#063

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Targeted Case Management
Reimbursement Methodology
(LAC 50:XV.10701)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:XV.10701 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.

As a result of 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 targeted case management (TCM) services to reduce the reimbursement rates and to revise these provisions as a result of the promulgation of the January 2013 Emergency Rules which terminated Medicaid reimbursement of TCM services provided to first-time mothers in the Nurse Family Partnership Program and TCM services rendered to HIV disabled individuals (*Louisiana Register*, Volume 39, Number 12).

The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for TCM services provided to new opportunities waiver (NOW) recipients in order to adopt a payment methodology based on a flat monthly rate rather than 15-minute increments (*Louisiana Register*, Volume 40, Number 6). This Emergency Rule is being promulgated to continue the provisions of the July 1, 2014 Emergency Rule. This action is being taken to promote the health and welfare of NOW participants by ensuring continued access to Medicaid covered services.

Effective February 28, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for TCM for NOW services.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 7. Targeted Case Management
Chapter 107. Reimbursement
§10701. Reimbursement

A. - H.3.a. …

I. - J. Reserved.

K. Effective for dates of service on or after July 1, 2014, reimbursement for case management services provided to participants in the new opportunities waiver shall be reimbursed at a flat rate for each approved unit of service.

1. The standard unit of service is equivalent to one month and covers both service provision and administrative costs.

a. Service provision includes the core elements in:

i. §10301 of this Chapter;

ii. the case management manual; and

iii. contracted performance agreements.

2. All services must be prior authorized.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:1040 (May 2004), amended LR 31:2032 (August 2005), amended LR 35:73 (January 2009), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1903 (September 2009), amended LR 36:1783 (August 2010), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Public Health, LR 39:97 (January 2013), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 39:3302 (December 2013), LR 40:1700,1701 (September 2014), 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 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

1502#064

DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Therapeutic Group Homes
Licensing Standards
(LAC 48:I.Chapter 62)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 48:I.Chapter 62 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2009. 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 the directives of R.S. 40:2009, the Department of Health and Hospitals, Bureau of Health Services Financing adopted provisions governing the minimum licensing standards for therapeutic group homes(TGH)in order to prepare for the transition to a comprehensive system of delivery for behavioral health services in the state (*Louisiana Register*, Volume 38, Number 2).

The department promulgated an Emergency Rule which amended the provisions governing TGH licensing standards to revise the current TGH licensing regulations (*Louisiana Register*, Volume 40, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 20, 2014 Emergency Rule. This action is being taken to promote the health and welfare of Medicaid recipients by ensuring sufficient provider participation and recipient access to services.

Effective March 19, 2015, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the licensing standards for TGH providers.

Title 48

PUBLIC HEALTH—GENERAL

Part I. General Administration

Subpart 3. Licensing

Chapter 62. Therapeutic Group Homes

Subchapter A. General Provisions

§6203. Definitions

Active Treatment—implementation of a professionally developed and supervised comprehensive treatment plan that is developed no later than seven days after admission and designed to achieve the client's discharge from inpatient status within the shortest practicable time. To be considered *active treatment*, the services must contribute to the achievement of the goals listed in the comprehensive treatment plan. Tutoring, attending school, and transportation are not considered *active treatment*. Recreational activities can be considered *active treatment* when such activities are community based, structured and integrated within the surrounding community.

* * *

Therapeutic Group Home (TGH)—a facility that provides community-based residential services to clients under the age of 21 in a home-like setting of no greater than 10 beds under the supervision and oversight of a psychiatrist or psychologist.

* * *

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 38:402 (February 2012), amended LR 41:

Subchapter B. Licensing

§6213. Changes in Licensee Information or Personnel

A. - C.1. ...

2. A TGH that is under provisional licensure, license revocation, or denial of license renewal may not undergo a CHOW.

D. - E. ...

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 38:405 (February 2012), amended LR 41:

§6219. 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. ...
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 38:406 (February 2012), amended LR 41:

§6221. 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 results. 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 38:407 (February 2012), amended LR 41:

§6223. 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 38:407 (February 2012), amended LR 41:

§6225. Cessation of Business

A. Except as provided in §6295 of this chapter, a license shall be immediately null and void if a TGH ceases to operate.

1. - 3. Repealed.

B. A cessation of business is deemed to be effective the date on which the TGH 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 TGH 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 TGH shall submit a written plan for the disposition of client 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 TGH fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a TGH for a period of two years.

H. Once the TGH has ceased doing business, the TGH 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 38:407 (February 2012), amended LR 41:

§6227. Denial of License, Revocation of License, or Denial of License Renewal

A. - C.3. ...

D. Revocation of License or Denial of License Renewal. A TGH license may be revoked or may be denied renewal for any of the following reasons, including but not limited to:

1. - 15. ...

16. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

17. failure to timely pay outstanding fees, fines, sanctions, or other debts owed to the department; or

18. failure to maintain accreditation, or for a new TGH that has applied for accreditation, the failure to obtain accreditation.

19. Repealed.

E. If a TGH 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 TGH may be prohibited from opening, managing, directing, operating, or owning another TGH 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 38:408 (February 2012), amended LR 41:

§6229. Notice and Appeal of License Denial, License Revocation, License Non-Renewal, and Appeal of Provisional License

A. - B. ...

1. The TGH provider 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 provider on a license denial, license non-renewal, or license revocation, the DAL or its successor 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 HSS 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 provider 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 DAL or its successor 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 38:409 (February 2012), amended LR 41:

Subchapter D. Provider Responsibilities

§6247. Staffing Requirements

A. - C.2. ...

3. A ratio of not less than one staff to five clients is maintained at all times; however, two staff must be on duty at all times with at least one being direct care staff when there is a client present.

D. - D.3....

4. Therapist. Each therapist shall be available at least three hours per week for individual and group therapy and two hours per month for family therapy.

5. Direct Care Staff. The ratio of direct care staff to clients served shall be 1:5 with a minimum of two staff on duty per shift for a 10 bed capacity. This ratio may need to be increased based on the assessed level of acuity of the youth or if treatment interventions are delivered in the community and offsite.

E. - G. ...

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 38:413 (February 2012), amended LR 41:

§6249. Personnel Qualifications and Responsibilities

A. - 1.a.ii.(c). ...

b. A supervising practitioner's responsibilities shall include, but are not limited to:

i. reviewing the referral PTA and completing an initial diagnostic assessment at admission or within 72 hours of admission and prior to service delivery;

ii. - iv. ...

v. at least every 28 days or more often as necessary, providing:

1.b.v.(a). - 6.b.viii. ...

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 38:414 (February 2012), amended LR 41:

Subchapter F. Services

§6267. Comprehensive Treatment Plan

A. Within seven days of admission, a comprehensive treatment plan shall be developed by the established multidisciplinary team of staff providing services for the client. Each treatment team member shall sign and indicate their attendance and involvement in the treatment team meeting. The treatment team review shall be directed and supervised by the supervising practitioner at a minimum of every 28 days.

B. - G.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 38:418 (February 2012), amended LR 41:

§6269. Client Services

A. - A.4. ...

B. The TGH is required to provide at least 16 hours of active treatment per week to each client. This treatment shall be provided and/or monitored by qualified staff.

C. The TGH shall have a written plan for insuring that a range of daily indoor and outdoor recreational and leisure opportunities are provided for clients. Such opportunities shall be based on both the individual interests and needs of the client and the composition of the living group.

C.1. - G.4. ...

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 38:419 (February 2012), 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 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

1502#065

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 February 27, 2015. Provider agencies must determine CMA competency annually during the two-year period.

Also effective February 27, 2015, 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. 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

1502#034

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 adopts the following Emergency Rule for the protection of public health, effective January 27, 2015. This Emergency Rule is being promulgated in accordance with the Administrative Procedure Act (R.S. 49:950 et seq.) and shall remain in effect for the maximum period allowed or until such time as a final Rule is promulgated.

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.

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. N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)-1H-indole-3-carboxamide;
2. N-(1-amino-3-phenyl-1-oxopropan-2-yl)-1-(5-fluoropentyl)-1H-indazole-3-carboxamide;
3. methyl 2-(1-(cyclohexylmethyl)-1H-indole-3-carboxamido)-3,3-dimethylbutanoate.

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 and Medical Director

1502#006

DECLARATION OF EMERGENCY

Department of Public Safety and Corrections
Office of State Fire Marshal

Door-to-Door Solicitations (LAC 55:V.3239)

The Department of Public Safety and Corrections, Office of the State Fire Marshal (SFM), avails itself of the provisions of R.S. 49:953(b)(1) and declares that the provisions of the *Louisiana Administrative Code* (LAC 55:V.3239) are hereby repealed effective close of business January 20, 2015, as being facially defective and therefore unconstitutional based upon Attorney General Opinion No. 08-0098 (2009), citing *Central Hudson Gas and Electric Corp v. Public Service Commission*, 447 U.S. 557 (1980) and *Board of Trustees of the State University of New York v. Fox*, 492 U.S. 469 (1989) as authority. The repealed rule requires licensees of the SFM engaging in door-to-door solicitation to "…*comply with all local permitting ordinances and requirements* …" The above cited cases have held that door-to-door solicitation is speech within the meaning of the First Amendment of the U.S. Constitution, and local ordinances banning all door-to-door solicitation are constitutionally defective. Therefore, the repealed rule requiring that licensees comply with all local ordinances is overly broad and therefore defective. This Emergency Rule shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever one comes first.

Title 55
PUBLIC SAFETY
Part V. Fire Protection
Chapter 32. Property Protection Licensing
§3239. Door-to-Door Solicitation

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:2746 (September 2011), repealed LR 41:

H. "Butch" Browning
Fire Marshal

1502#003

DECLARATION OF EMERGENCY

Department of Wildlife and Fisheries
Wildlife and Fisheries Commission

Shrimp Season Closures

In accordance with the emergency provisions of R.S. 49:953 of the Administrative Procedure Act which allows the Wildlife and Fisheries Commission to use emergency procedures to set shrimp seasons and R.S. 56:497 which allows the Wildlife and Fisheries Commission to delegate to the secretary of the department the powers, duties and authority to set shrimp seasons, and in accordance with a Declaration of Emergency adopted by the Wildlife and Fisheries Commission on August 7, 2014 which authorized the secretary of the Department of Wildlife and Fisheries to close the fall shrimp season when biological and technical data indicate the need to do so or if enforcement problems develop; and in accordance with a Declaration of Emergency adopted by the Wildlife and Fisheries Commission on December 4, 2014 which authorizes the secretary of the Department of Wildlife and Fisheries to close all or parts of state outside waters where significant numbers of small, sublegal size white shrimp are found in biological samples conducted by the department; and to reopen any area closed to shrimping when the closure is no longer necessary; the secretary of the Department of Wildlife and Fisheries does hereby declare:

The 2014 fall inshore shrimp season will close on January 28, 2015 at official sunset in Lake Pontchartrain, Chef Menteur and Rigolets Passes, Lake Borgne, Mississippi Sound, and the Mississippi River Gulf Outlet (MRGO); and that portion of state outside waters extending a distance of 3 nautical miles seaward of the inside/outside shrimp line as described in R.S. 56:495(A) from the northwest shore of Caillou Boca at -90 degrees 50 minutes 27 seconds west longitude westward to the Atchafalaya River Ship Channel at Eugene Island as delineated by the channel red buoy line.

R.S. 56:498 provides that the possession count on saltwater white shrimp for each cargo lot shall average no more than 100 (whole specimens) count per pound except during the time period from October 15 through the third Monday in December. Recent biological sampling conducted by the Department of Wildlife and Fisheries has indicated that average white shrimp size within the waters to be closed is smaller than the minimum possession count and this action is being taken to protect these small white shrimp and provide opportunity for growth to larger and more valuable sizes.

Robert J. Barham
Secretary

1502#040

Rules

RULE

Department of Agriculture and Forestry
Beef Industry Council

Beef Promotion and Research Program
(LAC 7:V.Chapter 27)

Under the enabling authority of R.S. 3:2054(E), and in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., the Louisiana Beef Industry Council (LBIC) has promulgated these rules and regulations ("the proposed action") in order to establish rules and regulations for its own government and for administration of the affairs of the council.

This action is required because the October, 2013 Louisiana Supreme Court ruling in Krielow v. Louisiana Department of Agriculture and Forestry, which declared R.S. 3:3534 and R.S. 3:3544, statutes that allow a voting majority of rice producers to levy an assessment on all producers, to be unconstitutional, calls into question the constitutionality of sections 3:2055 through 2062 of the *Louisiana Revised Statutes*. The *Revised Statutes* established, by referendum vote, the Louisiana Beef Promotion and Research Program (LBPRP) and the LBIC. Among other things, these statutes included procedures for the governance and administration of the LBIC.

Louisiana's cattle industry is essential to the health, safety and welfare of the citizens of this state. In 2004, Louisiana's cattle industry was the second-largest agricultural sector with about $365 million in sales. The LBPRP and the LBIC promote the growth and development of the cattle industry in Louisiana by research, advertisement, promotions, education, and market development, thereby promoting the general welfare of the people of this state.

The LBRPR and the LBIC are the mechanisms through which the state's cattle production and feeding industry develop, maintain, and expand the state, national, and foreign markets for cattle and beef products produced, processed, or manufactured in this state and through which the cattle production and feeding industry of this state contributes otherwise to the development and sustenance of a Louisiana coordinated promotion program and nationally coordinated programs of product improvement through research in consumer marketing via the accepted industry organization of the Cattleman's Beef Promotion and Research Board and its Beef Industry Council, thus benefiting the entire United States cattle industry and the American public.

This action is required in order to provide a means for the LBIC to continue to govern and administer the affairs of the council, and to allow the council to continue, to the maximum extent possible within the constraints announced in Krielow, the LBIC's support of the program and protection of the huge investment that has been made, thus insuring the marketability of Louisiana beef, until such time as there is a permanent legislative solution. Failure to promulgate these rules would jeopardize the significant investment to promote the growth and development of Louisiana's cattle industry since the program's inception, and would pose an imminent peril to the health and welfare of the Louisiana's citizens and the state's cattle industry.

This Rule shall have the force and effect of law five days after its promulgation in the official journal of the state of Louisiana.

Title 7
AGRICULTURE AND ANIMALS
Part V. Advertising, Marketing and Processing
Chapter 27. Beef Promotion and Research Program

§2701. Purpose

A. The purpose of this Chapter is to provide for the government and for the administration of the affairs of the Louisiana Beef Industry Council.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2051, 2052, and 2054.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Beef Industry Council, LR 41:332 (February 2015).

§2703. Powers and Duties of the Council; Quorum

A. The council shall:

1. receive and disburse funds, as prescribed elsewhere in this Chapter, to be used in administering and implementing the provisions and intent of this Chapter;

2. meet regularly, not less often than once in each calendar quarter or at such other times as called by the chairman, or when requested by six or more members of the council;

3. maintain a record of its business proceedings in accordance with R.S. 44:36 and the Louisiana Beef Industry Council retention schedule;

4. maintain a detailed record of its financial accounts in accordance with R.S. 44:36 and the Louisiana Beef Industry Council retention schedule;

5. prepare periodic reports and an annual report of its activities for the fiscal year;

6. prepare periodic reports and an annual accounting for the fiscal year of all receipts and expenditures of the council and shall retain a certified public accountant for this purpose;

7. appoint a licensed banking institution as the depository for program funds and disbursements;

8. maintain frequent communications with officers and industry representatives of the Cattlemen's Beef Promotion and Research Board.

B. Six members of the council shall constitute a quorum for the purpose of conducting business.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2051, 2052, and 2054.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Beef Industry Council, LR 41:332 (February 2015).

§2705. Use of Funds

A. The council may expend the funds available to it to:

1. contract for scientific research with any accredited university, college, or similar institution and enter into other contracts or agreements which will aid in carrying out the purposes of the program, including cattle and beef promotion, consumer market development, research advertising and, including contracts for the purpose of acquisition of facilities or equipment necessary to carry out purposes of the program;

2. disseminate reliable information benefiting the consumer and the cattle and beef industry on such subjects as, but not limited to, purchase, identification, care, storage, handling, cookery, preparation, serving, and the nutritive value of beef and beef products;

3. provide information to such government bodies as requested on subjects of concern to the cattle and beef industry and act jointly or in cooperation with the state or federal government and agencies thereof in the development or administration of programs deemed by the council to be consistent with the objectives of the program;

4. cooperate with any local, state, regional, or nationwide organization or agency engaged in work or activities consistent with the objectives of the program;

5. pay funds to other organizations for work or services performed which are consistent with the objectives of the program.

B. All funds available to the council shall be expended only to effectuate the purposes of this Chapter and shall not be used for political purposes in any manner. A fiscal year-end audited report shall be made available annually to the state conventions of the Louisiana Cattlemen's Association and the Louisiana Farm Bureau Federation, and shall be posted on the Division of Administration website in accordance with R.S. 49:1301 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2051, 2052, and 2054.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Beef Industry Council, LR 41:333 (February 2015).

§2707. Additional Powers of Council

A. The council may:

1. sue and be sued as a council, without individual liability of the members for acts of the council when acting within the scope of the powers of this Chapter, and in the manner prescribed by the laws of this state;

2. appoint advisory groups composed of representatives from organizations, institutions, governments, or business related to or interested in the welfare of the cattle and beef industry and consumers;

3. employ subordinate officers and employees of the council and prescribe their duties and fix their compensation and terms of employment;

4. accept grants, donations, contributions, or gifts from any source, but only if the use of such resources is not restricted in any manner which is deemed inconsistent with the objectives of the program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:2051, 2052, and 2054.

HISTORICAL NOTE: Promulgated by the Department of Agriculture and Forestry, Beef Industry Council, LR 41:333 (February 2015).

Dale Cambre
Chairman

1502#015

RULE

Department of Agriculture and Forestry
Office of Agricultural and Environmental Sciences
Structural Pest Control Commission

Hydraulic Injection (LAC 7:XXV.141)

Under the enabling authority of R.S. 3:3366, and in accordance with the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences and the Structural Pest Control Commission have adopted these rules and regulations for the implementation of hydraulic injection as an approved method of trench and treat for minimum specifications for termite control work.

This action will amend the current minimum specifications for termite control work for requirements for trench and treat to include hydraulic injection, an alternative method of termite control adopted by the Structural Pest Control Commission. Hydraulic injection is a high pressure unit that may be used in conjunction with an approved termiticide while performing a perimeter treatment.

Requirements for trench and treat are currently in place for termite control work. This action permits hydraulic injection to be used in lieu of trench and treat. The unit will be made available by the manufacturer for an annual rental rate. Hydraulic injection of termiticide treatment will be an alternative method for perimeter treatments for termite control in Louisiana and will be a strictly voluntary method.

Title 7
AGRICULTURE AND ANIMALS
Part XXV. Structural Pest Control
Chapter 1. Structural Pest Control Commission
§101. Definitions

A. The definitions in R.S. 3:3362 are applicable to this Part.

B. The following words and terms are defined for the purposes of this Part.

* * *

Household Pest—all species of insects and other pests which infest residences and other types of buildings and their immediate premises, such as cockroaches, flies fleas, mosquitoes, clothes moths, spiders, carpenter ants, carpenter bees, rodents and so forth, but does not include wood-destroying insects.

Hydraulic Injection—the non-trenching application of a termiticide mixture by high pressure into the soil.

Label—the written, printed or graphic matter on or attached to a pesticide or device or any of its containers or wrappers.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3362 and R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:323 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission LR 15:954 (November 1989), 17:251 (March 1991), LR 23:855 (July 1997), LR 30:1143 (June 2004), amended by the Department of Agriculture and Forestry, Office of Agriculture and Environmental Sciences, LR 31:26 (January 2005), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 32:796 (May 2006), repromulgated LR 32:1015 (June 2006), amended LR 33:39 (January 2007), LR 35:204 (February 2009), LR 35:1468 (August 2009), LR 37:272 (January 2011), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Structural Pest Control Commission, LR 39:300 (February 2013), LR 41:333 (February 2015).

§141. Minimum Specifications for Termite Control Work

A. - B.4. …

5. In lieu of trench and treat, a commission approved method of hydraulic injection shall be used in conjunction with an approved termiticide with label and labeling for hydraulic injection use.

C. - C.8.b. …

c. In lieu of trench and treat, a commission approved method of hydraulic injection shall be used in conjunction with an approved termiticide with label and labeling for hydraulic injection use. Hydraulic injection shall be performed around the slab to form a treatment zone.

C.9. - D.1.b. …

c. In lieu of trench and treat, a commission approved method of hydraulic injection shall be used in conjunction with an approved termiticide with label and labeling for hydraulic injection use. Hydraulic injection shall be performed around the slab to form a treatment zone.

D.2. - E.1.b. …

c. In lieu of trench and treat, a commission approved method of hydraulic injection shall be used in conjunction with an approved termiticide with label and labeling for hydraulic injection use. Hydraulic injection shall be performed around the slab to form a treatment zone.

E.2. - K.7.e. …

f. In lieu of trench and treat, a commission approved method of hydraulic injection shall be used in conjunction with an approved termiticide with label and labeling for hydraulic injection use. Hydraulic injection shall be performed around the slab to form a treatment zone.

8. - 8.b. …

c. In lieu of trench and treat, a commission approved method of hydraulic injection shall be used in conjunction with an approved termiticide with label and labeling for hydraulic injection use. Hydraulic injection shall be performed around the slab to form a treatment zone.

K.9. - L.1.c.iii. …

d. In lieu of trench and treat, a commission approved method of hydraulic injection shall be used in conjunction with an approved termiticide with label and labeling for hydraulic injection use. Hydraulic injection shall be performed around the slab to form a treatment zone.

2. - 2.a. …

b. In lieu of trench and treat, a commission approved method of hydraulic injection shall be used in conjunction with an approved termiticide with label and labeling for hydraulic injection use. Hydraulic injection shall be performed around the slab to form a treatment zone.

L.3. - M.2.a. …

b. rod under or drill through any slab(s) adjoining or abutting the slab and treat all areas beneath adjoining or abutting slab(s) as per label and labeling instructions. When any slab(s) is drilled, the holes shall be no more than 18 inches (unless label requires closer distance) apart along the above stated areas;

c. In lieu of trench and treat, a commission approved method of hydraulic injection shall be used in conjunction with an approved termiticide with label and labeling for hydraulic injection use. Hydraulic injection shall be performed around the slab to form a treatment zone.

3. - 9. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:3366.

HISTORICAL NOTE: Promulgated by the Department of Agriculture, Structural Pest Control Commission, LR 11:330 (April 1985), amended by the Department of Agriculture and Forestry, Structural Pest Control Commission, LR 15:958 (November 1989), LR 20:644 (June 1994), LR 21:931 (September 1995), LR 23:1285 (October 1997), LR 25:235 (February 1999), LR 25:1620 (September 1999), LR 26:2437 (November 2000), LR 27:1180 (August 2001), LR 29:1063 (July 2003), LR 30:1145 (June 2004), repromulgated LR 30:1614 (August 2004), amended LR 35:207 (February 2009), LR 35:1469 (August 2009), repromulgated LR 35:1872 (September 2009), amended, LR 37:286 (January 2011), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Structural Pest Control Commission, LR 39:301 (February 2013), amended by the Department of Agriculture and Forestry, Office of Agricultural and Environmental Sciences, Structural Pest Control Commission, LR 39:1413 (June 2013), LR 41:333 (February 2015).

Mike Strain, DVM
Commissioner

1502#016

RULE

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., the Louisiana Board of Examiners of Certified Shorthand Reporters has amended 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 41:334 (February 2015).

Judge Paul A. Bonin
Chair

1502#036

RULE

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., the Louisiana Board of Examiners of Certified Shorthand Reporters has adopted 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 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 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 41:335 (February 2015).

Judge Paul A. Bonin
Chair

1502#037

RULE

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, has amended Title 34, Government Contracts, Procurement and Property Control, Part III, Facility Planning and Control, Chapter 3, Louisiana Uniform Public Work Bid Form. This Rule 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 41:336 (February 2015).

Mark A. Moses
Director

1502#025

RULE

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 enhances member clarification and provide for the administration, operation, and management of health care benefits effectively for the program and member. Accordingly, OGB has adopted 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 41:338 (February 2015), effective March 1, 2015.

§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 41:338 (February 2015), effective March 1, 2015.

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 41:338 (February 2015), effective March 1, 2015.

§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 41:338 (February 2015), effective March 1, 2015.

§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 41:339 (February 2015), effective March 1, 2015.

§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 41:339 (February 2015), effective March 1, 2015.

§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 41:340 (February 2015), effective March 1, 2015.

§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 41:340 (February 2015), effective March 1, 2015.

§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 41:341 (February 2015), effective March 1, 2015.

§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 41:341 (February 2015), effective March 1, 2015.

§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 41:341 (February 2015), effective March 1, 2015.

§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 41:341 (February 2015), effective March 1, 2015.

§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 41:343 (February 2015), effective March 1, 2015.

§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 41:345 (February 2015), effective March 1, 2015.

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 41:345 (February 2015), effective March 1, 2015.

§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 41:345 (February 2015), effective March 1, 2015.

§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 41:345 (February 2015), effective March 1, 2015.

§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 41:346 (February 2015), effective March 1, 2015.

§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 41:346 (February 2015), effective March 1, 2015.

§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 41:346 (February 2015), effective March 1, 2015.

§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 41:346 (February 2015), effective March 1, 2015.

§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 41:346 (February 2015), effective March 1, 2015.

§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 41:346 (February 2015), effective March 1, 2015.

§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 41:346 (February 2015), effective March 1, 2015.

§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 41:347 (February 2015), effective March 1, 2015.

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 41:347 (February 2015), effective March 1, 2015.

§703. Candidate Eligibility

A. A candidate for a position on the Group Benefits Policy and Planning Board (OGB board) must be a participant 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 41:347 (February 2015), effective March 1, 2015.

§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 41:347 (February 2015), effective March 1, 2015.

§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 41:347 (February 2015), effective March 1, 2015.

§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 41:347 (February 2015), effective March 1, 2015.

§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 41:347 (February 2015), effective March 1, 2015.

§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 41:348 (February 2015), effective March 1, 2015.

§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 41:348 (February 2015), effective March 1, 2015.

§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 41:348 (February 2015), effective March 1, 2015.

§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 41:348 (February 2015), effective March 1, 2015.

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 41:348 (February 2015), effective March 1, 2015.

§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 41:348 (February 2015), effective March 1, 2015.

§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 41:348 (February 2015), effective March 1, 2015.

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 41:349 (February 2015), effective March 1, 2015.

§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 41:349 (February 2015), effective March 1, 2015.

§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 41:349 (February 2015), effective March 1, 2015.

§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 41:349 (February 2015), effective March 1, 2015.

§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 41:350 (February 2015), effective March 1, 2015.

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 41:350 (February 2015), effective March 1, 2015.

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 41:350 (February 2015), effective March 1, 2015.

§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 41:350 (February 2015), effective March 1, 2015.

§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 41:350 (February 2015), effective March 1, 2015.

§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: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	$25 Copayment per Visit	No Coverage
Allied Health/Other Professional Visits: • 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: • 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 • 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
Urgent Care Center	$50 Copayment	No Coverage

	Copayments and Coinsurance	
	Network Providers	**Non-Network Providers**
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 41:350 (February 2015), effective March 1, 2015.

§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 41:352 (February 2015), effective March 1, 2015.

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 41:352 (February 2015), effective March 1, 2015.

§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 41:352 (February 2015), effective March 1, 2015.

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 41:352 (February 2015), effective March 1, 2015.

§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 41:352 (February 2015), effective March 1, 2015.

§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 41:352 (February 2015), effective March 1, 2015.

§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 41:352 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:353 (February 2015), effective March 1, 2015.

§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 41:354 (February 2015), effective March 1, 2015.

§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 41:354 (February 2015), effective March 1, 2015.

§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 41:354 (February 2015), effective March 1, 2015.

§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 41:354 (February 2015), effective March 1, 2015.

§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 41:354 (February 2015), effective March 1, 2015.

§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 41:354 (February 2015), effective March 1, 2015.

§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 41:354 (February 2015), effective March 1, 2015.

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 41:354 (February 2015), effective March 1, 2015.

§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 41:354 (February 2015), effective March 1, 2015.

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 41:354 (February 2015), effective March 1, 2015.

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 41:354 (February 2015), effective March 1, 2015.

§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 41:354 (February 2015), effective March 1, 2015.

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 41:355 (February 2015), effective March 1, 2015.

§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 41:355 (February 2015), effective March 1, 2015.

§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 41:355 (February 2015), effective March 1, 2015.

§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 41:355 (February 2015), effective March 1, 2015.

§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 41:355 (February 2015), effective March 1, 2015.

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 41:355 (February 2015), effective March 1, 2015.

§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 41:355 (February 2015), effective March 1, 2015.

§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: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Allied Health/Other Professional Visits: • 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: • 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]
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]

	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**
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 • 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]
Oral Surgery for Impacted Teeth (*Authorization not required when performed in Physician's office*)	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. (*For a complete list of benefits, refer to the Preventive and Wellness Care Article in the Benefit Plan.*)	100% - 0%[3]	70% - 30%[1,3]	Network 100% - 0[3] Non-Network 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
Rehabilitation Services - Outpatient: • Speech • Physical/Occupational (*Limited to 50 Visits Combined PT/OT per Plan Year. Authorization required for visits over the Combined limit of 50.)* *(Visit limits do not apply when services are provided for Autism Spectrum Disorders)*	90% - 10%[1]	70% - 30%[1]	80% - 20%[1]
Skilled Nursing Facility (*limit 90 days per Plan Year*)	90% - 10%[1,2]	70% - 30%[1,2]	80% - 20%[1]
Sonograms and Ultrasounds (*Outpatient*)	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 (*low-tech imaging*)	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 41:356 (February 2015), effective March 1, 2015.

§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 41:358 (February 2015), effective March 1, 2015.

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 41:358 (February 2015), effective March 1, 2015.

§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 41:359 (February 2015), effective March 1, 2015.

§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: • General Practice • Family Practice • Internal Medicine • OB/GYN • Pediatrics	$25 Copayment per Visit	No Coverage
Allied Health/Other Professional Visits: • 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: • 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
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 • 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
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

	Copayments and Coinsurance	
	Network Providers	**Non-Network Providers**
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 perPlan 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
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 Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:359 (February 2015), effective March 1, 2015.

§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 41:360 (February 2015), effective March 1, 2015.

§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 41:360 (February 2015), effective March 1, 2015.

§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 41:361 (February 2015), effective March 1, 2015.

§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 41:361 (February 2015), effective March 1, 2015.

§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 41:361 (February 2015), effective March 1, 2015.

§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 41:361 (February 2015), effective March 1, 2015.

§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 41:361 (February 2015), effective March 1, 2015.

§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 41:361 (February 2015), effective March 1, 2015.

§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 41:361 (February 2015), effective March 1, 2015.

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 41:361 (February 2015), effective March 1, 2015.

§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 41:361 (February 2015), effective March 1, 2015.

§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: • 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]

	Coinsurance	
	Network Providers	**Non-Network Providers**
Specialist Office Visits including surgery performed in an office setting: • Physician • Podiatrist • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20%[1]	60% - 40%[1]
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[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: • 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 Office of the Governor, Division of Administration, Office of Group Benefits, LR 41:361 (February 2015), effective March 1, 2015.

§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 41:362 (February 2015), effective March 1, 2015.

§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 41:363 (February 2015), effective March 1, 2015.

§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 41:363 (February 2015), effective March 1, 2015.

§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 41:363 (February 2015), effective March 1, 2015.

§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 41:363 (February 2015), effective March 1, 2015.

§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 41:363 (February 2015), effective March 1, 2015.

§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 41:363 (February 2015), effective March 1, 2015.

§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 41:363 (February 2015), effective March 1, 2015.

§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 41:363 (February 2015), effective March 1, 2015.

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 41:363 (February 2015), effective March 1, 2015.

§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 41:364 (February 2015), effective March 1, 2015.

§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 • Optometrist • Midwife • Audiologist • Registered Dietician • Sleep Disorder Clinic	80% - 20%[1]	60% - 40%[1]
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]
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]

	Coinsurance	
	Network Providers	Non-Network Providers
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 41:364 (February 2015), effective March 1, 2015.

§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 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; 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 41:365 (February 2015), effective March 1, 2015.

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 41:365 (February 2015), effective March 1, 2015.

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 41:365 (February 2015), effective March 1, 2015.

§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 41:365 (February 2015), effective March 1, 2015.

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 41:365 (February 2015), effective March 1, 2015.

§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 41:365 (February 2015), effective March 1, 2015.

§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 41:365 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:366 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

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 41:367 (February 2015), effective March 1, 2015.

§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 41:367 (February 2015), effective March 1, 2015.

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 41:367 (February 2015), effective March 1, 2015.

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 41:368 (February 2015), effective March 1, 2015.

§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 41:368 (February 2015), effective March 1, 2015.

Susan T. West
Chief Executive Officer

1502#092

RULE

Office of the Governor
Real Estate Appraisers Board

Real Estate (LAC 46:LXVII.Chapters 103 and 104)

Under the authority of the Louisiana Real Estate Appraisers Law, R.S. 37:3397 et seq., and in accordance with the provisions of the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., the Louisiana Real Estate Appraisers Board has amended Chapters 103 and 104.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part LXVII. Real Estate
Subpart 2. Appraisers

Chapter 103. License Requirements

§10301. Examination

A. Applications for licensing shall be submitted on forms prescribed by the board and shall be accompanied by the prescribed fees in R.S. 37:3407.

B. - E. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1425 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1332 (June 2005), LR 37:332 (January 2011), LR 41:368 (February 2015).

§10303. Examination

A. Repealed.

B. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1425 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1332 (June 2005), LR 37:332 (January 2011), LR 41:368 (February 2015).

§10307. Education Requirements

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1425 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1333 (June 2005), LR 37:333 (January 2011), repealed LR 41:368 (February 2015).

§10308. Appraiser Trainees

A. - B. Repealed.

C. A certified residential or certified general real property appraiser may engage a licensed appraiser trainee to assist in the performance of real estate appraisals, provided the following criteria are met.

1. Repealed.

2. The certified residential or certified general real property appraiser shall supervise no more than three trainees at any one time, either as employees or subcontractors.

3. The certified residential or certified general real property appraiser shall be responsible for the conduct of the licensed appraiser trainees and shall supervise their work product, in accordance with the guidelines and requirements of the *2014-2015 Uniform Standards of Professional Appraisal Practice*.

a. For the purpose of this Chapter, to supervise implies that the certified residential or certified general real property appraiser will not sign or endorse an appraisal report that was not substantially produced by the licensed appraiser trainee. The term *substantial* shall mean that the licensed appraiser trainee contributed materially and in a verifiable manner to the research and/or analysis that led to the final opinion of value expressed in the appraisal report.

4. The supervising certified residential or certified general real property appraiser shall accompany the licensed appraiser trainee on inspections of the subject property until the certified residential or certified general real property appraiser feels the appraiser trainee is competent to do so.

5. Repealed.

6. The supervising certified residential or certified general real property appraiser shall sign every appraisal report prepared by a licensed appraiser trainee who acts under the supervision of the certified residential or certified general real property appraiser.

7. The supervising certified residential or certified general real property appraiser shall immediately notify the board and the licensed appraiser trainee in writing when the certified residential or certified general real property appraiser terminates the supervision of the licensed appraiser trainee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Office of the Governor, Real Estate Appraisers Board, LR 31:1333 (June 2005), amended LR 37:333 (January 2011), LR 41:368 (February 2015).

§10309. Application for Experience Credit

A. Applicants for a certified residential or certified general real property appraiser license shall satisfy the education and experience requirements prior to receiving an authorization for testing.

B. - C. Repealed.

D. Experience credit shall be approved by the board in accordance with *The Real Property Appraiser Qualification Criteria*, May 2013 prescribed by the Appraiser Qualifications Board of the Appraisal Foundation (AQB). Calculation of experience hours shall be based solely on actual hours of experience.

D.1. - E. Repealed.

F. Only those real property appraisals consistent with the *2014-2015 Uniform Standards of Professional Appraisal Practice*. (USPAP) will be accepted by the board for experience credit.

G. A peer review committee appointed by the board, as prescribed in R.S. 37:3395.1, shall serve in the following capacity.

1. Committee members shall serve at the discretion of the board and may be removed at any time, with or without cause, upon written notice from the board.

2. The initial term of each committee member shall be for a period of two years, which shall automatically extend for successive two year terms, until such time that the member resigns from the committee, is replaced by a new board appointee, or is removed by the board.

3. Committee members shall be certified residential or certified general real estate appraisers that have been licensed in good standing for a minimum of five years.

4. Committee members shall have completed the supervisory appraiser course, or its equivalent, as determined by the board.

5. Committee members may decline any request for direct mentoring without prejudice.

6. Duties of the peer review committee shall not require committee meetings or reports to the board, as each member shall operate independent of the other members; however, members shall be subject to oversight by the board and shall respond accordingly to any board inquiry.

7. Committee members shall be available to licensed trainees and certified appraisers via telephone or e-mail for direct mentoring, which may include one or more of the following:

a. examination of appraisals or other work samples;

b. feedback to mentored appraiser regarding examined work samples;

c. help with appraisal methodology; and

d. answering queries on specific appraisal assignments.

8. Committee members assigned to assist investigators shall provide the following assistance, as needed:

a. specific appraisal methodology insight;

b. uniform standards of professional appraisal practice insight;

c. benefit of competency and experience in appraisal practice; and

d. any other available assistance, as requested.

9. Committee members assigned to assist investigators shall remove themselves from any investigation where there may be an actual or perceived conflict of interest.

H. An applicant that is currently licensed and in good standing in a state approved by the Appraisal Subcommittee (ASC) of the Federal Financial Institutions Examination Council (FFEIC) shall be deemed to satisfy the experience requirements for the same level of licensure in Louisiana. The applicant shall provide appropriate documentation as required by the board.

AUTHORITY NOTE:Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1426 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1333 (June 2005), LR 37:333 (January 2011), LR 39:310 (February 2013), LR 41:368 (February 2015).

§10311. Residential Experience Points

A. A minimum of 2500 hours of appraisal experience in no fewer than 24 months is required. The maximum allowable credit that shall be applied toward the experience requirement in a 12 month period is 1250 hours.

1. When an appraisal report is signed by more than one person, credit for said assignment shall be claimed according to the number of actual hours worked by each person. For the purpose of granting credit, a person signing in the capacity of a review or supervisory appraiser is not considered as a co-signer on the report, provided that his or her role as such is clearly indicated in the report.

2. …

B. - E. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1426 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board of Certification, LR 29:126 (February 2003), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1334 (June 2005), LR 37:333 (January 2011), LR 41:369 (February 2015).

§10313. General Experience Points

A. A minimum of 3000 hours of appraisal experience in no fewer than 30 months is required. The maximum allowable credit that shall be applied toward the experience requirement in a 12 month period is 1000 hours.

1. When an appraisal report is signed by more than one trainee, credit for said assignment shall be claimed according to the number of actual hours worked by each person. For the purpose of granting credit, a person signing in the capacity of a review or supervisory appraiser is not considered as a co-signer on the report, provided that his or her role as such is clearly indicated in the report.

2. If the applicant for experience credit was unable to sign the report, but is mentioned in the certification as having provided significant professional assistance, a proportional amount of credit based on the number of contributors to the report can be requested. Credit will not be granted if professional assistance was not disclosed.

B. - D.15. Repealed.

E. - E.4 …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1427 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board of Certification, LR 29:126 (February 2003), amended by the Office of the Governor, Real Estate Appraisers Board, LR 31:1334 (June 2005), LR 37:333 (January 2011), LR 41:369 (February 2015).

Chapter 104. Education Providers/Course Approval

§10417. Distance Education Courses

A. Distance education courses may be used as qualifying education credit for obtaining a license or continuing education for license renewal, provided the courses and instructors are approved or certified by the Appraiser Qualifications Board of the Appraisal Foundation (AQB) or the International Distance Education Certification Center (IDECC).

B. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3395.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Real Estate Appraisers Board of Certification, LR 25:1427 (August 1999), amended by the Office of the Governor, Real Estate Appraisers Board, LR 41:370 (February 2015).

Bruce Unangst
Executive Director

1502#035

RULE

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, the Board of Elementary and Secondary Education has adopted revisions to *Bulletin 131—Alternative Education Schools/Programs Standards*: §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 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 41:370 (February 2015).

§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 41:370 (February 2015).

§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 41:370 (February 2015).

§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 41:371 (February 2015).

Shan N. Davis
Executive Director

1502#007

RULE

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, the Board of Elementary and Secondary Education has adopted 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 41:371 (February 2015).

Shan N. Davis
Executive Director

1502#008

RULE

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, the Board of Elementary and Secondary Education has adopted 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 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 41:371 (February 2015).

§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 41:372 (February 2015).

Shan N. Davis
Executive Director

1502#009

RULE

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, the Board of Elementary and Secondary Education has adopted 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 41:372 (February 2015).

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 on 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 41:372 (February 2015).

Shan N. Davis
Executive Director

1502#010

RULE

Student Financial Assistance Commission
Office of Student Financial Assistance

Scholarship/Grant Programs
TOPS Core Curriculum Equivalent
(LAC 28:IV.703)

The Louisiana Student Financial Assistance Commission (LASFAC) has amended its scholarship/grant rules (R.S. 17:3021-3025, R.S. 3041.10-3041.15, R.S. 17:3042.1, R.S. 17:3048.1, R.S. 17:3048.5 and R.S. 17:3048.6). (SG15156R)

Title 28
EDUCATION
Part IV. Student Financial Assistance—Higher Education Scholarship and Grant Programs
Chapter 7. Taylor Opportunity Program for Students (TOPS) Opportunity, Performance, and Honors Awards
§703. Establishing Eligibility

A. - A.5.a.ii.(c). …

* * *

(d).(i). For students graduating in academic year (high school) 2010-2011 through academic year (high school) 2016-17, for purposes of satisfying the requirements of §703.A.5.a.i above, or §803.A.6.a, the following courses shall be considered equivalent to the identified core courses and may be substituted to satisfy corresponding core courses.

Core Curriculum Course	Equivalent (Substitute) Course
Physical Science	Integrated Science
Algebra I	Algebra I, Parts 1 and 2, Integrated Mathematics I, Applied Algebra I
Applied Algebra IA and IB	Applied Mathematics I and II
Algebra I, Algebra II and Geometry	Integrated Mathematics I, II and III
Algebra II	Integrated Mathematics II
Geometry	Integrated Mathematics III, Applied Geometry
Geometry, Trigonometry, Calculus, or Comparable Advanced Mathematics	Pre-Calculus, Algebra III, Probability and Statistics, Discrete Mathematics, Applied Mathematics III*, Advanced Math - Pre-Calculus**, Advanced Math - Functions and Statistics***
Chemistry	Chemistry Com

Core Curriculum Course	Equivalent (Substitute) Course
Earth Science, Environmental Science, Physical Science, Biology II, Chemistry II, Physics, Physics II, or Physics for Technology or Agriscience I and II (both for 1 unit;	Anatomy and Physiology
Fine Arts Survey	Speech III and Speech IV (both units)
Western Civilization	European History
World Geography	AP Human Geography
Civics	AP American Government
*Applied Mathematics III was formerly referred to as Applied Geometry **Advanced Math—Pre-Calculus was formerly referred to as Advanced Mathematics II ***Advanced Math—Functions and Statistics was formerly referred to as Advanced Mathematics II	

(ii). For students graduating in academic year (high school) 2013-2014 only, for purposes of satisfying the requirements of §703.A.5.a.i above, or §803.A.6.a, in addition to the equivalent courses identified in §703.A.5.(a).ii.(d).(i) above, the following course shall be considered equivalent to the identified core courses and may be substituted to satisfy corresponding core courses.

Core Curriculum Course	Equivalent (Substitute) Course
World History, Western Civilization, World Geography or History of Religion	Law Studies

A.5.a.ii.(e). - A.5.a.iii.(b). …

* * *

iv. Beginning with academic year (high school) 2013-2014, for purposes of satisfying the requirements of §703.A.5.a.i above, in addition to the courses identified in §703.A.5.a.ii, the following courses shall be considered equivalent to the identified core courses and may be substituted to satisfy corresponding core courses for students of the New Orleans Center for Creative Arts.

Core Curriculum Course	Equivalent (Substitute) Course
English I	NOCCA Integrated English I
English II	NOCCA Integrated English II
English III	NOCCA Integrated English III
English IV	NOCCA Integrated English IV
Algebra I	NOCCA Integrated Mathematics I
Geometry	NOCCA Integrated Mathematics II
Algebra II	NOCCA Integrated Mathematics III
Advanced Math–Functions and Statistics	NOCCA Integrated Mathematics IV
Physical Science	NOCCA Integrated Science I
Biology	NOCCA Integrated Science II
Environmental Science	NOCCA Integrated Science III
Chemistry	NOCCA Integrated Science IV
World Geography	NOCCA Integrated History I
Civics	NOCCA Integrated History III
World History	NOCCA Integrated History II
U. S. History	NOCCA Integrated History IV

A.5.b. - J.4.b.ii. …

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

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:338 (May 1996), repromulgated LR 24:636 (April 1998), amended LR 24:1902 (October 1998), LR 24:2237 (December 1998), LR 25:257 (February 1999), LR 25:655 (April 1999), LR 25:1794 (October 1999), LR 26:64, 67 (January 2000), LR 26:689 (April 2000), LR 26:1262 (June 2000), LR 26:1602 (August 2000), LR 26:1996, 1999, 2001 (September 2000), LR 26:2268 (October 2000), LR 26:2753 (December 2000), LR 27:36 (January 2001), LR 27:702 (May 2001), LR 27:1219, 1219 (August 2001), repromulgated LR 27:1850 (November 2001), amended LR 28:772 (April 2002), LR 28:2330, 2332 (November 2002), LR 29:125 (February 2003), LR 29:2372 (November 2003), LR 30:1162 (June 2004), LR 30:1471 (July 2004), LR 30:2019 (September 2004), LR 31:37 (January 2005), LR 31:2213 (September 2005), LR 31:3112 (December 2005), LR 32:2239 (December 2006), LR 33:435 (March 2007), LR 33:2357 (November 2007), LR 33:2612 (December 2007), LR 34:1389 (July 2008), LR 35:228 (February 2009), LR 36:312 (February 2010), LR 36:490 (March 2010), LR 36:2269 (October 2010), LR 36:2855 (December 2010), LR 37:2987 (October 2011), LR 38:354 (February 2012), LR 38:3158 (December 2012), LR 39:481 (March 2013), LR 39:2485 (September 2013), LR 40:54 (January 2014), LR 41:373 (February 2015).

George Badge Eldredge
General Counsel

1502#087

RULE

Student Financial Assistance Commission
Office of Student Financial Assistance

Scholarship/Grant Programs
TOPS Tech Early Start Award
(LAC 28:IV.1001, 1003, 1005, 1007, 1009, 1011, 1013, 1015, 1017, and 1901)

The Louisiana Student Financial Assistance Commission (LASFAC) has amended its scholarship/grant rules (R.S. 17:3021-3025, R.S. 3041.10-3041.15, R.S. 17:3042.1, R.S. 17:3048.1, R.S. 17:3048.5 and R.S. 17:3048.6). (SG15154R)

Title 28
EDUCATION
Part IV. Student Financial Assistance—Higher Education Scholarship and Grant Programs
Chapter 10. TOPS-Tech Early Start Award
§1001. General Provisions

A. Legislative Authority. The TOPS-Tech Early Start Award was created by Act 348 of the 2005 Regular Session of the Louisiana Legislature and amended by Act 737 of the 2014 Regular Session of the Legislature.

B. Description, History and Purpose. The TOPS-Tech Early Start Award is established as part of the Taylor Opportunity Program for Students (TOPS) to provide grants for Louisiana residents taking a technical or applied course in pursuit of occupational or vocational training while being dually enrolled in a state public high school at the 11th and 12th grade levels and at a Louisiana public or nonpublic postsecondary institution or in an approved training program that offers an occupational or vocational education credential in a top demand occupation. The purpose of TOPS-Tech Early Start is to provide an incentive for qualified Louisiana public high school students to prepare for and pursue an industry-based occupational or vocational education credential in a top demand occupation while still in high school.

C. Effective Date. The TOPS-Tech Early Start Award shall be first awarded beginning with the 2005-2006 award year to 11th and 12th grade students meeting the eligibility criteria set forth in this Chapter.

D. Eligible Terms. The TOPS-Tech Early Start Award is limited to six credit hours per semester and 12 credit hours each academic year (college). TOPS-Tech Early Start is not payable for summer semesters or sessions.

E. Award Amount. The TOPS-Tech Early Start Award provides a payment not to exceed $300 for up to six credit hours each semester or $600 each academic year (college) at a rate of $50 per credit hour.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 31:3109 (December 2005), amended LR 35:231 (February 2009), LR 41:374 (February 2015).

§1003. Definitions

Approved Training Program—a program provided by an approved training provider of technical and/or applied courses toward a credential in a top demand occupation.

Approved Training Provider—a Louisiana provider recognized by the Louisiana Workforce Commission and approved by the state Board of Elementary and Secondary Education to provide technical and/or applied courses toward a credential in a top demand occupation.

Credential—industry-based certification, a certificate of applied science or a certificate of technical sciences approved by the Workforce Investment Council.

Top Demand Occupation—an occupation identified by the occupation forecasting conference as being in top demand in Louisiana and recognized by the state Industry-Based Certification Leadership Council.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 41:375 (February 2015).

§1005. Establishing Eligibility

A. To establish eligibility for the TOPS-Tech Early Start Award, the student applicant must meet all of the following criteria:

1. be in the 11th or 12th grade in a Louisiana public high school;

2. have prepared a five-year education and career plan, including a sequence of related courses with a career focus as provided by the high school career option subchapter in R.S. 17:183.2 et seq.;

3. have a cumulative high school grade point average on all courses attempted of not less than 2.0 when calculated on a 4.0 scale;

4. score at least 15 on the English subsection and 15 on the mathematics subsection of the ACT PLAN assessment administered as part of Louisiana's educational planning and assessment system;

5. enroll in a course in an industry-based occupational or vocational education credential program in a top demand occupation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 31:3110 (December 2005), amended LR 41:375 (February 2015).

§1007. Maintaining Eligibility

A. To continue receiving the TOPS-Tech Early Start Award, the recipient must meet all of the following criteria:

1. be a student in good standing in a Louisiana public high school; and

2. maintain a cumulative high school grade point average on all courses attempted of not less than 2.0 when calculated on a 4.0 scale; and

3. continue to pursue one or more courses leading to a credential in a top demand occupation; and

4. be a student in good standing while enrolled in a Louisiana public or nonpublic postsecondary education institution or an approved training program; and

5. maintain *steady academic progress* as defined in §301.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 31:3110 (December 2005), amended LR 41:375 (February 2015).

§1009. Responsibilities of LOSFA

A. Upon receipt of bills from institutions submitted in accordance with §1903.B, LOSFA will reimburse the institution for each eligible student in accordance with §1903.

B. LOSFA shall conduct audits of participating Louisiana public and nonpublic postsecondary institutions, approved training providers, and high schools to ensure compliance with program requirements.

C. LOSFA shall provide the information necessary to fully inform Louisiana public high school students and their parents on the requirements of and procedures for applying for and maintaining the award.

D. In the event that the funds appropriated for the TOPS-Tech Early Start Award are insufficient to pay all awards for all eligible students, LOSFA shall develop and submit to LASFAC a plan to limit the awards to the amount appropriated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 31:3110 (December 2005), amended LR 36:2029 (September 2010), LR 41:375 (February 2015).

§1011. Responsibilities of High Schools

A. The high school shall comply with the reporting requirements of §1703 for all students enrolled in high school.

B. The high school shall determine whether the student is eligible to participate in the TOPS-Tech Early Start program and approve or disapprove the student's participation in the program.

C. The high school's approval of a student's participation in the program by signing the student's application certifies that the student meets the eligibility criteria provided in §1005.A.1-5, and, if applicable, §1007.A.1 and 2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance,

LR 31:3110 (December 2005), amended LR 36:2029 (September 2010), LR 41:375 (February 2015).

§1013. Responsibilities of Louisiana Public and Nonpublic Postsecondary Institutions and Approved Training Providers

A. Each Louisiana public and nonpublic postsecondary institution and each approved training provider that offers an industry based occupational or vocational education credential in a top demand occupation shall:

1. determine whether an eligible student has applied for enrollment in a course at that institution or provider to pursue an industry based occupational or vocational education credential in a top demand occupation in accordance with §1903.D;

2. determine whether the student has met the requirements to maintain an award as required by §1007.A.3-5;

3. submit bills to LOSFA in accordance with §1903.B for each eligible student so enrolled; and

4. comply with the reporting and records retention requirements of §1903.A and F.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 31:3111 (December 2005), amended LR 36:2030 (September 2010), LR 41:376 (February 2015).

§1015. Responsibilities of the Workforce Investment Council

A. The Workforce Investment Council shall define, maintain, and make available to LOSFA and to public and nonpublic postsecondary institutions and to Louisiana training providers a list of industry based occupational or vocational education credentials.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 31:3111 (December 2005), amended LR 36:2030 (September 2010), LR 41:376 (February 2015).

§1017. Responsibilities of the State Board of Elementary and Secondary Education (BESE)

A. BESE shall determine which training providers are approved to provide courses each academic year for the TOPS-Tech Early Start Award in accordance with R.S. 17:3048.5(B)(4).

B. BESE shall notify LOSFA of the names and addresses for the approved training providers no later than March 1 for the fall of that year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1, R.S. 17:3048.1 and R.S. 17:3048.5.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 41:376 (February 2015).

Chapter 19. Eligibility and Responsibilities of Post-Secondary Institutions

§1901. Eligibility of Post-Secondary Institutions to Participate

A. Undergraduate degree granting schools which are components of Louisiana public university medical centers and two- and four-year public colleges and universities are authorized to participate in the Taylor Opportunity Program for Students (TOPS), TOPS-Tech, TOPS-Tech Early Start, Rockefeller State Wildlife Scholarship, and the GO-Youth ChalleNGe Program.

B. Regionally accredited private colleges and universities which are members of the Louisiana Association of Independent Colleges and Universities, Inc. (LAICU) are authorized to participate in TOPS (for both academic programs and programs for a vocational or technical education certificate or diploma or a non-academic undergraduate degree), TOPS-Tech, TOPS Tech Early Start Award, and the GO-Youth ChalleNGe Program. As of April 2000, LAICU membership included Centenary College, Dillard University, Louisiana College, Loyola University, New Orleans Theological Seminary, Our Lady of the Lake College, Our Lady of Holy Cross College, St. Joseph Seminary College, Tulane Medical Center, Tulane University and Xavier University.

C. Campuses of Louisiana Technical College are authorized to participate in TOPS, TOPS-Tech, TOPS-Tech Early Start, and the GO-Youth ChalleNGe Program.

D. Eligible Louisiana proprietary and cosmetology schools are authorized to participate in TOPS for all awards and TOPS Tech Early Start Awards.

E. Out-of-state colleges and universities may participate in TOPS if all the conditions of §703.I are met.

F. Approved training providers may participate in the TOPS Tech Early Start Award Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:3021-3036, R.S. 17:3042.1 and R.S. 17:3048.1 and R.S. 17:3050.1-3050.4.

HISTORICAL NOTE: Promulgated by the Student Financial Assistance Commission, Office of Student Financial Assistance, LR 22:338 (May 1996), repromulgated LR 24:645 (April 1998), amended LR 24:1914 (October 1998), LR 25:1459 (August 1999), LR 26:1998 (September 2000), repromulgated LR 27:1864 (November 2001), amended LR 28:448 (March 2002), LR 30:784 (April 2004), LR 31:3111, 3114 (December 2005), LR 35:235 (February 2009), LR 35:1490 (August 2009), LR 36:2857 (December 2010), LR 41:376 (February 2015).

George Badge Eldredge
General Counsel

1502#086

RULE

Department of Environmental Quality
Office of the Secretary
Legal Division

Minor Source Permit Requirements
(LAC 33:III.503 and 519)(AQ266)

Under the authority of the Environmental Quality Act, R.S. 30:2001 et seq., and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the secretary has amended the Air regulations, LAC 33:III.503 and 519 (AQ266).

This Rule establishes a regulatory framework setting forth maximum terms and renewal procedures for minor source permits. Per R.S. 30:2023(A), permits "shall have, as a matter of law, a term of not more than ten years"; however, Louisiana's air quality regulations (LAC 33:III) are currently silent with respect to the term of minor source permits. The

basis and rationale for this Rule are to establish a regulatory framework setting forth maximum terms and renewal procedures for minor source permits. 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 III. Air

Chapter 5. Permit Procedures

§503. Minor Source Permit Requirements

A. …

B. The following provisions may be utilized to meet the permitting requirements for minor sources.

1. Exemption. The owner or operator of a stationary source which is not a *part 70 source* as defined in LAC 33:III.502 may apply for an exemption provided the criteria in LAC 33:III.501.B.4 are met.

2. Small Source Permit. The owner or operator of a stationary source which is not a *part 70 source* may apply for a small source permit provided the source emits and has the potential to emit less than 25 tons per year of any criteria pollutant and 10 tons per year of any toxic air pollutant.

3. …

C. Permit Duration, Expiration, and Renewal

1. Permit Duration

a. Permits issued to a minor source shall have an effective term of ten years from the effective date of the permit, unless a shorter period is provided in the permit. Permits are effective on the date of issuance unless a later date is specified therein.

b. Any revision or reopening of the permit shall establish the start of a new permit term. An administrative amendment or approval to relocate a portable facility shall not establish the start of a new permit term.

2. Permit Expiration

a. Unless renewed in accordance with Paragraph C.3 of this Section, a minor source permit shall expire at the end of its effective term.

b. Permit expiration terminates the owner's or operator's right to operate the source.

3. Permit Renewal

a. Any permit application that renews an existing permit shall be submitted at least 6 months prior to the date of permit expiration. In no event shall the application for permit renewal be submitted more than 18 months before the date of permit expiration.

b. Notwithstanding Subparagraph C.3.a of this Section, the permit application to renew an existing permit that expires on or before December 31, 2015, shall be submitted in accordance with the schedule specified by the department and published in the *Louisiana Register* unless the existing permit provides that a renewal application shall be submitted by an earlier date. In no event shall an owner or operator be provided less than three months to prepare a renewal application.

c. Provided a timely and complete renewal application has been submitted, the terms and conditions of the existing permit shall remain in effect until such time as the department takes final action on the application for renewal.

d. Any permit being renewed shall be subject to the same procedural requirements that apply to initial permit issuance as found in LAC 33:III.519.

D. No permit shall be rendered invalid by Subsection C of this Section unless the owner or operator fails to submit a timely and complete renewal application in accordance with LAC 33:III.503.C.3.

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

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Nuclear Energy, Air Quality Division, LR 13:741 (December 1987), amended by the Office of Air Quality and Radiation Protection, Air Quality Division, LR 19:1420 (November 1993), amended by the Office of the Secretary, Legal Affairs Division, LR 37:1146 (April 2011), amended by the Office of the Secretary, Legal Division, LR 41:377 (February 2015).

§519. Permit Issuance Procedures for New Facilities, Initial Permits, Renewals and Significant Modifications

A. - C.3. …

4. Notwithstanding the 18-month allowance in Paragraph C.3 of this Section, final action shall be taken on any application relating to a *new facility* or to a *substantial permit modification*, as defined in LAC 33:I.Chapter 15, in accordance with the time frames specified in LAC 33:I.1505.

5. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:2022 and 2054.

HISTORICAL NOTE: Promulgated by the Department of Environmental Quality, Office of Air Quality and Radiation Protection, Air Quality Division, LR 19:1420 (November 1993), amended by the Office of Environmental Assessment, LR 30:2021 (September 2004), amended by the Office of the Secretary, Legal Division, LR 41:377 (February 2015).

Herman Robinson, CPM
Executive Counsel

1502#014

RULE

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 have amended 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 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 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 41:378 (February 2015).

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 41:378 (February 2015).

§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 41:378 (February 2015).

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 41:378 (February 2015).

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

1502#072

RULE

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 has amended 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 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 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 41:379 (February 2015).

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 41:379 (February 2015).

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 41:379 (February 2015).

Kathy H. Kliebert
Secretary

1502#073

RULE

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 have amended 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 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 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 41:379 (February 2015).

§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 41:381 (February 2015).

§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 41:382 (February 2015).

§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 5 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 41:382 (February 2015).

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

1502#074

RULE

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)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health have amended 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 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 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 41:384 (February 2015).

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 41:385 (February 2015).

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

1502#076

RULE

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 hereby repeals LAC 67:VII.1101-1129 and promulgates LAC 48:I.19101-19121 as authorized by R.S. 46.2116.2. This 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 Rule adopts 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 41:385 (February 2015).

§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 41:385 (February 2015).

§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 41:386 (February 2015).

§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 41:386 (February 2015).

§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 41:386 (February 2015).

§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 41:386 (February 2015).

§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 41:386 (February 2015).

§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 41:387 (February 2015).

§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 41:387 (February 2015).

§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 41:387 (February 2015).

§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 41:388 (February 2015).

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 41:388 (February 2015).

§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 41:388 (February 2015).

§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 41:388 (February 2015).

§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 41:388 (February 2015).

§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 41:388 (February 2015).

§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 41:389 (February 2015).

§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 41:389 (February 2015).

§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 41:389 (February 2015).

§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 41:389 (February 2015).

§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 41:389 (February 2015).

§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 41:389 (February 2015).

§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 41:389 (February 2015).

§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 41:389 (February 2015).

§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 41:389 (February 2015).

§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 41:389 (February 2015).

Tara LeBlanc
Interim Assistant Secretary

1502#018

RULE

Department of Health and Hospitals
Office of Public Health

Plumbing Fixtures and Water Supply and Distribution
(LAC 51:XIV.411 and 609)

Under the authority of R.S. 40:4 and 40:5, and in accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the state health officer, acting through the Department of Health and Hospitals, Office of Public Health (DHH, OPH), has amended Part XIV (Plumbing) of the Louisiana state *Sanitary Code* [LAC 51 (*Public Health—Sanitary Code*)]. This amendment provides an exception for certain small retail stores to have a drinking fountain installed and available for public use. This exception is only applicable to retail stores having 2,000 square feet or less of usable floor space.

When meeting certain specified criteria, the Rule provides a waiver to the normal requirement calling for the installation of a containment device backflow preventer for multiple residential dwelling units served by a master meter. This waiver is only applicable to multiple residential dwelling units when serving only two units and their water service or water distribution lines are connected together by a master water meter.

Additionally, the Rule corrects several typographical errors contained in the 2013 publication of LAC 51:XIV (Plumbing). The first involves a single word typographical omission on earlier versions of Table 411 relative to the calculation of the number of lavatories when over 750 persons are served in assembly type occupancies. The second correction involves referencing metal plating plants (instead of meat plating plants) in Table 609.F.5.

Title 51
PUBLIC HEALTH—SANITARY CODE
Part XIV. Plumbing

Chapter 4. Plumbing Fixtures

§411. Minimum Plumbing Fixtures

A. - A.10. …

Table 411
Minimum Plumbing Fixtures
[The figures shown are based upon one fixture being the minimum required for the number of persons indicated or any fraction thereof, i.e., if the calculation yields any fraction (no matter how small), the next whole number greater than the fractional number is the minimum fixture requirement]

Building or Occupancy[1]	Occupant Content[1]	Water Closets (Urinals can be substituted for up to half of the required water closets)			Lavatories[2]			Bathtubs, Showers and Miscellaneous fixtures
Dwelling or Apt. House	Not Applicable	1 for each dwelling or dwelling unit			1 for each dwelling or dwelling unit			Washing machine connection per unit[3]. Bathtub or shower – one per dwelling or dwelling unit. Kitchen sink – one per dwelling or dwelling unit
Schools: Licensed Pre-School, Day Care or Nursery[21]	Maximum Daily Attendance	Children (total)		Fixtures	To be provided in the same proportions as the number of water closets required			Kitchen: Children (total) 7-15: 3 compartment sink (or approved domestic or commercial dishwashing machine and a 2 compartment sink)[12] 16 - up: 3 compartment sink (dishwashing machine, if provided, must be a commercial type)[12] One laundry tray, service sink, or curbed cleaning facility with floor drain on premises for cleaning of mops/mop water disposal. Caring for Infants: One extra laundry tray, service sink, or similar fixture is required to clean and sanitize toilet training potties immediately after each use. Such fixture shall be dedicate solely for this purpose and shall not be in the food preparation/storage, utensil washing, or dining areas.
		Age 0-4 years			Kitchen:			
		1-20		1				
		21-40		2	1 in each food preparation and utensil washing area located to permit convenient use by all food and utensil handlers.			
		41-80		3				
		For each additional 40 children over 80, add		1	Caring for Infants: 1 in or adjacent to each diaper changing area but never to be located in a food preparation/storage or utensil washing area.			
		Age 5 years and above	Male	Female				
		1-40	1	1				
		41-80	1	2				
		81-120	2	3				
		121-160	2	4				
		For each additional 40 females over 160, add		1				
		For each additional 80 males over 160, add	1					
Schools: Elementary and Secondary	Maximum Daily Attendance	Persons (total)	Male	Female	Persons (total)	Male	Female	One drinking fountain for each 3 classrooms, but not less than one each floor
		1-50	2	2	1-120	1	1	
		51-100	3	3	121-240	2	2	
		101-150	4	4	For each additional 120 persons over 240, add	1	1	
		151-200	5	5				
		For each additional 50 persons over 200, add	1	1				

Table 411
Minimum Plumbing Fixtures
[The figures shown are based upon one fixture being the minimum required for the number of persons indicated or any fraction thereof, i.e., if the calculation yields any fraction (no matter how small), the next whole number greater than the fractional number is the minimum fixture requirement]

Building or Occupancy[1]	Occupant Content[1]	Water Closets (Urinals can be substituted for up to half of the required water closets)			Lavatories[2]			Bathtubs, Showers and Miscellaneous fixtures	
								Drinking Fountains	
Office[4] and Public Buildings	100 sq ft per person	Persons (total)	Male	Female	Persons (total)	Male	Female	Persons	Fixtures
(Applies to educational occupancies above the 12th grade$_{(L)}$)		1-15	1	1	1-15	1	1	1-100	1
		16-35	1	2	16-35	1	2	101-250	2
		36-55	2	2	36-60	2	2	251-500	3
		56-100	2	3	61-125	2	3	No less than one fixture each floor subject to access.	
		101-150	3	4	For each additional 120 persons over 125, add	1	1.5		
		For each additional 100 persons over 150, add	1	1.5					
								Drinking Fountains	
Common toilet facilities for areas of commercial buildings of multiple tenants[5,6,20]	Use the sq ft per person ratio applicable to the single type occupancy(s) occupying the greatest aggregate floor area (Consider separately each floor area of a divided floor)	Persons (total)	Male	Female	Persons (total)	Male	Female	Persons	Fixtures
(Not applicable to do-it-yourself laundries, beauty shops and similar occupancies where persons must remain to receive personal services)		1-50	2	2	1-15	1	1	1-100	1
		51-100	3	3	16-35	1	2	101-250	2
		101-150	4	4	36-60	2	2	251-500	3
		For each additional 100 persons over 150, add	1	1.5	61-125	2	3	501-1000	4
					For each additional 120 persons over 125, add	1	1.5	Not less than one fixture each floor subject to access.	
								Drinking Fountains[18]	
Retail Stores [4,14,16, 18]	200 sq ft per person	Persons (total)	Male	Female	Persons (total)	Male	Female	Persons	Fixtures
		1-35	1	1	1-35	1	1	1-100	1
		36-55	1	2	36-55	1	2	101-250	2
		56-80	2	3	56-80	2	3	251-500	3
		81-100	2	4	81-100	2	4	501-1000	4
		101-150	2	5	101-150	2	5		
		For each additional 200 persons over 150, add	1	1.75	For each additional 200 persons over 150, add	1	1.75	Not less than one fixture each floor subject to access.	
					Retail Food Markets that also processes or packages meat or other food items: 1 lavatory in each food processing, packaging, and utensil washing area located to permit convenient use by all food and utensil handlers.			All Retail Food Markets: One laundry tray, service sink, or curbed cleaning facility with floor drain on premises for cleaning of mops/mop water disposal. Retail Food Markets that also processes or packages meat or other food items: 3 compartment sink[12]	
								Drinking Fountains[17]	
Restaurants/Food Service Establishments[4,11, 16, 17]	30 sq ft per person	Persons (total)	Male	Female	Persons (total)	Male	Female	Persons	Fixtures
(If alcoholic beverages are to be served, facilities shall be as required for clubs or lounges- See LAC 51:XXIII.3119.B.		1-50	1	1	1-150	1	1	1-100	1
		51-100	2	2	151-200	2	2	101-250	2
		101-200	3	3	201-400	3	3	251-500	3
		201-300	4	4	For each additional 200 persons over 400, add	1	1	Kitchen: 3 compartment sink (dishwashing machine, if provided, must be a commercial type)[12]	
		For each additional 200 persons over 300, add	1	2	Kitchen:			Other Fixtures:	

Table 411
Minimum Plumbing Fixtures
[The figures shown are based upon one fixture being the minimum required for the number of persons indicated or any fraction thereof, i.e., if the calculation yields any fraction (no matter how small), the next whole number greater than the fractional number is the minimum fixture requirement]

Building or Occupancy[1]	Occupant Content[1]	Water Closets (Urinals can be substituted for up to half of the required water closets)			Lavatories[2]			Bathtubs, Showers and Miscellaneous fixtures	
2 for further details)					1 lavatory in each food preparation and utensil washing area located to permit convenient use by all food and utensil handlers.			One laundry tray, service sink, or curbed cleaning facility with floor drain on premises for cleaning of mops/mop water disposal.	
Clubs, Lounges, and Restaurants/ Food Service Establishments with Club, or Lounge[11,16, 17]	30 sq ft per person	Persons (total)	Male	Female	Persons (total)	Male	Female	Drinking Fountains[17] Persons	Fixtures
		1-25	1	1	1-150	1	1	1-100	1
		26-50	2	2	151-200	2	2	101-250	2
		51-100	3	3	201-400	3	3	251-500	3
		101-300	4	4				501-1000	4
		For each additional 200 persons over 300, add	1	2	For each additional 200 persons over 400, add	1	1	Bar: 3 compartment sink (dishwashing machine, if provided, must be a commercial type)[12]	
					Bar: 1 lavatory in each drink preparation area and utensil washing area located to permit convenient use by all drink and utensil handlers.			Other Fixtures: One laundry tray, service sink, or curbed cleaning facility with floor drain on premises for cleaning of mops/mop water disposal.	
Do it yourself Laundries[4]	50 sq ft per person	Persons (total)	Male	Female	Persons (total)	Male	Female	One drinking fountain and one service sink.	
		1-50	1	1	1-100	1	1		
		51-100	1	2	101-200	2	2		
Beauty Shops, Barber shops, nail Salons, and Tanning Facilities[4]	50 sq ft per person	Persons (total)	Male	Female	Persons (total)	Male	Female	One drinking fountain and one service sink or other utility sink.	
		1-35	1	1	1-75	1	1		
		36-75	1	2					
Heavy manufacturing[7], warehouses[8], foundries, and similar establishments[9,10]	Occupant content per shift, substantiated by owner. Also see §411.B.2 of this code	Persons (total)	Male	Female	Persons (total)	Male	Female	One drinking fountain for each 75 persons. One shower for each 15 persons exposed to excessive heat or to skin contamination with poisonous, infectious, or irritating material.	
		1-10	1	1	1-15	1	1		
		11-25	2	1	16-35	2	1		
		26-50	3	1	36-60	3	1		
		51-75	4	1	61-90	4	1		
		76-100	5	1	91-125	5	1		
		For each additional 60 persons over 100, add	1	0.1	For each additional 100 persons over 125, add	1	0.1		
					Where there is exposure to skin contamination with poisonous, infectious, or irritating materials, provide 1 lavatory for each 15 persons.				
Light manufacturing[7], Light Warehousing[8], and workshops, etc.[9,10]	Occupant content per shift, substantiated by owner. Also see §411.B.2 of this code	Persons (total)	Male	Female	Persons (total)	Male	Female	One drinking fountain for each 75 persons. One shower for each 15 persons exposed to excessive heat or to skin contamination with poisonous, infectious, or irritating material.	
		1-25	1	1	1-35	1	1		
		26-75	2	2	36-100	2	2		
		76-100	3	3	101-200	3	3		
		For each additional 60 persons over 100, add	1	1	For each additional 100 persons over 200, add	1	1		
					Where there is exposure to skin contamination with poisonous, infectious, or irritating materials, provide 1 lavatory for each 15 persons				

Table 411
Minimum Plumbing Fixtures
[The figures shown are based upon one fixture being the minimum required for the number of persons indicated or any fraction thereof, i.e., if the calculation yields any fraction (no matter how small), the next whole number greater than the fractional number is the minimum fixture requirement]

Building or Occupancy[1]	Occupant Content[1]	Water Closets (Urinals can be substituted for up to half of the required water closets)			Lavatories[2]			Bathtubs, Showers and Miscellaneous fixtures	
Dormitories (For exclusively male or female dorms, the fixtures provided shall be double the amount required for the particular gender in a co-ed dorm)	50 sq ft per person (calculated on sleeping area only)	Persons (total)	Male	Female	Persons (total)	Male	Female	One drinking fountain for each 75 persons. One shower or bathtub for each 8 persons, over 150 persons add 1 shower or bathtub for each additional 20 persons. One laundry tray or washing machine for each 50 persons. Service sinks, 1 for each 100 persons.	
		1-10	1	1	1-12	1	1		
		11-30	1	2	13-20	2	2		
		31-100	3	4					
		For each additional 50 persons over 100, add	1	1	For each additional 30 persons over 20, add	1	1		
Places of Public Assembly without seats and Waiting Rooms at Transportation Terminals and Stations	70 sq ft per person (calculated from assembly area.) Other areas considered separately (see Office or Public Buildings).	Persons (total)	Male	Female	Persons (total)	Male	Female	Drinking Fountains Persons	Drinking Fountains Fixtures
		1-50	2	2	1-200	1	1	1-100	1
		51-100	3	3	201-400	2	2	101-350	2
		101-200	4	4	401-750	3	3		
		201-400	5	5				Over 350 add one fixture for each 400.	
		For each additional 250 persons over 400, add	1	2	Over 750 persons, lavatories for each sex shall be required at a number equal to not less than 1/2 of total of required male water closets and urinals.				
Theaters, Auditoriums, Stadiums[15], Arenas[15], and Gymnasiums	Use the number of seats as basis (For pew or bench type seating, each 18 inches of pew or bench shall equate to one person)	Persons (total)	Male	Female	Persons (total)	Male	Female	Drinking Fountains Persons	Drinking Fountains Fixtures
		1-50	2	2	1-200	1	1	1-100	1
		51-100	3	3	201-400	2	2	101-350	2
		101-200	4	4	401-750	3	3		
		201-400	5	5				Over 350 add one fixture for each 400.	
		For each additional 250 persons over 400, add	1	2	Over 750 persons, lavatories for each sex shall be required at a number equal to not less than 1/2 of total of required male water closets and urinals.				
Churches, Mosques, Synagogues, Temples, and other places of Worship	Use the number of seats as basis (For pew or bench type seating, each 18 inches of pew or bench shall equate to one person)	Persons (total)	Male	Female	Persons (total)	Male	Female	Drinking Fountains Persons	Drinking Fountains Fixtures
		1-70	1	1	1-200	1	1	1-100	1
		71-150	2	2	201-400	2	2	101-350	2
		151-500	3	3	401-750	3	3		
		For each additional 500 persons over 500, add	1	1	Over 750 persons, lavatories for each sex shall be required at a number equal to not less than 1/2 of total of required male water closets and urinals.			Over 350 add one fixture for each 400.	
Retail Fuel Stations (Along an Interstate highway when the station property is located within ½ mile of the nearest toe[19] of the exit/entrance ramp)[16]	Use the number of Fueling Points[13] as the basis	Fueling Points	Male	Female	Fueling Points	Male	Female	Drinking Fountains Fueling Points	Drinking Fountains Fixtures
		1-8	1	1	1-12	1	1	1-12	1
		9-12	2	2	13 or more	1	2	13 or more	2
		13 or more	2	3					
Retail Fuel Stations not meeting above criteria[16]	Use the number of Fueling Points[13] as the initial basis	Fueling Points	Male	Female	Fueling Points	Male	Female	Drinking Fountains Fueling Points	Drinking Fountains Fixtures
		1 or more	1	1	1 or more	1	1	1 or more	1

Table 411 Minimum Plumbing Fixtures [The figures shown are based upon one fixture being the minimum required for the number of persons indicated or any fraction thereof, i.e., if the calculation yields any fraction (no matter how small), the next whole number greater than the fractional number is the minimum fixture requirement]				
Building or Occupancy[1]	**Occupant Content[1]**	**Water Closets (Urinals can be substituted for up to half of the required water closets)**	**Lavatories[2]**	**Bathtubs, Showers and Miscellaneous fixtures**
Other Miscellaneous Buildings or Occupancies[22]				

NOTES:

1. - 17. …

18. Drinking fountains shall not be required in retail stores with 2,000 square feet or less of usable floor space.

19. "Toe" is defined as the point where the Interstate highway's exit/entrance ramp meets the intersecting highway. See §203 of this Code—Toe definition.

20. Central facilities shall be installed such that the path of travel to such facilities shall not exceed a distance of 500 feet. The maximum travel distance to the central toilet facilities shall be measured from the main entrance of any store or tenant space. See §411.A.5 of this Code.

21. For pre-school children, between the ages of 0-4, fixtures shall be size appropriate for the age of the children being cared for (toilets 11 inches maximum height and lavatories 22 inches maximum height), or if standard size fixtures are used, safe, cleanable step aids shall be provided. See LAC 51:XXI.105.C.5.a.

22. Refer to the following Parts of the Louisiana State Sanitary Code (LAC 51) for specific information relative to the number of plumbing fixtures required for these other miscellaneous buildings or occupancies:

Building or Occupancy	Louisiana State Sanitary Code (LAC 51)
Wholesale Seafood Plants (Marine and Freshwater)	Part IX
Campsites	Part XVI
Jails, Prisons and Other Institutions of Detention or Incarceration (See §415.L.4 of this code)	Part XVIII
Hospitals, Ambulatory Surgical Centers, Renal Dialysis Centers	Part XIX
Nursing Homes	Part XX
Temporary Food Service (Festivals or Fairs)	Part XXIII, Chapter 47
Swimming Pools	Part XXIV
Mass Gathering Areas	Part XXV

B. - C. …

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 38:2816 (November 2012), repromulgated LR 39:511 (March 2013), amended LR 41:390 (February 2015).

Chapter 6. Water Supply and Distribution

§609. Protection of Potable Water Supply

A. - F.5.a. ...

Table 609.F.5 (Containment)
Air Gap
* * *

Table 609.F.5 (Containment)
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

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 41:394 (February 2015).

Jimmy Guidry, M.D.
State Health Officer
and
Kathy H. Kliebert
Secretary

1502#032

RULE

Department of Public Safety and Corrections
Liquefied Petroleum Gas Commission

Classes of Permits (LAC 55:IX.113)

The Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, in accordance with R.S. 40:1846 and with the Administrative Procedure Act., R.S. 49:950 et seq., hereby amends Section 113, "Classes of Permits and Regulations". This text has been amended to repeal the prohibition against a dealer holding a class VI and a class VI-X permit at the same location.

Title 55
PUBLIC SAFETY
Part IX. Liquefied Petroleum Gas
Chapter 1. General Requirements
Subchapter A. New Dealers
§113. Classes of Permits and Registrations

A. The commission shall issue upon application the following classes of permits and registrations upon meeting all applicable requirements of §107 and the following:

1. - 7.a.…

b. Any current class VI permit holder may convert to a class VI-X permit by filing formal application with the commission and submitting a $25 filing fee. Presence of the applicant at the commission meeting will be waived. Upon receipt of the application and filing fee, permit shall be issued.

7.c. - 13.c. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Adopted by the Department of Public Safety, Liquefied Petroleum Gas Commission, November 1972, amended December 1974, amended and promulgated LR 3:315 (July 1977), amended LR 7:633 (December 1981), LR 8:53 (January 1982), amended by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 11:557 (May 1985), LR 12:841 (December 1986), LR 15:855 (October 1989), LR 16:1063 (December 1990), LR 19:904 (July 1993), LR 20:1400 (December 1994), LR 21:701 (July 1995), LR 24:461 (March 1998), LR 25:2411 (December 1999), LR 29:2509 (November 2003), LR 33:1141 (June 2007), effective July 1, 2007, LR 38:1259 (May 2012), LR 41:395 (February 2015).

Jill Boudreaux
Undersecretary

1502#089

RULE

Department of Public Safety and Corrections
Liquefied Petroleum Gas Commission

Liquefied Petroleum Gas
(LAC 55:IX.107, 159, 163, 166,
201, 203, 205, 1507 and 1543)

The Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, in accordance with R.S. 40:1846 and with the Administrative Procedure Act., R.S. 49:950 et seq., hereby amends: §107 to adjust the permit fees for LP Gas permit applicants; §159 to remove requirements for school buses and mass transit vehicles which are now addressed elsewhere; §163 to align requirements for automatic dispensers of liquefied petroleum gas with the recent statutory changes; §166 to outline registration and inspection requirements for delivery trucks of liquefied petroleum gas; §201 to specify registration and inspection requirements for school buses and mass transit vehicles; §203 to delete its provisions now provided elsewhere; §205 to correct the NFPA edition citation; §1507 to specify registration requirements for transporters of anhydrous ammonia; and §1543 to also specify registration and inspection requirements for transporters of anhydrous ammonia.

Title 55
PUBLIC SAFETY
Part IX. Liquefied Petroleum Gas
Chapter 1. General Requirements
Subchapter A. New Dealers
§107. Requirements

A. - A.4.b. …

5.a. Where applicable, applicant shall provide adequate transport and/or delivery trucks satisfactory to the commission. Each transport and/or delivery truck shall be registered in accordance with commission rules and regulations, LAC 55:IX.166.

b. - c. …

6. Applicants shall have paid a permit fee in the amount of $75, except for class VII-E, which shall be $100, and R-1, R-2 registrations, which shall be $37.50 and class VI-X shall be in the amount of $75 for the first location, plus $50 for each 2-11 locations, plus $25 for each 12-infinity locations. For fiscal year 2013-2014, the permit fee shall be 0.1304 of 1 percent of annual gross sales of liquefied petroleum gas with a minimum of $75, except in the case of class VI-X for which the minimum permit fee shall be $75 for the first location, plus $50 for each 2-11 locations, plus $25 for each 12-infinity locations; or 0.1304 of 1 percent of annual gross sales of liquefied petroleum gases of all locations whichever is greater. For fiscal year 2014-2015, and for each subsequent fiscal year, the permit fee shall be 0.1369 of 1 percent of annual gross sales of liquefied petroleum gas with a minimum of $75, except in the case of class VI-X for which the minimum permit fee shall be $75 for the first location, plus $50 for each 2-11 locations, plus $25 for each 12-infinity locations; or 0.1369 of 1 percent of annual gross sales of liquefied petroleum gases of all locations whichever is greater. For classes not selling liquefied petroleum gases in succeeding years the permit fee shall be $75, except registrations shall be $37.50 per year.

6.a. - 15. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Adopted by the Department of Public Safety, Liquefied Petroleum Gas Commission, November 1972, amended December 1974, LR 1:315 (July 1975), LR 4:86 (March 1978), LR 7:633 (December 1981), amended by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 11:557 (May 1985), LR 15:854 (October 1989), LR 16:1063 (December 1990), LR 20:1400 (December 1994), LR 24:461 (March 1998), LR 24:2311 (December 1998), LR 25:1262 (July 1999), LR 25:2410 (December 1999), LR 26:1487 (July 2000), LR 27:2256 (December 2001), LR 28:2553 (December 2002), LR 29:2509 (November 2003), LR 31:2567 (October 2005), LR 33:1140 (June 2007), effective July 1, 2007, LR 35:2201 (October 2009), LR 35:2465 (November 2009), LR 38:1256 (May 2012), LR 41:395 (February 2015).

Subchapter D. Forms and Reports
§159. Required Forms and Reports

A. - A.2. …

a. Repealed.

2.b. - 7. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Adopted by the Department of Public Safety, Liquefied Petroleum Gas Commission, November 1972, amended December 1974, amended by the Department of Public

Safety and Corrections, Liquefied Petroleum Gas Commission, LR 11:559 (May 1985), LR 15:861 (October 1989), LR 24:466 (March 1998), LR 38:1265 (May 2012), LR 41:395 (February 2015).

Subchapter E. Automatic Dispensers Used for Motor Fuel

§163. Automatic Dispensers Used for Motor Fuel

A. All self-service automatic dispensing stations shall obtain a class VI permit with the LP Gas Commission before engaging in business.

B. The filling of ICC or DOT cylinders at a self-service site is prohibited.

C. Step-by-step operating instructions and fire emergency telephone numbers shall be posted in a conspicuous place in the immediate vicinity of the automatic dispenser.

D. All dispenser meters shall be calibrated at least once every two years. Calibration reports shall be retained by the dealer for at least three years. The commission reserves the right to review the calibration reports upon demand.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 20:1402 (December 1994), amended LR 24:467 (March 1998), LR 38:1265 (May 2012), LR 41:396 (February 2015).

Subchapter F. Tank Trucks, Semi-Trailers and Trailers

§166. Truck/Delivery Truck Cargo Containers Compliance Requirements

A. Registration. Dealers that operate transport and/or delivery trucks in the state of Louisiana shall register each unit with the commission annually, the annual registration fee is $50 for each unit registered. The annual registration period and procedure will be established by the Office of the Director of the commission. Any transport and/or delivery truck operating over the highways of the state of Louisiana with no registration decal or an expired registration decal affixed to the unit will be considered in violation of commission regulations and subject to penalties, this includes any unit operating beyond the established registration period without a current registration affixed to the unit. It is unlawful to load or unload any cargo unit not meeting commission regulations.

B. Safety Inspections. It is incumbent upon dealers and drivers to insure that all transports and/or delivery trucks being operated over the highways of Louisiana meet all federal and state requirements. The commission reserves the right to inspect any transport and/or delivery truck being registered at any time. Inspections may be performed by commission inspectors or a qualified agency acceptable to the commission. Dealer safety inspections performed by a commission inspector outside the state of Louisiana shall be solely at the discretion and procedures established by the Office of the Director.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 24:467 (March 1998), amended LR 25:2412 (December 1999), LR 27:2256 (December 2001), LR 38:1266 (May 2012), LR 41:396 (February 2015).

Chapter 2. School Bus and Mass Transit Installations [Formerly Chapter 12]

§201. Registration/Inspection of School Bus/Mass Transit Vehicles

A. Prior to placing in service any school bus or mass transit vehicle installed with a liquefied petroleum gas system used as a motor fuel system, the owner shall register the unit with the Office of the Director or the LP Gas Commission. The Office of the Director shall establish a procedure to register, perform inspections, and affix decals on these vehicles on a periodic basis.

B. It shall be a violation of commission regulations for an owner to operate any school bus/mass transit vehicle which is propelled by liquefied petroleum gas, to which a current registration decal is not permanently affixed.

C. A liquefied petroleum gas dealer or owner shall not fuel any school bus/mass transit vehicle which is propelled by liquefied petroleum gas to which a current registration decal is not permanently affixed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 18:866 (August 1992), amended LR 24:471 (March 1998), LR 26:1488 (July 2000), LR 38:1271 (May 2012), LR 41:396 (February 2015).

§203. Inspections

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 24:471 (March 1998), amended LR 26:1488 (July 2000), LR 38:1271 (May 2012), repealed LR 41:396 (February 2015).

§205. Installation of Liquefied Petroleum Gas Systems Used as Engine Fuel System for School Bus/Mass Transit Vehicles

A. Installation of a liquefied petroleum gas system used as an engine fuel system for school bus/mass transit vehicles shall be in accordance with the applicable sections of Chapter 11 of the NFPA 58 of the 2008 edition that the commission has adopted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1846.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 18:866 (August 1992), amended LR 26:1488 (July 2000), LR 38:1271 (May 2012), LR 41:396 (February 2015).

Chapter 15. Sale, Storage, Transportation and Handling of Anhydrous Ammonia

Subchapter A. New Dealers

§1507. Requirements

A. - A.4.a. …

5. Where applicable, the applicant shall provide adequate transport and/or delivery trucks satisfactory to the commission. Each transport and/or delivery truck shall be registered in accordance with commission rules and regulations, LAC 55:XI.1543.

6. - 12. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1354. Effective August 15, 2010, Act 579 of the 2010 Regular

Session repealed R.S. 3:1354 and enacted R.S. 40:1911 et seq., and particularly R.S. 40:1914 as authority for anhydrous ammonia regulations.

HISTORICAL NOTE: Adopted by the Department of Agriculture, Anhydrous Ammonia Commission (January 1967), amended by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 19:898 (July 1993), LR 25:2413 (December 1999), amended LR 27:423 (March 2001), repromulgated LR 27:565 (April 2001), amended LR 33:1144 (June 2007), effective July 1, 2007, LR 38:1273 (May 2012), LR 41:396 (February 2015).

Subchapter B. Dealers

§1543. Transport/Delivery Truck Cargo Compliance

A. Registration. Dealers that operate transport and/or delivery trucks in the state of Louisiana shall register each unit with the commission annually, the annual registration fee is $50 for each unit registered. The annual registration period and procedure will be established by the Office of the Director of the commission. Any transport and/or delivery truck operating over the highways of the state of Louisiana with no registration decal or an expired registration decal affixed to the unit will be considered in violation of commission regulations and subject to penalties, this includes any unit operating beyond the established registration period without a current decal affixed to the unit. It is unlawful to load or unload any cargo unit not meeting commission regulations.

B. Safety Inspections. It is incumbent upon dealers and drivers to insure that all transport and/or delivery trucks being operated over the highways of Louisiana meet all federal and state regulations. The commission reserves the right to inspect any transport and/or delivery truck being registered at any time. Inspections may be performed by commission inspectors or a qualified agency acceptable to the commission. Dealer safety inspections performed by a commission inspector outside the State of Louisiana shall be solely at the discretion and procedures established by the Office of the Director.

AUTHORITY NOTE: Promulgated in accordance with R.S. 3:1354. Effective August 15, 2010, Act 579 of the 2010 Regular Session repealed R.S. 3:1354 and enacted R.S. 40:1911 et seq., and particularly R.S. 40:1914 as authority for anhydrous ammonia regulations.

HISTORICAL NOTE: Adopted by the Department of Agriculture, Anhydrous Ammonia Commission (January 1967), amended by the Department of Public Safety and Corrections, Liquefied Petroleum Gas Commission, LR 19:903 (July 1993), LR 25:2414 (December 1999), LR 38:1278 (May 2012), LR 41:397 (February 2015).

Jill P. Boudreaux
Undersecretary

1502#090

RULE

Department of Treasury
Board of Trustees of the Teachers' Retirement System of Louisiana

Defined Benefit Plan (LAC 58:III.Chapter 17)

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 adopted of LAC 58:III.1701 through 1709 in order to provide certain *Internal Revenue Code* provisions governing qualified governmental retirement plans.

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 41:397 (February 2015).

§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 41:397 (February 2015).

§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 41:397 (February 2015).

§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 41:398 (February 2015).

§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 41:400 (February 2015).

Maureen H. Westgard
Director

1502#033

RULE

Department of the Treasury
Louisiana Housing Corporation

Workforce Housing Initiative Program
(LAC 16:II.Chapter 9)

Under the authority of R.S. 40:600.91(A)(3), and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Louisiana Housing Corporation hereby adopts the Workforce Housing Initiative Program. The program will allow the Louisiana Housing Corporation to assist potential homebuyers that have a demonstrated good credit history, and sound historical savings practices but with inconsistent or unverifiable income to qualify for a fixed rate mortgage loan.

Title 16
COMMUNITY AFFAIRS
Part II. Housing Programs
Chapter 9. Workforce Housing Initiative

§901. Introduction

A.1. The Workforce Housing Initiative Program is designed to provide citizens of the state of Louisiana that have:

a. a demonstrated good credit history with a minimum credit score of at least 660;

b. accumulation of borrower's own funds for a substantial down payment. There is a minimum down payment requirement of 20 percent of the purchase price. Borrower must also have minimum of 2 months principal, interest, taxes and insurance in reserve after paying down payment, pre-paids and closing costs. No gift funds allowed;

c. consistent employment history of at least 2 years in current profession; and

d. stated income at a level that is typical of the borrower's profession;

2. to purchase a home for primary residence occupancy utilizing the Workforce Housing Initiative Program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.600.86 et seq.

HISTORICAL NOTE: Promulgated by the Department of Treasury, Louisiana Housing Corporation, LR 41:401 (February 2015).

§903. Definitions

A. Notwithstanding the definitions set forth in the LAC 16:I.301, the following terms, when used in this Chapter, are defined as follows.

Annual Family Income—stated annual income as reported by the borrower, not to exceed those incomes typical of the borrower's profession. Borrower(s) annual income as reported in the last two years complete tax returns may not exceed $99,000. Income will be from all sources and before taxes or with-holding, of all members of a family living in a housing unit.

Borrower—an individual or family applying to receive mortgage funding under the Workforce Housing Initiative Program.

Housing Unit—living accommodations intended for occupancy by a single family, consisting of one to two units, and which will be owned by the occupant thereof; one-two unit principal residences that are detached structures, condominiums, town homes/planned unit development or duplexes subject to Fannie Mae/Freddie Mac guidelines

AUTHORITY NOTE: Promulgated in accordance with R.S. 40.600.86 et seq.

HISTORICAL NOTE: Promulgated by the Department of Treasury, Louisiana Housing Corporation, LR 41:401 (February 2015).

§905. Eligible Borrowers

A. Borrowers will be determined to be eligible to participate under the Workforce Housing Initiative Program if they meet the following criteria.

1. The borrower is seeking a first mortgage loan for the purchase of a housing unit in the state, whether purchasing as a first time homebuyer or a non-first time homebuyer.

2. The borrower will occupy the property as the primary residence. Borrower seeking to purchase properties for use as recreational homes, second homes, vacation homes, and/or investment properties are ineligible to participate in the program.

3. The borrower's annual household income must not exceed established income limits as defined by the provisions set forth in the LAC 16:I.303.B, which limit is currently a maximum of $99,000 per year.

4. The borrower meets the minimum credit score determined by the program guidelines but in no instance shall be lower than 660.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:600.86 et seq.

HISTORICAL NOTE: Promulgated by the Department of Treasury, Louisiana Housing Corporation, LR 41:401 (February 2015).

§907. Processing Qualifications of Borrowers Applications

A. An application for a mortgage loan shall be processed by a Louisiana Housing Corporation designated preferred lending institution on behalf of the Louisiana Housing Corporation and on the basis of the Louisiana Housing Corporation's evaluation criteria. The lending institution shall undertake its own due diligence and other matters as may be determined to be appropriate to insure that the proposed loan is consistent in all respects with the Louisiana

Housing Corporation's evaluation factors. The Louisiana Housing Corporation will also underwrite the application.

B. When processing mortgage loan applications lenders must adhere to the published acquisition cost limits and or maximum loan sizes as defined by Fannie Mae and Freddie Mac.

C. Upon completion of the processing and approval of the application but not prior to the Louisiana Housing Corporation's approval, the lending institution shall initiate a loan closing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:600.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Treasury, Louisiana Housing Corporation, LR 41:401 (February 2015).

§909. Interest Rates

A. The interest rates charged by the lending institution for a borrower's mortgage loan shall be monitored and adjusted as needed based on the current market rates. The corporation will post to its website at www.lhc.la.gov daily rates for the Workforce Housing Initiative Program as long as funds are available for participation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:600.86 et seq.

HISTORICAL NOTE: Promulgated by the Department of Treasury, Louisiana Housing Corporation, LR 41:402 (February 2015).

§911. Types of Assistance and Proscribed Use

A. Down payment and closing costs assistance is not available for the Workforce Housing Initiative Program.

B. Borrowers will pay a 1.5 percent origination fee and 1 percent discount point.

C. Borrower will pay reasonable and customary fees and closing costs.

D. Sellers concessions up to 3 percent of the sales price is permitted.

E. Maximum loan amount is $300,000 based upon current appraisal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:600.86 et seq.

HISTORICAL NOTE: Promulgated by the Department of Treasury, Louisiana Housing Corporation, LR 41:402 (February 2015).

Frederick Tombar, III
Executive Director

1502#004

Notices of Intent

NOTICE OF INTENT

Department of Children and Family Services
Economic Stability Section

TANF Initiatives (LAC 67:III.5541 and 5579)

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 15, Temporary Assistance for Needy Families (TANF) Initiatives, Chapter 55, TANF Initiatives, Section 5541, Court-Appointed Special Advocates and adopt Section 5579, State Child Care Tax Credit.

Pursuant to Louisiana's Temporary Assistance for Needy Families (TANF) block grant, amendment of Section 5541 is necessary to indicate that the initiative is reasonably expected to accomplish TANF goal three, to prevent and reduce out-of-wedlock pregnancies, and adoption of Section 5579 is necessary to govern the collection of eligible child care tax credit expenditures for low-income individuals and families who have a qualified dependent that may be counted as maintenance of effort (MOE) for the TANF grant.

Title 67
SOCIAL SERVICES
Part III. Economic Stability
Subpart 15. Temporary Assistance for Needy Families (TANF) Initiatives
Chapter 55. TANF Initiatives

§5541. Court-Appointed Special Advocates

A. The department shall enter into an agreement with the Supreme Court of Louisiana to provide services to needy children identified as abused or neglected who are at risk of being placed in foster care or, are already in foster care. Community advocates provide information gathering and reporting, determination of and advocacy for the children's best interests, and case monitoring to provide for the safe and stable maintenance of the children in their own homes or the return of children to their own homes or the homes of a relative.

B. The services meet TANF goal 1, to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives by ensuring that the time children spend in foster care is minimized, and TANF goal three, to prevent and reduce the incidence of out-of-wedlock pregnancies by providing the child with support and guidance and with encouragement and empowerment to be successful in becoming a responsible decision maker.

C. Eligibility for services is limited to needy families, that is, one in which any member receives a Family Independence Temporary Assistance Program (FITAP) grant, Kinship Care Subsidy Program (KCSP) grant, Supplemental Nutritional Assistance Program (SNAP) benefits, Child Care Assistance Program (CCAP) services, Title IV-E, Medicaid, Louisiana Children's Health Insurance Program (LaCHIP) benefits, supplemental security income (SSI), free or reduced school lunch, or who has earned income at or below 200 percent of the federal poverty level. A family consists of minor children residing with custodial parents, or caretaker relatives of minor children.

D. Services are considered non-assistance by the department.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq.; R.S. 46:231 and R.S. 36:474; Act 12, 2001 Reg. Session; Act 1, 2004 Reg. Session, Act 18, 2007 Reg. Session.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Office of Family Support, LR 28:871 (April 2002), amended LR 31:485 (February 2005), LR 34:694 (April 2008), amended by the Department of Children and Family Services, Economic Stability Section, LR 41:

§5579. State Child Care Tax Credit

A. The department shall enter into a memorandum of understanding with the Louisiana Department of Revenue to collect information on state child care tax credit expenditures for the purpose of claiming eligible expenditures that may count as maintenance of effort (MOE) effective TANF state plan FY 2014 for the Temporary Assistance for Needy Families (TANF) grant. The state child care tax credit is an annual refundable tax credit for low-income individuals and families who have a qualified dependent who is under the age of 13, and the parent or qualified relative has paid someone to provide care for the qualified dependent so that they can work or look for work. Also, this credit may be available if a nonresident or part-year resident individual income tax return for Louisiana is filed when the child care expenses have been incurred in Louisiana during the time as a resident.

B. These services meet TANF goal two, to end dependence of needy parents on government benefits, by promoting job preparation, work, and marriage.

C. Eligibility for services attributable to TANF/MOE funds is limited to those families with minor children as noted above who meet the Louisiana Department of Revenue child care tax credit eligibility standards. The earned income must be $25,000 or less, in order for this credit to be refunded. The individuals or families must meet the same tests for earned income, qualifying dependents, and qualifying expenses as required by the Internal Revenue Service. A family consists of minor children residing with custodial parents or caretaker relatives of minor children.

D. Services are considered non-assistance by the department.

AUTHORITY NOTE: Promulgated in accordance with 42 U.S.C. 601 et seq.; P.L. 104-193, and R.S. 36:474.

HISTORICAL NOTE: Promulgated by the Department of Children and Family Services, Economic Stability Section, LR 41:

Family Impact Statement

The proposed Rule is not anticipated to have an impact on family formation, stability, and autonomy as described in R.S. 49:972.

Poverty Impact Statement

The proposed Rule is not anticipated to have an impact on poverty as described in R.S. 49:973.

Small Business Statement

The proposed Rule is not anticipated to have an adverse impact on small businesses as defined in the Regulatory Flexibility Act.

Provider Impact Statement

The proposed Rule is not anticipated to have an 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 March 31, 2015 to Sammy Guillory, 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 March 31, 2015 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: TANF Initiatives

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

This rule proposes to amend Louisiana Administrative Code (LAC), Title 67, Part III, Subpart 15 Temporary Assistance for Needy Families (TANF) Initiatives, Chapter 55 TANF Initiatives to amend Section 5541 and to adopt Section 5579. The proposed rule amends Section 5541—Court-Appointed Special Advocates (CASA) to include an additional TANF purpose as articulated in the federal TANF statute. Services provided through the CASA Initiative are reasonably expected to accomplish TANF goal #3, which is to prevent and reduce out-of-wedlock pregnancies.

Also, the proposed rule adopts Section 5579—State Child Care Tax Credit to claim state expenditures that are anticipated to be counted as Maintenance of Effort (MOE) for Louisiana's federal TANF grant.

The department shall collect information on the State Child Care Tax Credit expenditures from the Department of Revenue for the purpose of claiming eligible expenditures that may count as MOE towards the federal TANF grant retroactive to the TANF State Plan FY 2014.

The proposed rule will not impact the overall revenues or expenditures of the department. However, the rule allows the department to maintain their existing federal TANF grant funding of $164 M. The only cost associated with this proposed rule is the cost of publishing rulemaking. It is anticipated that $1,065 (Federal) 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)

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)

Implementation of this proposed rule will have no cost or economic benefit to directly affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This proposed rule will not have an impact on competition and employment for low-income families.

Sammy Guillory
Deputy Assistant Secretary
1502#081

John D. Carpenter
Legislative Fiscal Officer
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 §1107 of the Quality Jobs Program as LAC 13:I.Chapter 11. The proposed regulation maintains the current 60 day period for companies to request renewal of their quality jobs contract but also gives the Board of Commerce and Industry ("board") discretion to approve a late renewal request for participating businesses who failed to request renewal of their quality jobs contract within the requisite 60 day period. In addition to allowing the board to approve a late renewal request, this Rule will allow the board to impose a penalty including a reduction in the remaining contract term for the late renewal request.

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. An application to renew a contract shall be filed within 60 days of the initial contract expiring. A fee of $50 must be filed with the renewal contract. The board may approve a request for renewal filed more than 60 days but less than five years after expiration of the initial contract, and may impose a penalty for the late filing of the renewal request, including a reduction of the five-year renewal period.

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 should 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 March 25, 2015.

Public Hearing

A public hearing to receive comments on the Notice of Intent will be held on March 26, 2015 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 maintains the current 60 day period for companies to request renewal of their Quality Jobs contract but also gives the Board of Commerce and Industry ("Board") discretion to approve a late renewal request for participating businesses who failed to request renewal of their Quality Jobs contract within the requisite 60 day period. In addition to allowing the Board to approve a late renewal request, this rule change will allow the Board to impose a penalty including a reduction in the remaining contract term for the late renewal request. The rule change does not specify a penalty amount or define how penalties might be determined or calculated if imposed by the Board. To date, LED is aware of only four companies who have initial Quality Jobs contracts that have been expired more than 60 days that would be eligible to request a late renewal from the Board. LED estimates that credits/rebates from these four companies will decrease state governmental revenues by approximately $3,860,000 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 petition the Board 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. Penalties, if imposed by the Board, would offset some of the decrease in state governmental revenues associated with approval of late renewal requests authorized by the proposed rule change.

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.

Anne G. Villa
Undersecretary
1502#042

Greg Albrecht
Chief Economist
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 741—Louisiana Handbook for
School Administrators (LAC 28:CXV.2318)

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*: Chapter 23, Curriculum and Instruction. The revision designates media arts I, II, III, and IV as approved art equivalents for the TOPS university diploma.

Title 28
EDUCATION
Part CXV. Bulletin 741—Louisiana Handbook for School Administrators
Chapter 23. Curriculum and Instruction
Subchapter A. Standards and Curricula
§2318. The TOPS University Diploma

A. - C.3.e.i. …

f. art—one unit chosen from the following:

i. art (§2333);
ii. music (§2355);
iii. dance (§2337);
iv. theatre (§2369);
v. speech III and IV—one unit combined;
vi. fine arts survey;
vii. drafting;
vii. media arts (§2354);

3.g. - 6.a.vi. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:7, R.S. 17:24.4, R.S. 17:183.2, and R.S. 17:395.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 31:1291 (June 2005), amended LR 31:2211 (September 2005), LR 31:3070 (December 2005), LR 31:3072 (December 2005), LR 32:1414 (August 2006), LR 33:429 (March 2007), LR 33:432 (March 2007), LR 33:2050 (October 2007), LR 33:2354 (November 2007), LR 33:2601 (December 2007), LR 34:1607 (August 2008), LR 36:1486 (July 2010), LR 37:547 (February 2011), LR 37:1128 (April 2011), LR 37:2129 (July 2011), LR 37:2132 (July 2011), LR 37:3193 (November 2011), LR 38:754, 761 (March 2012), LR 38:1001 (April 2012), LR 38:1584 (July 2012), LR 40:994 (May 2014), LR 40:1328 (July 2014), LR 40:1679 (September 2014), LR 40:2525 (December 2014), 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., March 11, 2015, to Shan N. Davis,

Board of Elementary and Secondary Education, P.O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Shan N. Davis
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Bulletin 741—Louisiana Handbook for School Administrators

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

The proposed policy revision will have no effect on costs or savings to state or local governmental units over the next three fiscal years.

The revision designates Media Arts I, II, III, and IV as approved Art equivalents for the TOPS University Diploma.

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	Evan Brasseaux
Deputy Superintendent	Staff Director
1502#026	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)

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 (Nonpublic)—Louisiana Handbook for Nonpublic School Administrators*: Chapter 21, Curriculum and Instruction. The revision designates media arts I, II, III, and IV as approved art equivalents for the TOPS university diploma.

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. - D.5.a. …

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;
   h. media arts (§2324);

D.7. - F.3.b. …

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 40:1682 (September 2014), LR 40:2535 (December 2014), 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., March 11, 2015, to Shan N. Davis, Board of Elementary and Secondary Education, P.O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Shan N. Davis
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 proposed policy revision will have no effect on costs or savings to state or local governmental units over the next three fiscal years.

The revision designates Media Arts I, II, III, and IV as approved Art equivalents for the TOPS University Diploma.

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
1502#027

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 746—Louisiana Standards for
State Certification of School Personnel
(LAC 28:CXXXI.204, 243, 341, 344, 604, and 605)

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 746—Louisiana Standards for State Certification of School Personnel*: §204, Minimum Requirements for Approved Regular Education Programs for Birth to Kindergarten; §243, PRAXIS Exams and Scores; §341, Introduction; §344, Early Childhood Ancillary Certificate; §604, Requirements to add Birth to Kindergarten; and §605, Requirements to add Early Childhood (Grades PK-3). The proposed revisions include the creation of a birth to kindergarten teaching certificate and the creation of an early childhood ancillary certificate.

Title 28
EDUCATION
Part CXXXI. Bulletin 746—Louisiana Standards for State Certification of School Personnel
Chapter 2. Louisiana Educator Preparation Programs
Subchapter A. Traditional Teacher Preparation Programs
§204. Minimum Requirements for Approved Regular Education Programs for Birth to Kindergarten

A. For certification as a teacher of birth to kindergarten children in the state of Louisiana, the focus is on birth to kindergarten education.

1. General Education—39 semester credit hours. Requirements provide the birth to kindergarten teacher with basic essential knowledge and skills.

English	12 semester hours
Mathematics	6 semester hours
Sciences	9 semester hours
Social studies	9 semester hours
Arts	3 semester hours

2. Focus Area—Birth to Kindergarten—30 semester credit hours. Requirements provide the prospective birth to kindergarten teacher with a strong foundation pertaining to the growth and development of young children. All courses are to be aligned to state and national standards for birth to kindergarten.

Birth to kindergarten content knowledge and instruction identified by the State as being required for an Early Childhood/Ancillary Certificate	9 semester credit hours
Infant/Toddler and Preschool/Kindergarten Development	6 semester credit hours
Infant/Toddler and Preschool/Kindergarten Methodology	6 semester credit hours
Language and Literacy Development	3 semester credit hours
Family Systems and Practicum	6 semester credit hours

3. Knowledge of the Learner and Learning Environment—9 semester credit hours. Requirements provide the prospective birth to kindergarten teacher with a fundamental understanding of the birth to kindergarten learner and the teaching and learning process. Coursework should address the needs of the regular and the exceptional child, as follows:

a. educational psychology;
b. assessment of young children;
c. behavior management;
d. diverse/multicultural education.

4. Methodology and Teaching—15 semester hours. Requirements provide the prospective birth to kindergarten teacher with fundamental pedagogical skills.

Teaching methodology	6 semester hours
Advanced Language Development and Literacy	6 semester hours
Professional Teaching Residency and Seminar I and Professional Teaching Residency and Seminar II	24 semester hours
Flexible hours for the university's use	6 semester hours
Total required hours in the program	120 semester hours

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:17:6(A)(10), (11), and (15), R.S. 17:7(6), and R.S. 17:407.81.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Subchapter D. Testing Required for Licensure Areas

§243. PRAXIS Exams and Scores

A. A teacher applicant for certification must successfully complete the appropriate written or computer delivered tests identified prior to Louisiana teacher certification.

1. - 2. …

* * *

B. Content and Pedagogy Requirements

Certification Area	Name of Praxis Test	Content Exam Score	Pedagogy: Principles of Learning and Teaching		
			PLT K-6 (#0622 or 5622)	PLT 5-9 (#0623 or 5623)	PLT 7-12 (#0624 or 5624)
Birth to Kindergarten	Early Childhood Content Knowledge (5022/5025 after September 2015)	160 (for 5022)	PLT: Early Childhood 0621 or 5621 (Score 157)		
	OR				
	Education of Young Children (5024)	160			
	OR				
	PreK Education (5531)	155			
* * *					

C. - E. ...

* * *

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 32:1833 (October 2006), amended LR 36:485 and 488 (March 2010), LR 36:2265 (October 2010), LR 37:551 (February 2011), repromulgated LR 37:556 (February 2011), amended LR 37:3210 (November 2011), LR 39:1461 (June 2013), LR 40:277 (February 2014), LR 40:1680 (September 2014), LR 41:

Chapter 3. Teaching Authorizations and Certifications

Subchapter C. Ancillary Teaching Certificates

§341. Introduction

A. Ancillary certificates are issued by Louisiana for those who provide teaching, support, administrative, or supervisory services to children in pre-k-12 schools and early learning centers serving children ages birth to five. See Chapter 4 of this bulletin for an explanation of ancillary certificates issued for those who provide support services in pre-k-12 schools and early learning centers serving children ages birth to five. See Chapter 7 of this bulletin for an explanation of ancillary certificates issued for those who provide administrative and supervisory services in pre-k-12 schools. There are six types of ancillary teaching certificates: ancillary artist or talented certificate, early childhood ancillary certificate, nonpublic Montessori teacher certificate, a certificate for family and consumer sciences—occupational programs, Junior Reserve Officers Training Corps instructor (ROTC), and math for professionals certificate.

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 32:1805 (October 2006), amended LR 41:

§344. Early Childhood Ancillary Certificate

A. The early childhood ancillary certificate authorizes an individual to teach in a publicly-funded early learning center serving children ages birth to five as defined in R.S 17:407.33, unless program requirements mandate a professional level certificate. After June 30, 2019, an individual shall have, at a minimum, an early childhood ancillary certificate to serve as a lead teacher in a publicly-funded early learning center.

B. Early Childhood Ancillary Certificates Issued

1. Eligibility Requirements. An early childhood ancillary certificate shall be issued to an applicant who submits evidence of one of the following to the LDE:

a. a bachelor's degree or higher from a regionally accredited college or university;

b. a current child development associate (CDA) credential, either infant/toddler or preschool, awarded by the Council for Professional Recognition and a high school

diploma or equivalent. After January 1, 2018, coursework for the CDA shall be earned from a BESE-approved provider for initial CDA credentials and subsequent renewals. After January 1, 2018, applicants who obtained a CDA or completed coursework from a provider that is not BESE-approved while residing in another state shall submit additional documentation of program components for approval. Coursework counting towards the early childhood ancillary certificate shall include at least 10 training hours in each of the following subject areas:

i. planning and implementing a safe and healthy learning environment;

ii. advancing children's physical and intellectual development;

iii. supporting children's social and emotional development;

iv. building productive relationships with families;

v. managing an effective program operation;

vi. maintaining a commitment to professionalism;

vii. observing and recording children's behavior;

viii. understanding principles of child development and learning;

c. an associate degree in an early childhood related field from a regionally accredited college or university;

d. a technical diploma or certificate of technical studies in an early childhood related field from an accredited technical or community college. After January 1, 2018, coursework for technical diplomas and certificates of technical studies shall be earned from a BESE-approved provider;

e. a career diploma that has been approved by the Louisiana Pathways Career Development System, and is earned prior to January 1, 2018.

2. Renewal Guidelines

a. For individuals meeting eligibility requirements with a CDA, the early childhood ancillary certificate shall be valid for a three-year period. The ancillary certificate may be renewed by the LDE at the request of the applicant's employer with submission of either documentation of a renewed CDA credential, awarded by the Council for Professional Recognition, or documentation of:

i. either 4.5 continuing education units, a 3 credit-hour course, or 45 clock hours of training in early childhood care and education; and

ii. a minimum of 80 hours of work experience with young children or families with young children within the last three years.

b. For individuals meeting eligibility requirements with a bachelor's degree or higher, associate degree, technical diploma, certificate of technical studies, or career diploma, the early childhood ancillary certificate shall be valid for a three-year period. The certificate may be renewed by the LDE at the request of the applicant's employer with submission of documentation of:

i. either 4.5 continuing education units, a 3 credit-hour course, or 45 clock hours of training in early childhood care and education; and

ii. a minimum of 80 hours of work experience with young children or families with young children within the last three years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:17:6(A)(10), (11), and (15), R.S. 17:7(6), and R.S. 17:407.81.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

Chapter 6. Endorsements to Existing Certificates

Subchapter A. Regular Education Level and Area Endorsements

§604. Requirements to add Birth to Kindergarten

A. Individuals holding a valid early childhood certificate (e.g., PK-K, PK-3), elementary certificate (e.g., 1-4, 1-5, 1-6, or 1-8) or early interventionist certificate must achieve one of the following:

1. successfully teach on an extended endorsement license (EEL) certificate in birth to kindergarten for one year in an approved Louisiana licensed child care facility or publicly-funded early childhood program based on criteria determined by the LDE;

2. passing score for Praxis—principles of learning and teaching early childhood (0621 or 5621); or

3. 12 semester hours of combined early childhood and kindergarten coursework.

B. The certificated teacher's Louisiana employing authority must verify that he/she has completed one year of successful teaching experience in birth to kindergarten in an approved Louisiana licensed child care facility and recommend the applicant for further employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(A)(10), (11), and (15), R.S. 17:7(6), R.S. 17:10, and R.S. 17:22(6).

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 41:

§605. Requirements to add Early Childhood (Grades PK-3)

A. Individuals holding a valid elementary certificate (e.g., 1-4, 1-5, 1-6, or 1-8) must achieve one of the following:

1. successfully teach on an extended endorsement license (EEL) certificate in birth to kindergarten for one year in an approved Louisiana licensed child care facility or publicly-funded early childhood program based on criteria determined by the LDE;

2. passing score for Praxis—principles of learning and teaching early childhood (0621 or 5621); or

3. 12 semester hours of combined early childhood and kindergarten coursework.

B. Individuals holding a valid upper elementary or middle school certificate (e.g., 4-8, 5-8, 6-8), secondary school certificate (e.g., 6-12, 7-12, 9-12), special education certificate (other than early interventionist), or an all-level K-12 certificate (art, dance, foreign language, health, physical education, health and physical education, music) must achieve the following:

1. passing score for Praxis—elementary education: content knowledge or multiple subjects exam (5001 or 5018);

2. passing score for Praxis—principles of learning and teaching early childhood (0621 or 5621) or accumulate 12 credit hours of combined nursery school and kindergarten coursework.

C. Individuals holding a valid early interventionist certificate must achieve the following:

1. passing score for Praxis—elementary education: content knowledge or multiple subjects exam (5001 or 5018);

2. 12 credit hours of combined nursery school and kindergarten coursework (art, math, science, social studies); and

3. 9 semester hours of reading coursework or passing score for Praxis—teaching reading exam (0204 or 5204).

D. Individuals holding a valid birth to kindergarten certificate must achieve the following:

1. passing score for Praxis-elementary education: content knowledge or multiple subjects exam (5018 or 5001); and

2. nine semester hours of reading coursework or passing score for Praxis—teaching reading exam (0204 or 5204).

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 32:1815 (October 2006), amended LR 37:883 (March 2011), repromulgated LR 37:1561 (June 2011), amended LR 37:3215 (November 2011), LR 38:44 (January 2012), LR 39:1464 (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 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., March 11, 2015, to Shan N. Davis, Board of Elementary and Secondary Education, P.O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Shan N. Davis
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Bulletin 746—Louisiana Standards for State Certification of School Personnel

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

The proposed policies may result in indeterminable implementation costs to colleges and universities to develop curriculum and coursework for the new certifications. Additionally, while there are currently just under $1 million in Child Care and Development Block Grant (CCDF) funds allocated to scholarships available to individuals seeking certification, the Department of Education (DOE) will experience increased scholarship costs as educational requirements are raised and the DOE increases the scholarship allocation up to $5 million.

Act 868 of the 2014 Regular Session encourages early learning staff to obtain certification through training programs. The proposed revisions include the creation of a Birth to Kindergarten teaching certificate and the creation of an Early Childhood Ancillary Certificate.

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

The proposed policy revisions may result in an indeterminable increase in revenues in the form of tuition and

fees for colleges and universities which offer courses for the new certifications. The Department will not charge fees for the Ancillary Teaching Certificate or Birth to Kindergarten Certificate.

School Readiness Tax Credits are refundable tax credits to families, child care providers, child care directors and staff, and businesses that participate in the Quality Start Child Care Rating System (QRS). The amount of the credit varies by eligible entity and the QRS rating of the child care center. Points are awarded for various factors, including education and training of staff. Increased educational standards will result in an increase in QRS scores of participating centers, which increases the amount of allowable tax credits. More specifically, increased educational attainment qualifies eligible staff for higher tax credits. The resulting decrease in state general fund is indeterminable and will depend upon the number of individuals and providers who meet the eligibility criteria and claim the tax credit.

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

There may be an indeterminable increase in costs and/or economic benefits to directly affected persons or non-governmental groups.

While individuals seeking the new certifications will incur costs for required coursework, the Department of Education will allocate up to $5,000,000 in scholarship funds from the Child Care and Development Fund block grant to aid individuals in obtaining the ancillary teaching certificate. Once certified, these higher qualified teachers may demand higher compensation and may also become eligible for the School Readiness Tax Credit. Furthermore, increases in compensation would, in turn likely increase operating expenses of early learning centers. It is possible that providers may receive subsidies to offset these increases or may otherwise be forced to pass along increased costs to parents.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1502#030

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Board of Elementary and Secondary Education

Bulletin 996—Standards for Approval of Teacher and/or Educational Leader Preparation Programs
(LAC 28:XLV.501)

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 996—Standards for Approval of Teacher and/or Educational Leader Preparation Programs*: §501, Process/Procedures. The proposed revision adds the Early Childhood Ancillary Certificate Program to the list of programs for which in-state and out-of-state non-university providers may seek approval.

Title 28
EDUCATION
Part XLV. Bulletin 996—Standards for Approval of Teacher and/or Educational Leader Preparation Programs
Chapter 5. State Approval for Non-University Private Provider Teacher and/or Educational Leader Preparation Programs

§501. Process/Procedures

A. In-state and out-of-state non-university private providers seeking state approval may submit proposals to the Louisiana Department of Education for a Practitioner Teacher Program, Certification-Only Alternate Teacher Program, Educational Leader Practitioner Program, and Early Childhood Ancillary Certificate Program that leads to Louisiana licensure as a teacher or educational leader.

B. Proposals must be submitted using the private provider application packet available at www.teachlouisiana.net and must include the following:

1. cover page signed by the program director;
2. program overview briefly describing the program, including goals of the program and the design to accomplish the goals;
3. documentation of collaborative agreements with school districts/charter schools to develop and implement the program, provide mentoring for candidates and improve the program once implemented;
4. a description of the process used to recruit, screen and select outstanding candidates and support program completers;
5. evidence that the curriculum is aligned to the requirements set forth in *Bulletin 746—Louisiana Standards for State Certification of School Personnel*;
6. measurable objectives that clearly identify the most critical competencies candidates will demonstrate and a description of instruments and processes used to assess performance;
7. a list of proposed resources and materials;
8. names and credentials of staff, including curriculum vitae of key personnel;
9. an audited financial statement. If one is not currently available, then the applicant must submit a written assurance that one will be provided within the first year of the program. Additionally, the proposal should delineate any costs to individual program participants and procedures for handling of all fees.

C. Private providers are limited to the submission of one proposal every 12 months. The 12-month cycle begins on the date that the proposal is received by the Louisiana Department of Education.

D. Private providers with programs established in other states must provide verification that their teacher preparation or educational leader programs are approved in the states in which they operate. In addition, the following data must be provided:

1. number of program completers;
2. certification areas approved and offered in other states;

3. letters of references from employing school districts; and

4. teacher effectiveness data, if available.

AUTHORITY NOTE: Promulgated in accordance with R.S. 17:6(10); R.S. 17:7(6), and R.S. 17:7.2.

HISTORICAL NOTE: Promulgated by the Board of Elementary and Secondary Education, LR 37:562 (February 2011), 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., March 11, 2015, to Shan N. Davis, Board of Elementary and Secondary Education, P.O. Box 94064, Capitol Station, Baton Rouge, LA 70804-9064.

Shan N. Davis
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Bulletin 996—Standards for Approval of Teacher and/or Educational Leader Preparation Programs

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

The proposed revision adds the Early Childhood Ancillary Certificate Program to the list of programs for which in-state and out-of-state non-university providers may seek approval.

Currently, Child Care and Development Block Grant Funds (CCDF) are used to provide scholarships to individuals to aid in obtaining an ancillary teaching certificate. In addition to increases in the scholarship allocation, the Department of Education will provide funds through a competitive process to providers which offer teacher preparation programs at low or no cost. The total anticipated allocation for both individual scholarships and provider awards is not expected to exceed $5 million, an increase from the current allocation of just under $1 million.

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

The Department will not charge fees for the Ancillary Teaching Certificate or Birth to Kindergarten Certificate.

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

The proposed policy change will result in economic benefits to non-university providers providing the new certification programs, which qualify for competitive funds. It may also result in an increase in the choice of providers and course offerings for individuals seeking additional training.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This policy will have no effect on competition and employment.

Beth Scioneaux
Deputy Superintendent
1502#031

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Student Financial Assistance Commission
Office of Student Financial Assistance

Scholarship/Grant Programs—TOPS Core Curriculum Equivalents—Art Media I-IV (LAC 28:IV.703)

The Louisiana Student Financial Assistance Commission (LASFAC) announces its intention to amend its scholarship/grant rules (R.S. 17:3021-3025, R.S. 3041.10-3041.15, R.S. 17:3042.1, R.S. 17:3048.1, R.S. 17:3048.5 and R.S. 17:3048.6).

This rulemaking adds media arts I–IV as course equivalents to art in the TOPS core curriculum for students who graduate from high school beginning in the 2017-2018 academic year (high school). (SG15161NI)

The full text of this Notice of Intent can be found in the Emergency Rule section of this *Louisiana Register*.

Family Impact Statement

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

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

The proposed Rule will have no adverse impact on small businesses as described in R.S. 49:965.2 et seq.

Provider Impact Statement

The proposed Rule will have no adverse impact on providers of services for individuals with developmental disabilities as described in HCR 170 of 2014.

Public Comments

Interested persons may submit written comments on the proposed changes (SG15161NI) until 4:30 p.m., March 12, 2015, by email to LOSFA.Comments@la.gov or to Sujuan Williams Boutté, Ed. D., Executive Director, Office of Student Financial Assistance, P.O. Box 91202, Baton Rouge, LA 70821-9202.

George Badge Eldredge
General Counsel

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Scholarship/Grant Programs—TOPS Core Curriculum Equivalents—Art Media I-IV

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

In accordance with the requirements of R.S. 17:3048.1.C(2)(e) and with the prior approval of BESE and the concurrence of Regents, the proposed rule change modifies the Scholarship and Grant Program rules to add Media Arts I-IV courses as an equivalent (substitute) course to the Art Core Curriculum Course effective for students graduating during the 2017-2018 high school academic year and thereafter. There are no estimated implementation costs or savings to state or local governmental units.

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

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

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

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

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

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

George Badge Eldredge
General Counsel
1502#024

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Office of the Governor
Crime Victims Reparations Board

Compensation to Victims (LAC 22:XIII.303 and 503)

In accordance with the provisions of R.S. 49:950 et seq., which is the Administrative Procedure Act, and R.S. 46:1801 et seq., which is the Crime Victims Reparations Act, the Crime Victims Reparations Board hereby gives notice of its intent to promulgate rules and regulations regarding the awarding of compensation to applicants.

Title 22
CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT
Part XIII. Crime Victims Reparations Board
Chapter 3. Eligibility and Application Process
§303. Application Process

A. Claimant Responsibility

1. ...
2. Applications

a. Must be signed and dated by the victim/claimant. Only original signatures, no copies, will be accepted. If the victim is a minor, the parent or guardian is the claimant and must sign. If the victim is deceased, the person responsible for the bill is the claimant and must sign the application.

b. The application is only valid if the crime resulting in the personal injury, death, or catastrophic property loss was reported to the appropriate law enforcement officers within 72 hours after the date of the crime or within such longer period as the board determines is justified by the circumstances. Victims of sexual assault may take up to one year to meet the reporting requirements in this Part.

c. Victims of sexual assault may assign their right to collect medical expenses associated with the sexual assault to a hospital/health care facility; however, the cost of the forensic medical examination is not reimbursable by the board as provided in §503.M.2. The hospital/health care facility may then apply for reparations.

A.3 - D.3. …

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

HISTORICAL NOTE: Promulgated by the Office of the Governor, Commission on Law Enforcement and Administration of Criminal Justice, Crime Victims Reparations Board, LR 20:539 (May 1994), amended LR 22:710 (August 1996), amended by the Office of the Governor, Crime Victims Reparations Board, LR 41:

Chapter 5. Awards

§503. Limits on Awards

A. - L.1. ...

M. Crime Scene Evidence

1. - 1.c. ...

2. Medical Examination of Sexual Assault Victims

a. Costs of the forensic medical examination are the responsibility of the coroner or his designee as provided by law and are not reimbursable by the Crime Victims Reparations Board (CVR Board) under this Section. All other expenses related to victims of sexual assault are reimbursable by the board at 100 percent, subject to the provisions of the Crime Victims Reparations Act and its administrative rules.

b. In instances where the sexual assault victim assigns his or her rights to collect reparations for reimbursable medical expenses beyond those associated with the forensic medical examination to the hospital/health care facility, the hospital/health care facility must submit the following items directly to the CVR Board within one year of the date of service in order to receive reimbursement:

i. victim of sexual assault assignment of rights form, signed by the victim;

ii. hospital/health care facility application;

iii. itemized bill for services rendered.

c. The sexual assault victim may submit these expenses to his or her private insurance or other third-party payor. If these expenses are paid by insurance or other third-party payor, the hospital/health care facility shall not file an application with the CVR Board.

d. Nothing in this Section shall preclude a sexual assault victim or claimant from filing a regular or emergency application for additional benefits.

3. A forensic medical examination for a victim of sexual assault is considered an expense associated with the collection and securing of crime scene evidence. Payment for this examination by the parish governing authority is mandated by state law. All other expenses related to these crimes are eligible for reimbursement by the board at 100 percent, subject to the provisions of the Crime Victims Reparations Act and its administrative rules.

N. - O.3.b. ...

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 20:539 (May 1994), amended LR 22:710 (August 1996), LR 24:328 (February 1998), LR 25:26 (January 1999), LR 26:1019 (May 2000), LR 29:577 (April 2003), LR 31:1330 (June 2005), LR 32:242 (February 2006), LR 35:65 (January 2009), LR:37:1605 (June 2011), LR 39:1042 (April 2013), 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 has been considered. This proposed Rule will have no impact on family functioning, stability, or autonomy as described in R.S. 49:972 since it only clarifies the procedures for applying for reparations.

Poverty Impact Statement

The 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. the effect on household income, assets, and financial security;

2. the effect on early childhood development and preschool through post-secondary education development;

3. the effect on employment and workforce development;

4. the effect on taxes and tax credits;

5. the effect on 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:

1 the effect on the staffing level requirement 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 this proposed Rule no later than March 12, 2015 at 5 p.m. to Bob Wertz, Louisiana Commission on Law Enforcement, P.O. Box 3133, Baton Rouge, LA 70821.

Lamarr Davis
Chairman

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Compensation to Victims

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

The proposed administrative rule change may result in an indeterminable net increase in expenditures from the statutorily dedicated Crime Victims Reparation (CVR) Fund, which is funded by fees associated with criminal court cases. Currently, the CVR fund has a cash balance of $1.5M. Pursuant to Executive Order BJ 2014-17, the proposed administrative rule change allows a victim/claimant to assign their rights to a hospital/health care facility to recover medical costs associated with forensic medical examinations, potentially allowing for a greater number of claims to be considered. No costs to local governmental units are anticipated beyond the ones they are already liable for by state law, such as the costs of the forensic medical examination and rape kit for the purposes of evidence collection.

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

There is no effect on revenue collections of state and local governmental units. However, implementation of the proposed rule may increase federal grant awards in FY 16 and subsequent fiscal years for the Crime Victims Reparations Fund. For every dollar appropriated in a particular fiscal year for crime victim reparations, the federal Office for Victims of Crimes (OVC) will appropriate sixty cents of funding in the next fiscal year through the Victims of Crime Act (VOCA).

Therefore, increased state expenditures may generate additional federal funding for the agency in the next fiscal year.

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

Implementation of the proposed rule will allow victims of sexual assault to assign their rights to a hospital/health care provider for treatment for personal injury, and mitigate expenses of the victim associated with the collection and securing of crime scene evidence.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no effect on competition or employment in the public or private sector as a result of the proposed rule change.

Joseph Watson	Evan Brasseaux
Executive Director	Staff Director
1502#082	Legislative Fiscal Office

NOTICE OF INTENT

Office of the Governor
Crime Victims Reparations Board

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

In accordance with the provisions of R.S. 49:950 et seq., which is the Administrative Procedure Act, and R.S. 46:1801 et seq., which is the Crime Victims Reparations Act, the Crime Victims Reparations Board hereby gives notice of its intent to promulgate rules and regulations regarding the awarding of compensation to applicants.

Title 22
CORRECTIONS, CRIMINAL JUSTICE AND LAW ENFORCEMENT
Part XIII. Crime Victims Reparations Board
Chapter 3. Eligibility and Application Process
§301. Eligibility

A. To be eligible for compensation, an individual must have suffered personal injury, death or catastrophic property loss as a result of a violent crime.

1. Victim Conduct and Behavior

a. - 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:

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule has been considered. This proposed Rule will have no impact on family functioning, stability, or autonomy as described in R.S. 49:972 since it only clarifies the conditions of eligibility for victims of crime.

Poverty Impact Statement

The 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. the effect on household income, assets, and financial security;

2. the effect on early childhood development and preschool through post secondary education development;

3. the effect on employment and workforce development;

4. the effect on taxes and tax credits;

5. the effect on 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:

1. the effect on the staffing level requirement 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 provider the same level of service.

Public Comments

Interested persons may submit written comments on this proposed Rule no later than March 12, 2015 at 5 p.m. to the attention of Bob Wertz, Criminal Justice Policy Planner, Louisiana Commission on Law Enforcement and Administration of Criminal Justice, P.O. Box 3133, Baton

Rouge, LA 70821. He is responsible for responding to inquiries regarding this proposed Rule.

Lamarr Davis
Chairman

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Eligibility for Sexual Assault Victims

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

The proposed administrative rule change may result in an indeterminable net increase in expenditures from the statutorily dedicated Crime Victims Reparation Fund, which is funded by fees associated with criminal court cases. The proposed administrative rule change clarifies the conditions for claim eligibility of sexual assault claims, outlines why claims cannot be denied, and potentially allows for a greater number of claims to be considered. No costs to local governmental units are anticipated.

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

There is no effect on revenue collections of state and local governmental units. However, implementation of the proposed rule could increase federal grant awards in FY 16 and subsequent fiscal years. To the extent that extra state dollars are appropriated in a particular fiscal year for crime victim reparations, the federal Office for Victims of Crimes (OVC) will appropriate sixty cents of funding in the next fiscal year through the Victims of Crime Act (VOCA). Therefore, increased state expenditures may generate additional federal funding for the agency in the next fiscal year.

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

Implementation of the proposed rule will allow victims of sexual assault to access benefits related to treatment for personal injury, and mitigate expenses of the victim associated with the collection and securing of crime scene evidence.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no effect on competition or employment in the public or private sector as a result of the proposed rule change.

Joseph Watson
Executive Director
1502#012

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Behavior Analyst Board

Continuing Education (LAC 46:VIII.Chapter 8)

This Rule establishes the requirements for each licensed behavior analyst and state certified assistant behavior analyst to complete continuing education hours within biennial reporting periods beginning in December 2016. Continuing education is an ongoing process consisting of learning activities that increase professional development.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part VIII. Behavior Analysts
Chapter 8. Continuing Education Requirements for Licensed Behavior Analysts and State Certified Assistant Behavior Analysts

§801. Preface

A. Pursuant to R.S. 37:3713, each licensed behavior analyst and state certified assistant behavior analyst 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. Continuing professional development activities:

1. are relevant to the practice of behavior analysis, education and science;

2. enable behavior analysts to keep pace with emerging issues and technologies; and

3. allow behavior analysts to maintain, develop, and increase competencies in order to improve services to the public and enhance contributions to the profession.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3713.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 41:

§803. Requirements

A. For the reporting periods that begin December 2016 and henceforth, 32 credits of continuing professional development will be required in the biennial reporting period for licensed behavior analysts and 20 credits for state certified assistant behavior analysts. The hours must conform to the distribution listed below.

B. Within each reporting period, four of the required hours or credits of continuing professional development must be within the area of ethics.

C. Licensees can accumulate continuing professional development credits in six categories.

1. Academic

a. Completion of graduate level college or university courses. Course content must be entirely behavior analytic. Courses must be from a United States or Canadian institution of higher education fully or provisionally accredited by a regional, state, provincial or national accrediting body, or approved by the board.

b. One academic semester credit is equivalent to 15 hours of continuing education and one academic quarter credit is equivalent to 10 hours of continuing education. Any portion or all of the required number of hours of continuing education may be applied from this category during any two-year certification period.

c. Required documentation is a course syllabus and official transcript.

2. Traditional Approved Events

a. Completion of events sponsored by providers approved by the Behavior Analyst Certification Board. Any portion or all of the total required number of hours of continuing education may be applied from this category during any three-year certification period.

b. Required documentation is a certificate or letter from the approved continuing education (ACE) provider.

3. Non-Approved Events

a. Completion or instruction of a seminar, colloquium, presentation, conference event, workshop or symposium not approved by the BACB, only if they relate directly to the practice of behavior analysis. A maximum of 25 percent of the total required number of hours of continuing education may be applied from this category during any two-year certification period.

b. Required documentation is an attestation signed and dated by the certificant.

c. Approval of these events is at the discretion of the board.

4. Instruction of Continuing Education Events

a. Instruction by the applicant of a category 1 or 2 continuing education events, on a one-time basis for each event, provided that the applicant was present for the complete event. A maximum of 50 percent of the total required number of hours of continuing education may come from this category during any two-year certification period.

b. Required documentation is a letter from the department chair on letterhead from the university at which a course was taught or a letter from the approved continuing education (ACE) provider's coordinator.

5. Passing BACB Exam

a. Passing, during the second year of the applicant's certification period, the BACB certification examination appropriate to the type of certification being renewed. LBA's may only take the BCBA examination; SCABA's may only take the BCaBA examination for continuing education credit. Passing the appropriate examination shall satisfy the continuing education requirement for the current recertification period.

b. Required documentation is a verification letter of passing score from the BACB.

6. Scholarly Activities

a. Publication of an ABA article in a peer-reviewed journal or service as reviewer or action editor of an ABA article for a peer reviewed journal. A maximum of 25 percent of the total required number of hours of continuing education may come from this category during any two-year certification period. The credit will only be applied to the recertification cycle when the article was published or reviewed:

i. one publication = 8 hr.;

ii. one review = 1 hr.

b. Required documentation is a final publication listing certificant as author, editorial decision letter (for action editor activity), or letter of attestation from action editor (for reviewer activity).

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3713.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 41:

§805. Extensions/Exemptions

A. Licensees on extended active military service outside the state of Louisiana during the applicable reporting period and who do not engage in delivering behavior analysis services within the state of Louisiana may be granted in extension or an exemption if the board receives a timely confirmation of such status.

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

C. Newly licensed behavior analysts or state certified assistant behavior analysts are exempt from continuing professional development requirements for the remainder of the year for which their license or certification is granted.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3713.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 41:

§807. Noncompliance

A. Noncompliance shall include, in part, incomplete reports, unsigned reports, failure to file a report, and failure to report a sufficient number of acceptable continuing professional development credits.

B. Failure to fulfill the requirements of the continuing professional development rule shall cause the license to lapse pursuant to

C. If the licensee fails to meet continuing professional development requirements by the appropriate date, the license shall be regarded as lapsed at the close of business December 31 of the year for which the licensee is seeking renewal.

D. The Louisiana Behavior Analyst Board shall serve written notice of noncompliance on a licensee determined to be in noncompliance. The notice will invite the licensees to request a hearing with the board or its representative to claim an exemption or to show compliance. All hearings shall be requested by the licensee and scheduled by the board in compliance with any time limitations of the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3713.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 41:

§809. 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 professional development requirements applicable through the date of reinstatement and upon payment of all fees due under R.S. 37:3714.

B. After a period of two years from the date of lapse of the license, the license may be renewed by payment of a fee equivalent to the application fee and renewal fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:3713-3714.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Behavior Analyst Board, LR 41:

Family Impact Statement

The Behavior Analyst Board hereby issues this Family Impact Statement as set forth in R.S. 49:972. The proposed Rule and adoption of the Rule related to continuing education is being implemented to guarantee the licensing authority can safeguard the public welfare of this state and will have no known foreseeable impact on the stability of the family; authority and rights of parents regarding the education and supervision of their children; functioning of the family; family earnings and family budget; behavior and personality responsibility of children; or the ability of the family or a local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

The proposed Rule creates a new Rule, LAC 46:VIII. Chapter 8. The 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. the effect on household income, assets, and financial security;
2. the effect on early childhood development and preschool through postsecondary education development;
3. the effect on employment and workforce development;
4. the effect on taxes and tax credits;
5. the effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance.

Public Comments

Interested persons may submit written comments to Kelly Parker, Executive Director, 8706 Jefferson Highway, Suite B, Baton Rouge, LA 70809. All comments must be submitted by 12 p.m. on March 23, 2015.

Kelly Parker
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Continuing Education

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

The proposed rule will result in a one-time expenditure by the La Behavior Analysts Board of approximately $500 to cover publication costs. There is no implementation costs or savings anticipated for any other state or local governmental unit. The proposed rule codifies and establishes rules regarding continuing education requirements for Licensed Behavior Analysts as enacted under the authority of Act 351 of the 2013 Legislative Session. Act 351 created the Louisiana Behavior Analyst Board and granted authority to require continuing education for all persons licensed or certified under the Act.

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.

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

The proposed rule establishes guidelines regarding continuing education requirements for Licensed Behavior Analysts.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule is not estimated to have an effect on competition and employment.

Kelly Parker
Executive Director
1502#077

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Board of Examiners of Psychologists

Continuing Education (LAC 46:LXIII.811)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Department of Health and Hospitals, Board of Examiners of Psychologists hereby gives notice of its intent to modify LAC 46:LXIII.Chapter 8, Continuing Education, §811, Extensions/Exemptions. This modification provides for an exemption for emeritus licenses until 2015 and 2016. Emeritus licensees who hold an odd license will begin accruing continuing education hours on July 1, 2015 and will report by June 30, 2017. Emeritus licensees who hold an even license will begin accruing continuing education hours on July 1, 2016 and will report by June 30, 2018.

Title 46
Professional and Occupational Standards
Part LXIII. Psychologists
Chapter 8. Continuing Education
§811. Extensions/Exemptions

A. - C. ...

D. Emeritus licensees will be exempt until reporting periods beginning July 1, 2015 and July 1, 2016.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2354

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 19:47 (January 1993), amended LR 32:1229 (July 2006), LR 39:2755 (October 2013), LR 41:

Family Impact Statement

The State Board of Examiners of Psychologists hereby issues this Family Impact Statement as set forth in R.S. 49:972. The proposed Rule and adoption of the Rule related emeritus licensees is being implemented to guarantee the licensing authority can safeguard the public welfare of this state and will have no known foreseeable impact on the stability of the family; authority and rights of parents regarding the education and supervision of their children; functioning of the family; family earnings and family budget; behavior and personality responsibility of children; or the ability of the family or a local government to perform the function as contained in the proposed Rule.

Poverty Impact Statement

The proposed Rule creates a new Rule, LAC 46:LXIII.Chapter 8. The 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. the effect on household income, assets, and financial security;
2. the effect on early childhood development and preschool through postsecondary education development;
3. the effect on employment and workforce development;

4. the effect on taxes and tax credits;

5. the effect on 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:

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 to Kelly Parker, Executive Director, 8706 Jefferson Highway, Suite B, Baton Rouge, LA 70809. All comments must be submitted by 12 p.m. on March 23, 2015.

Kelly Parker
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Continuing Education

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

The estimated implementation cost for this rule totals approximately $200 in state FY 15 and only applies the Board of Examiners of Psychologists. Those costs are related to publishing the proposed and final rule in the *Louisiana Register*. The proposed rule provides clarification that Emeritus licensees must acquire coninuing education credits and provides a short-term exemption of continuing education requirements for those individuals until the reporting periods beginning in July 2015 and July 2016.

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

No impact on state or local government revenue collections is anticipated as a result of the proposed rule change,

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

This amendment provides clarification in regards to continuing education for Emeritus licensees. Emeritus licensees are licensed psychologists who have licenses in good standing, have held continuous licensure, and have at least reached the age of 65 and work at most part time. Continuing education provides for essential continuing professional development and is necessary to ensure public protection even if the licensee is working part-time. The modification exempts Emeritus licensees until the reporting periods beginning in July 2015 and July 2016.

The cost of any continuing education program is to be borne by the licensee and paid directly to the entity organizing the course or program. The amended language will have a minimal impact on licensees and is in agreement with the recommended national guidelines issued by the Association of State Provincial Psychology Boards (ASPPB). There are approximately 706 licensed psychologists regulated by this Board, and it is estimated that 54 hold Emeritus status.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no estimated effect on competition and employment as a result of this rule change.

Kelly Parker
Executive Director
1502#078

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Board of Examiners of Psychologists

Provisional Licensure of Psychologists
(LAC 46:LXIII.Chapter 1-21)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Department of Health and Hospitals, State Board of Examiners of Psychologists hereby notices its intent to create a subpart of LAC 46:LXIII.Chapters 1-21 to include regulations for licensed specialists in school psychology. This modification is necessary pursuant to Act 136 of the 2014 Legislative Session.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part LXIII. Psychologists
Subpart 2. Licensed Specialists in School Psychology
Chapter 1. Definitions
§101. Definition of Board

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 4 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 1 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

§301. Definition

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 State 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 Paragraph.
4. has completed a school specialist degree from a National Association of School Psychologists approved program or equivalent;
5. has completed a one-thousand-two-hundred hour, at least a nine-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 1200 hundred 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 consisted 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;

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, measureable, 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 sires 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 there formal education is equivalent to specialist-level training in a 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

§501. Limits in Practice

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. Examinations

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.

B. 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.1. 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.

a. 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.

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

2. 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

1. 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

2. Required documentation: official college or university transcript.

C. Training and In-service Activities

1. 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

2. 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

1. 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

2. Required documentation: board approved form.

E. Supervision of Graduate Students

1. 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

2. Required documentation: board approved form.

F. Supervised Experience

1. 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

2. Required documentation: board approved form.

G. Program Planning/Evaluation

1. 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

2. 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.

one hour of participation in either type	1 credit
maximum credits	25 credits

2. Required documentation: certificate of completion.

I. Professional Organization Leadership

1. 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

2. 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

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

C. 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

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:

Poverty Impact Statement

The proposed modifications regulate provisionally licensed psychologists. The provisional license was established in Act 137 of the 2014 Legislative Session. The rules 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. the effect on household income, assets, and financial security;

2. the effect on early childhood development and preschool through postsecondary education development;

3. the effect on employment and workforce development;

4. the effect on taxes and tax credits;

5. the effect on 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:

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 to Kelly Parker, Executive Director, 8706 Jefferson Highway, Suite B, Baton Rouge, LA 70809. All comments must be submitted by 12 noon on March 12, 2015.

Kelly Parker
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Provisional Licensure of Psychologists

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

The estimated implementation cost for the proposed rule totals approximately $1,000 in FY 15. Those costs are related to publishing the proposed and final rules in the Louisiana Register. The proposed rule codifies and provides regulations for licensed specialists in school psychology [LSSP] pursuant to Act 136 of the 2014 Legislative Session.

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

The proposed rule establishes licensure for a specialist in school psychology and creates a fee schedule for application, examination, renewal, reinstatement, background checks and administrative processes. Any increase in self-generated revenues to the Board is difficult to estimate because the licensure is optional and not required. Any impact on revenues to the Board as a result of the proposed rule are likely to be minimal. There is no estimated impact on state or local government revenue collections as a result of the proposed rule change.

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

The proposed rules provide regulations for licensed specialists in school psychology pursuant to Act 136 of the 2014 Legislative Session. Individuals that attain licensure as a specialist in school psychology could potentially realize unspecified economic benefits in terms of employability, particularly if the licensure becomes a desired qualification for employment. The cost of any licensure fees is to be borne by the applicant for specialist license and paid to the Board. The proposed language will not affect current licenses. The proposed language is consistent with national guidelines issued by the National Association of School Psychologists (NASP).

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no estimated effect on competition and employment as a result of this rule change.

Kelly Parker	John D. Carpenter
Executive Director	Legislative Fiscal Officer
1502#080	Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Board of Examiners of Psychologists

Provisional Licensure of Psychologists
(LAC 46:LXIII.102, 105, 601, 603, 701, 705, 709, 901, 902, 1101, 1301, 1503, 1901, and 2103)

In accordance with R.S. 49:950 et seq., the Administrative Procedure Act, the Department of Health and Hospitals, Board of Examiners of Psychologists hereby gives notice of its intent to modify LAC 46:LXIII.Chapters 1-21 to include references to provisionally licensed psychologists. This modification is necessary pursuant to Act 137 of the 2014 Legislative Session.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part LXIII. Psychologists

Chapter 1. Definitions

§102. Definition of Applicant for Provisional Licensure

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 an intention to become a citizen. A statement by the person, under oath, to apply for citizenship upon becoming eligible to make such application shall be sufficient proof of compliance with this requirement; and

4. holds a doctoral degree with a major in psychology from a university offering a full-time graduate course of study in psychology that is approved by the board with such requirements as designated in the board's rules and regulations; and

5. has completed a minimum of one year of experience practicing psychology under the supervision of a licensed psychologist or medical psychologist licensed in accordance with R.S. 37:1360.51 et seq., or has completed an approved predoctoral internship as defined in the rules and regulations of the board and required as part of the doctoral degree in psychology as defined by the board and all other experience being post-doctoral;

6. all applicants for provisional licensure must submit and obtain preapproval of a supervised practice plan as a requirement for licensure;

7. is not in violation of any of the provisions of R.S. 37:2351-2367 and the rules and regulations adopted thereunder; and

8. submits such number of full sets of fingerprints and fees and costs as may be incurred by the board in requesting or obtaining criminal history record information as authorized by R.S. 37:2372.1, and in the form and manner

prescribed by the boards rules and regulations. The results of the criminal history record information search to be obtained, reviewed and considered acceptable by the board prior to admission to candidacy status.

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

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

§105. Definition of Candidate for Licensure

A. A candidate for licensure is an applicant or provisional licensee (as defined in the rules and regulations of the board) who:

1. has been judged by the board to have met the requirements set forth under the definition applicant or definition of applicant for provisional license; and
2. is therefore admitted to the written examination.

B. An applicant may be admitted to candidacy, and therefore may take the required written examination, prior to completion of the two years of full-time supervised and documented postdoctoral experience, which is required for licensure and as defined in the rules and regulations of the board, or prior to expiration of the provisional license.

C. A candidate for licensure may retake the written examination as frequently as it is offered by the board, however, the candidate shall not be allowed to take the examination more than three times without meeting the minimum criterion set by the board for successful completion.

D. A candidate shall have a maximum of four years to pass the written examination.

E. A candidate who fails to pass the written examination three times (as in §105.C) or within four years (as in §105.D) shall be removed from candidacy for licensure and shall not be issued a license to practice psychology in Louisiana.

F. Candidates who are provisionally licensed who fail the written exam three times or fail to complete the written exam within four years shall have the provisional license revoked and be removed from candidacy for licensure and shall not be issued a license to practice psychology in Louisiana.

G. The above requirements of a written examination shall not prohibit a modified administration of the examination to an otherwise qualified candidate who is handicapped and whose handicap would interfere with the ability of the candidate to demonstrate satisfactory knowledge of psychology as measured by the examination.

H. A candidate who successfully completes the written examination will be admitted to the oral examination before the board.

I. A candidate who successfully completes the oral examination, in the judgment of the board, shall be issued a license in psychology upon the completion of the two years of full-time supervised and documented postdoctoral experience which is required for licensure under R.S. 37:2351-2367 and as defined in the rules and regulations of the board.

J. A candidate denied licensure under the preceding provisions, may reapply to the board after more than two years have elapsed from the effective date of the notification by the board of such denial.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Examiners of Psychologists, LR 5:248 (August 1979), amended by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 6. Fees

§601. Licensing Fees

Licensing Fees	Amount
Application for Licensure	$200
Application for Provisional Licensure	$150
Oral Examination (Licensure, specialty change or additional specialty)	$250
Temporary Registration	$125
Jurisprudence Examination	$75
Licensed Psychologist Renewal	$320
Provisional License Renewal	$100
Emeritus License Renewal	$160
Reinstatement of Lapsed License (Application plus renewal fee)	$520

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2354.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 33:647 (April 2007), amended LR 41:

§603. Administrative/Other Fees

Administrative/Other Fees	Amount
Address List/Labels	$ 100
License Verification	15
Disciplinary Action Report	25
Replacement License Certificate	25
Photo ID Card	15

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2354.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 33:648 (April 2007), amended LR 41:

Chapter 7. Supervised Practice Leading toward Licensure

§701. Preface

A. This document details reasonable minimal standards for supervised practice and establishes the legal, administrative and professional responsibility of the licensed psychologist or medical psychologist licensed in accordance with R.S. 27:1360.51 et seq., designated as supervisor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Examiners of Psychologists, LR 5:249 (August 1979), amended LR 7:187 (April 1981), amended by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§705. Qualifications of Supervisors

A. Responsibility for the overall supervision of the supervisee's professional growth resides in the licensed psychologist or medical psychologist. Supervising psychologists shall at least be licensed for one year and have training in the specific area of practice in which they are offering supervision. Specific skill training may be assigned to other specialists, under the authority of the supervising psychologist. The non-psychologist specialist shall have

clearly established practice and teaching skills demonstrable to the satisfaction of both the supervising psychologist and the supervisee.

B. The supervisor shall limit the number of persons supervised so as to be certain to maintain a level of supervision and practice consistent with professional standards insuring the welfare of the supervisee and the client. The supervisor must be licensed for one year and may not supervise any more than two candidates for licensure at the same time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Examiners of Psychologists, LR 5:249 (August 1979), amended LR 7:187 (April 1981), amended by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

§709. Conduct of Supervision

A. The board recognizes that the variability in preparation for practice of the trainee will require individually tailored supervision. The specific content of the supervision procedures will be worked out between the individual supervisor and the supervisee.

B. The licensed psychologist or medical psychologist who provides supervision for the candidate for licensure must have legal functioning authority over and professional responsibility for the work of the supervisee. This means that the supervisor must be available to the supervisee at the point of the decision-making. The supervisor's relationship with the supervisee shall be clearly differentiated from that of consultant, who may be called in at the discretion of the consultee and who has no functional authority for, nor none of the legal or professional accountability for the services performed or for the welfare of the client.

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

1. All clients will be informed of the availability or possible necessity of meetings with the supervising psychologist at the request of the client, the supervisee, or the psychologist. The supervisor will be available for emergency consultation and intervention.

2. All written communication will clearly identify the licensed psychologist or medical psychologist as responsible for all psychological services provided. Public announcement of services and fees, and contact with the public or professional community shall be offered only by or in the name of the licensed psychologist or medical psychologist. It is the responsibility of both the supervising psychologist and the supervisee to inform the client, to whatever extent is necessary for the client to understand, of the supervisory status and other specific information as to supervisee's qualifications and functions

3. Billing and receipt of payment is the responsibility of the employing agency or the licensed psychologist/medical psychologist and/or provisional licensed psychologist. The setting and the psychological work performed shall be clearly identified as that of the licensed psychologist. The physical location where services are delivered may not be owned, leased, or rented by the supervisee.

4. The supervisor must be paid either directly by the client or by the agency employing the supervisee. The supervisee may not pay the supervisor for supervisory services, nor may the supervisee and/or his/her immediate family have any financial interest in the employing agency.

5. 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 for that client to understand, that the supervising psychologist or the employing agency is to be the source of access to this information in the future.

D. In the event the supervisee publicly represents himself/herself inappropriately, or supervision is not conducted according to LAC 46:LXIII.709, the board may rule that any experience gained in that situation is not commensurate with ethical standards and thus not admissible as experience toward licensure. The board may further rule that any psychologist providing supervision under those circumstances is in violation of ethical standards which results in disciplinary action such as suspension or revocation of licensure.

E. Termination of supervision of a provisionally licensed psychologist must be reported to the board by both the supervisor and supervisee, in writing via postal mail, within seven calendar days from when either party knew or should have known supervision was terminated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Examiners of Psychologists, LR 5:249 (August 1979), amended LR 7:187 (April 1981), amended by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 9. Licensees

§901. Provisional License Renewal

A. A psychologist is eligible to renew their provisional license until July 31 of each year upon submission of the required renewal fee, renewal application form and fulfillment of all continuing education requirements as defined in LAC 46:LXIII.Chapter 8.

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

C. A person whose provisional license has been suspended is not eligible for renewal. Reinstatement procedures of a suspended provisional license are at the discretion of the board.

D. A person whose provisional license has been revoked is not eligible for renewal.

E. Provisionally licensed psychologists shall be eligible for renewal of provisional licensure no more than three consecutive years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Examiners of Psychologists, LR 6:489 (August 1980), amended LR 10:795 (October 1984), amended by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 29:2074 (October 2003), LR 33:648 (April 2007), LR 36:1007 (May 2010), LR 41:

§902. Lapsed Provisional License

A. If a provisional license is not renewed by July 31st, due notice having been given, the license shall be regarded as lapsed for the year beginning with that August. Such license is not eligible for reinstatement unless such

requirements are satisfied within six months from the date of lapse.

B. If a provisional license lapses for a period longer than 6 months, one may make a new application to the board. It is at the discretion of the board that any requirements not fulfilled during the year prior to lapse be completed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

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

Chapter 11. Supervision of Assistants to Psychologists

§1101. Conditions for Utilization of Assistants

A. An assistant providing psychological services must be under the general and continuing professional supervision of a licensed psychologist. General supervision means the procedure is furnished under the psychologist's overall direction and control, but the psychologist's presence is not required during the performance of the procedure. Under general supervision, the training of the non-psychologist personnel who actually performs the diagnostic procedure and maintenance of the necessary equipment and supplies are the continuing responsibility of the psychologist.

B. In order to maintain ultimate legal and professional responsibility for the welfare of every client, a licensed psychologist must be vested with functional authority over the psychological services provided by assistants.

C. 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 also be available for emergency consultation and intervention.

D. Work assignments shall be commensurate with the skills of the assistant and procedures shall under all circumstances be planned in consultation with the supervisor.

E. The supervisory contact with assistants shall occur in the service delivery setting, unless otherwise approved by the board of examiners.

F. Public announcement of fees and services and contact with lay or professional public shall not be offered in the name of the assistant.

G. Billing for psychological services shall not be in the name of an assistant.

H. A provisional licensed psychologist may not supervise unlicensed assistants.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Examiners of Psychologists, LR 5:250 (August 1979), amended by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 36:1246 (June 2010), LR 41:

Chapter 13. Ethical Standards of Psychologists

§1301. Ethical Principles and Code of Conduct

A. The Board of Examiners of Psychologists incorporates by reference and maintains that Psychologists shall follow the APA Ethical Principles of Psychologists and Code of Conduct with the 2010 amendments adopted by the American Psychological Association's Council of Representatives on February 20, 2010, effective June 1, 2010. The *Ethics Code* and information regarding the Code can be found on the APA website, http://www.apa.org/ethics, or from the LSBEP web site at http://www.lsbep.org.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Examiners of Psychologists, LR 6:66 (February 1980), amended LR 10:791 (October 1984), amended by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 29:703 (May 2003), LR 41:

Chapter 15. Rules for Disciplinary Action

Subchapter A. Applicability; Processing Complaints

§1503. Complaints

A. A *complaint* is defined as the receipt of any information by the board indicating that there may be grounds for disciplinary action against a licensed psychologist or provisional licensed psychologist, or any other individual, under the provisions of title 37, chapter 28 of the *Louisiana Revised Statutes*, or other applicable law, regulation or rule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Examiners of Psychologists, LR 9:461 (July 1983), amended LR 12:833 (December 1986), amended by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 36:1008 (May 2010), LR 41:

Chapter19. Public Information

§1901. Public Display of License

A. The license of the licensed psychologist or provisional licensed psychologist shall be publicly displayed in the office where services are offered. When a psychologist works in two or more settings, the license should be publicly displayed in the primary office location.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 15:88 (February 1989), amended by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 41:

Chapter 21. Disclosure of Financial Interests and Prohibited Payments

§2103. Definitions

* * *

Provisional Licensed Psychologist—any individual who practices under the supervision of a Louisiana licensed psychologist and has met all minimal requirements as determined by the Louisiana State Board of Examiners of Psychologists.

* * *

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:2353.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Examiners of Psychologists, LR 21:1335 (December 1995), amended LR 41:

Poverty Impact Statement

The proposed modifications regulate provisionally licensed psychologists. The provisional license was established in Act 137 of the 2014 Legislative Session. The rules 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. the effect on household income, assets, and financial security;

2. the effect on early childhood development and preschool through postsecondary education development;

3. the effect on employment and workforce development;

4. the effect on taxes and tax credits;

5. the effect on 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:

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 to Kelly Parker, Executive Director, 8706 Jefferson Highway, Suite B, Baton Rouge, LA 70809. All comments must be submitted by 12 p.m. on March 23, 2015.

Kelly Parker
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Provisional Licensure of Psychologists

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

The estimated implementation cost for the proposed rule to the Board is approximately $800 in state FY 15. These costs are related to publishing the proposed and final rule in the *Louisiana Register*. The proposed rule codifies and provides updates to regulations to include provisionally licensed psychologists pursuant to Act 137 of the 2014 Legislative Session. There is no implementation costs or savings to other state or local governmental units.

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

The proposed rule establishes licensure for a provisionally licensed psychologist and creates a fee schedule for application and license renewal. The impact on self-generated revenues to the Board of Examiners of Psychologists is expected to be immaterial. There is no estimated impact on state or local government revenue collections as a result of the proposed rule change.

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

The proposed rules provide updates to regulations to include regulations for provisionally licensed psychologists pursuant to Act 137 of the 2014 Legislative Session.

The cost of any provisional licensure fees is to be borne by the applicant for provisional licensure and paid to the Board. The amended language will not affect current licenses. The proposed language is consistent with recommended national guidelines issued by the Association of State and Provincial Psychology Boards (ASPPB) and American Psychological Association (APA).

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

Creation of a provisionally licensed psychologist may afford individuals with an enhanced opportunity to gain employment while acquiring minimal practice hours for full licensure.

Kelly Parker
Executive Director
1502#079

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Board of Medical Examiners

Physician Assistants, Licensure and Certification; Practice
(LAC 46:XLV.1521, 4505, 4506, 4511, and 4512)

Notice is hereby given that in accordance with the Louisiana Administrative Procedure Act, R.S. 49:950 et seq., and pursuant to the authority vested in the Louisiana State Board of Medical Examiners (board) by the Louisiana Medical Practice Act, R.S. 37:1270, and the Louisiana Physician Assistant Practice Act, R.S. 37:1360.21-1360.38, the board intends to amend its rules governing physician assistants (PAs), LAC 46:XLV.1521.A.5.f, 1521.A.5.h., 4505.D, 4506.A.2, 4511.A.4 and 4512. The proposed amendments eliminate the need for a supervising physician (SP) to countersign all records documenting the activities, functions, services and treatment measures prescribed or delivered to patients by a PA (§§1521.A.5.f, 4505.D, 4506.A.2 and 4511.A.4). Section 4512 provides that a performance plan must be included in a PA's clinical practice guidelines or protocols and identify the SP responsible for plan compliance (§4512.B). Flexibility is provided in plan development, which must include some chart review and any other items that the SP and PA deem appropriate (§4512.A.2). Increased chart review is necessary for new PAs during the first 12 months of practice and during the first 6 months for a PA shifting into an entirely new area of practice. (§4512.A.1.a). If the PA/SP work together at the same primary practice site, routinely confer with respect to patient care, and document their services in the charts and records maintained at the primary practice site, the increased chart review requirement is deemed satisfied. (§4512.A.1.b). Records regarding the plan must be maintained and made available to board representatives upon request. (§4512.C). The proposed amendments are set forth below.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part XLV. Medical Professions
Subpart 2. Licensure and Certification
Chapter 15. Physician Assistants
§1521. Qualifications for Physician Assistant Registration of Prescriptive Authority

A. Legend Drugs/Medical Devices. To be eligible for registration of prescriptive authority for legend drugs or medical devices, or both, a physician assistant shall:

1. - 4.b. …

5. practice under supervision as specified in clinical practice guidelines or protocols that shall, at a minimum, include:

a. - e. …

f. an acknowledgment of the mutual obligations and responsibilities of the supervising physician and physician assistant to comply with all requirements of §4511 of these rules; and

g. …

h. a performance plan, as specified in Section 4512 of these rules.

B. - E. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), 1360.23(D) and (F), and 1360.31(B)(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 31:75 (January 2005), amended LR 38:3174 (December 2012), LR 41:

Subpart 3. Practice

Chapter 45. Physician Assistants

§4505. Services Performed by Physician Assistants

A. - C. …

D. A physician assistant may administer medication to a patient, or transmit orally, electronically, or in writing on a patient's record, a prescription from his or her supervising physician to a person who may lawfully furnish such medication or medical device. The supervising physician's prescription, transmitted by the physician assistant, for any patient cared for by the physician assistant, shall be based on a patient-specific order by the supervising physician. At the direction and under the supervision of the supervising physician, a physician assistant may hand deliver to a patient of the supervising physician a properly labeled prescription drug prepackaged by a physician, a manufacturer or a pharmacist.

E. - E.6. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), 37:1360.23(D) and (F), 37:1360.31(B)(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Medical Examiners, LR 4:111 (April 1978), amended by the Department of Health and Hospitals, Board of Medical Examiners, LR 17:1105 (November 1991), LR 22:204 (March 1996), LR 25:32 (January 1999), LR 31:78 (January 2005), LR 41:

§4506. Services Performed by Physician Assistants Registered to Prescribe Medication or Medical Devices; Prescription Forms; Prohibitions

A.1. - A.1.c. …

2. The medical record of any patient for whom the physician assistant has prescribed medication or a medical device, or delivered a bona fide medication sample, shall be properly documented by the physician assistant.

B. - C.6. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), 37:1360.23(D) and (F), 37:1360.31(B)(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 31:79 (January 2005), amended LR 41:

§4511. Mutual Obligations and Responsibilities

A. The physician assistant and supervising physician shall:

1. - 3. …

4. insure that, with respect to each direct patient encounter, all activities, functions, services, treatment measures, medical devices or medication prescribed or delivered to the patient by the physician assistant are properly documented in written form in the patient's record by the physician assistant;

A.5. - C. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), 37:1360.23(D) and (F), 37:1360.31(B)(8).

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Board of Medical Examiners, LR 4:112 (April 1978), amended by the Department of Health and Hospitals, Board of Medical Examiners, LR 17:1106 (November 1991), LR 22:206 (March 1996), LR 25:33 (January 1999), LR 31:79 (January 2005), LR 41:

§4512. Performance Plan

A. For each practice setting, a PA and SP shall develop and implement a meaningful performance plan for evaluating whether the PA has performed medical services delegated by the SP with professional competence and with reasonable skill and safety to patients. At a minimum, the plan shall include:

1. for new graduates/major shift in practice:

a. *different primary practice sites*—if the PA's primary practice site (as defined in §1503.A of these rules e.g., the location at which a PA spends the majority of time engaged in the performance of his or her profession) is different from the SP's primary practice site then, during the first 12 months of supervised practice after passing the credentialing examination, and the first 6 months after entering into an entirely new field of practice, such as from primary care or one of its sub-specialties to a surgical specialty or sub-specialty, monthly chart review conducted by a SP of no less than 50 percent of the PA's patient encounters, as documented in the patient records;

b. *same primary practice site*—where the SP and PA work together, have the same primary practice site, routinely confer with respect to patient care, and the PA and SP document their services in the charts and records maintained at the primary practice site, the requirements of §4512.A.1.a shall be considered satisfied;

2. for all other PAs not falling within §4512.A.1: a review of such number of charts and records of the PA on a monthly basis as the SP deems appropriate to meet the purposes of §4512.A. If the PA has prescriptive authority the plan shall include a review of a representative sample of the PA's prescriptions. The plan should also include any other items that the SP and PA deem appropriate to insure that the purposes of this Section are met (e.g., documented conferences between the PA and SP concerning specific patients, a sample of medical orders, referrals or consultations issued by the PA, observation of the PA's performance, the SP's examination of a patient when he or she deems such indicated, etc.).

B. The plan shall be a component of the clinical practice guidelines. The SP responsible for compliance with the plan shall be designated in the PA's clinical practice guidelines. Questions respecting the applicability of this paragraph in specific cases shall be determined at the discretion of the board.

C. Accurate records and documentation regarding the plan for each PA, including a list of the charts and any other items reviewed, shall be maintained for three years and made available to board representatives upon request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(B)(6), 37:1360.23, 37:1360.28.

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

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of the proposed amendments on the family has been considered. It is not anticipated that the proposed amendments will have any impact on family, formation, 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 impact of the proposed amendments on those that may be living at or below one hundred percent of the federal poverty line has been considered. It is not anticipated that the proposed amendments will have any 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 HCR 170 of the 2014 Regular Session of the Louisiana Legislature, the impact of the proposed amendments on organizations that provide services for individuals with development disabilities has been considered. It is not anticipated that the proposed amendments will have any impact on the staffing, costs or overall ability of such organizations to provide the same level of services, as described in HCR 170.

Public Comments

Interested persons may submit written data, views, arguments, information or comments on the proposed amendments to Rita Arceneaux, Confidential Executive Assistant, Louisiana State Board of Medical Examiners, 630 Camp Street, New Orleans, LA 70130, (504) 568-6820, ex. 242. She is responsible for responding to inquiries. Written comments will be accepted until 4 p.m., March 23, 2015. If a public hearing is requested to provide data, views, arguments, information or comments in accordance with the Louisiana Administrative Procedure Act, the hearing will be held on March 27, 2015, at 9:30 a.m. at the office of the Louisiana State Board of Medical Examiners, 630 Camp Street, New Orleans, LA 70130. Any person wishing to attend should call to confirm that a hearing is being held.

Public Hearing

A request pursuant to R.S. 49:953(A)(2) for a public hearing must be made in writing and received by the board within 20 days of the date of this notice.

Cecilia Mouton, M.D.
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Physician Assistants, Licensure and Certification; Practice

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

Other than the rule publication costs of $654 in FY15, it is not anticipated that the proposed rule changes will impact costs or savings to the Board of Medical Examiners (Board) or any state or local governmental unit. The proposed rule changes eliminate the current requirement that Supervising Physicians must countersign specific enumerated actions prescribed or delivered by a Physician Assistant in the treatment of a patient. The rule changes detail practice guidelines and protocols to facilitate this change.

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

It is not anticipated that the proposed rule changes will impact revenue collections of the Board of Medical Examiners or any state or local governmental unit.

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

The Board proposes to amend its Physician Assistant (PA) Rules to eliminate the current requirement that all documented activities, functions, services and treatment measures prescribed or delivered to patients by a PA must be countersigned by the supervising physician (SP). (1521.A.5.f, 4505D, 4506A.2 and 4511A.4). The changes also add Section 4512, which calls for the development and inclusion of a performance plan into a PA's existing clinical practice guidelines or protocols and the identity of the SP responsible for plan compliance (4512B). Flexibility is provided to the parties to develop a plan that works best in their particular practice setting. The plan must include some chart review and any other items that the SP and PA deem appropriate (4512A.2). Increased chart review is required for new PAs during the first 12 months of practice and during the first 6 months for a PA shifting into an entirely new area of practice. If the PA/SP work together at the same primary practice site, routinely confer with respect to patient care, and document their services in the charts and records maintained at the primary practice site, the increased chart review requirement is deemed satisfied. (4512A.1). Records regarding the plan must be maintained and made available to board representatives upon request. (4512C).

PAs and SPs will spend some amount of time developing a performance plan. The board is not in a position to estimate the proposed impact on individual medical practices with regard to developing this plan but believes it will be much less than that currently devoted by SPs to countersigning PA chart entries. The proposed amendments may result in a savings in time and/or reduction in workload for SPs and, in turn, serve to increase receipts and/or income of SPs to an indeterminable amount. Otherwise, it is not anticipated that the proposed amendments will have any material effect on receipts, costs, paperwork or workload of PAs or SPs licensed to practice in this state or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed changes may decrease, to some extent, the time required to supervise a PA by physicians who utilize them in their practice. This may, to an extent not quantifiable, enhance employment opportunities for PAs. Otherwise, it is not anticipated that the proposed amendments will have any impact on competition or employment in either the public or private sector.

Cecilia Mouton, M.D.
Executive Director
1502#044

John D. Carpenter
Legislative Fiscal Officer
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Board of Veterinary Medicine

License Procedures (LAC 46:LXXXV.303)

Louisiana Board of Veterinary Medicine proposes to adopt LAC 46:LXXXV.303.E 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) and 37:1533. 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.

Pursuant to current legal authority, a member of the faculty at LSU-School of Veterinary Medicine is exempt from active licensure when performing his educational function in a classroom setting or giving instructions at a continuing education seminar. However, faculty member conduct is extending beyond what can reasonably be considered part of education, such as engaging in the active (direct) or constructive (indirect) practice of veterinary medicine on an animal owned by a member of the public whether by referral from a private practice veterinarian, or by direct patient solicitation/access without referral, as part of his employment at the school. Such conduct is occurring without administrative regulatory accountability to insure the health, welfare, and protection of the animals and the public. The proposed rules are being adopted to require a faculty member to possess a veterinary faculty license when his conduct, through employment at the public university, extends to the care and treatment of an animal owned by the public, and related matters.

The proposed Rule regarding the veterinary faculty license shall become effective for the 2016-2017 annual license period (beginning October 1, 2016), and for every annual license renewal period thereafter.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part LXXXV. Veterinarian
Chapter 3. Licensure Procedures
§303. Examinations

A. - D. …

E. Veterinary Faculty License

1. Section 1514(7) of the Veterinary Practice Act grants an exception to the requirement for a license to practice veterinary medicine for a member of the faculty at LSU-SVM when performing his educational function in a classroom setting or giving instructions at a continuing education seminar; however, when the conduct extends beyond what can reasonably be considered part of education, such as engaging in the active (direct) or constructive (indirect) practice of veterinary medicine on an animal owned by the public whether by referral from another veterinarian, or by direct patient access without referral, as part of his employment at the school, the faculty member then enters the realm of veterinary practice without first having to meet the requirements necessary to have a license as established by the Veterinary Practice Act and the board's rules.

2. Pursuant to Section 1533 of the Veterinary Practice Act, a faculty license to practice veterinary medicine issued by the board to a member of the faculty at LSU-SVM is required when the conduct extends to the active (direct) or constructive (indirect) practice of veterinary medicine on an animal owned by the public whether by referral from another veterinarian, or by direct patient access without referral, as part of his employment at the school.

3. A faculty license shall not be used to practice veterinary medicine beyond the holder's employment at the school as defined in these rules. Such prohibition includes the holder practicing veterinary medicine at a private practice facility or an emergency care facility which requires an active license. However, an active license to practice veterinary medicine issued by the board to a qualified faculty veterinarian may be used by the holder for all aspects of his employment and practice at the school, as well as within the emergency and private practice settings.

4. Further criteria for issuance of a faculty license is when the applicant:

a. provides proof of graduation from a school of veterinary medicine with a degree of doctor of veterinary medicine or its equivalent accredited by the American Veterinary Medical Association, or graduation from a foreign veterinary school proof of completion of the ECFVG program offered by the AVMA or the PAVE program offered by the AAVSB; and

i. has possessed an active license in good standing issued by another state, territory, or district in the United States within the five years prior to the date of application for a faculty license; or

ii. has a current certificate of special competency in a particular field of veterinary medicine recognized by the AVMA at the time of application for a faculty license;

b. all other requirements for the issuance of a license, and thereafter, for renewal, are applicable, including annual continuing education for licensure renewal and payment of fees;

c. all applicants for a license must satisfy the preceptorship program requirement, or be granted a waiver by the board pursuant to preceptorship program waiver criteria, or possess an active license in good standing issued by another state, territory, or district in the United States at the time of application for a faculty license;

d. all applicants for a faculty license must successfully pass the state jurisprudence examination.

5. The faculty license shall be subject to cancellation for any of the reasons and under the same conditions set forth in R.S. 37:1526 and the board's rules, or if the holder permanently moves out of Louisiana, or leaves the employment of LSU-SVM.

6. Pending issuance of a faculty license or an active license, an intern or resident, who is a graduate of a board approved school of veterinary medicine, may practice veterinary medicine at LSU-SVM, provided the practice is limited to such duties as intern or resident, and is under the supervision of a veterinarian who holds a faculty license issued by the board (or a faculty veterinarian with an active license issued by the board). Supervision as used in this rule shall mean the presence of the supervising, faculty licensed veterinarian (or a faculty veterinarian with an active license issued by the board) on the premises and his availability for

prompt consultation and treatment. The supervising, faculty licensed veterinarian (or a faculty veterinarian with an active license issued by the board) shall be ultimately responsible for and held accountable by the board for the duties, actions, or work performed by the intern or resident.

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 8:66 (February 1982), amended LR 8:144 (March 1982), amended by the Department of Health and Hospitals, Board of Veterinary Medicine, LR 19:343 (March 1993), LR 19:1327 (October 1993), LR 23:964 (August 1997), LR 25:2232 (November 1999), LR 28:1982 (September 2002), LR 38:1592 (July 2012), LR 40:308 (February 2014), LR 41:

Family Impact Statement

In accordance with section 953 of title 49 of the *Louisiana Revised Statutes*, the following Family Impact Statement will be published in the *Louisiana Register* with the rules.

1. The effect on the stability of the family. We anticipate 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. We anticipate 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. We anticipate no effect on the functioning of the family.

4. The effect on family earnings and family budget. The rules regarding application and renewal fees should have no significant adverse effect on family earnings and family budget.

5. The effect on the behavior and personal responsibility of children. We anticipate no effect on the behavior and personal responsibility of children.

6. The ability of the family or a local government to perform the function as contained in the proposed Rules. We anticipate no effect on the ability of the family or a local government to perform the function as contained in the rules.

Poverty Impact Statement

In accordance with section 973 of title 49 of the *Louisiana Revised Statutes*, the following Poverty Impact Statement will be published in the *Louisiana Register* with the rules.

1. The effect on household income, assets, and financial security. The rules regarding application and renewal fees should have no significant adverse effect on household income, assets, and financial security.

2. The effect on early childhood development and pre-school through post-secondary education development. We anticipate no effect on early childhood development and pre-school through post-secondary education development regarding the rules.

3. The effect on employment and workforce development. The rules regarding application and renewal fees should have no significant effect on employment and workforce development.

4. The effect on taxes and tax credits. We anticipate no effect on taxes and tax credits regarding the rules.

5. The effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance. We anticipate no effect on child and dependent care, housing, health care, nutrition, transportation, and utilities assistance regarding the rules.

Small Business Statement

In accordance with section 965 of title 49 of the *Louisiana Revised Statutes*, the following regulatory flexibility analysis will be published in the *Louisiana Register* with the rules.

1. The establishment of less stringent compliance or reporting requirements for small businesses. There are no changes in record keeping or reporting requirements for small businesses.

2. The establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses. There are no changes in the deadlines for compliance or reporting requirements for small businesses.

3. The consolidation or simplification of compliance or reporting requirements for small businesses. The rules regarding application and renewal fees have no adverse effect on compliance or reporting requirements for small businesses.

4. The establishment of performance standards for small businesses to replace design or operational standards in the proposed rules. There are no design or operational standards in the rules.

5. The exemption of small businesses from all or any part of the requirements contained in the rules. There are no exemptions for small businesses in the rules, however, the rules do not apply to small businesses.

Provider Impact Statement

In accordance with HCR 170 of the 2014 Regular Legislative Session, the following Provider Impact Statement will be published in the *Louisiana Register* with the rules.

1. Staffing level requirements or qualifications. It is not anticipated that the rules will have any significant impact on the effect on the staffing level requirements or qualifications required to provide the same level of service.

2. Direct and indirect effect of costs. It is not anticipated that the rules will have any significant impact on the total direct and indirect effect on the cost to providers to provide the same level of service.

3. Ability to provide same level of service. It is not anticipated that rules will have any significant impact on 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 Wendy D. Parrish, Executive Director, Louisiana Board of Veterinary Medicine, 263 Third Street, Suite 104, Baton Rouge, LA 70801, or by facsimile to (225) 342-2142. Comments will be accepted through the close of business on Thursday, March 26, 2015.

Public Hearing

If it becomes necessary to convene a public hearing to receive comments in accordance with the Administrative Procedure Act, the hearing will be held on Tuesday, March 31, 2015, at 10 a.m. at the office of the Louisiana Board of Veterinary Medicine, 263 Third Street, Suite 104, Baton Rouge LA.

Wendy D. Parrish
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: License Procedures

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

The proposed rule changes will result in an expenditure of approximately $800 Fees and Self-Generated Revenues in state FY 15 for the Board of Veterinary Medicine and will result in no estimated costs (savings) to other state or local governmental units. This cost is routinely included in the board's annual operating budget. The proposed rules amend Louisiana Administrative Code (LAC) Title 46, Part LXXXV, Section 303.E regarding clarification of the Louisiana veterinary faculty license. The proposed rule creates a veterinary faculty license, requires licensure for veterinary school faculty, and details permissible practices under such license as well as requirements for licensure.

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

The Board of Veterinary Medicine anticipates an increase of approximately $32,250 in self-generated revenues in FY16, and increasing to approximately $8,250 above current revenue levels beginning in FY17 and beyond. The proposed increase in annual license renewal fees shall become effective for the 2016-2017 license renewal period (October 1, 2016-September 30, 2017) and annually thereafter; and the rules regarding application, state board examination, original license, and late renewal fees shall become effective upon promulgation.

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

The proposed fees regarding faculty license application, state board examination, and original license will create one-time costs of $550 to each faculty veterinarian associated with initial application, examination and licensure. The license renewal fee will be incurred thereafter annually at a rate of $100. The proposed rule will create administrative oversight by the Board regarding the treatment of animals at veterinary schools by faculty veterinarians.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rules are anticipated to have no effect on competition and employment in the public and private sectors.

Wendy D. Parrish	Evan Brasseaux
Executive Director	Staff Director
1502#029	Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Applied Behavior Analysis-Based Therapy Services
(LAC 50:XV.Chapters 1-7)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt LAC 50:XV.Chapters 1-7 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This proposed Rule is promulgated in accordance with the 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 for Citizens with Developmental Disabilities promulgated an Emergency Rule which amended the provisions of the children's choice waiver in order to provide for the allocation of waiver opportunities to Medicaid-eligible children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* class action litigation (hereafter referred to as *Chisholm* class members) who have a diagnosis of pervasive developmental disorder or autism spectrum disorder, and are in need of applied behavior analysis-based (ABA) therapy services (*Louisiana Register*, Volume 39, Number 10). This action was taken as a temporary measure to ensure *Chisholm* class members would have access to ABA therapy services as soon as possible.

To ensure continued, long-lasting access to ABA-based therapy services for *Chisholm* class members and other children under the age of 21, the department promulgated an Emergency Rule which adopted provisions to establish coverage and reimbursement for ABA-based therapy services under the Medicaid state plan (*Louisiana Register*, Volume 40, Number 2). The department promulgated an Emergency Rule which amended the provisions of the February 1, 2014 Emergency Rule to ensure compliance with all of the provisions required by the court order issued in *Melanie Chisholm, et al vs. Kathy Kliebert* class action litigation (*Louisiana Register*, Volume 40, Number 10). This proposed Rule is being promulgated to continue the provisions of the October 20, 2014 Emergency Rule.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 1. Applied Behavior Analysis-Based Therapy Services
Chapter 1. General Provisions
§101. Program Description and Purpose

A. Applied behavior analysis-based (ABA) therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement or prompting to teach each step of targeted behavior. ABA-based therapies are based on reliable evidence and are not experimental.

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 41:

§103. Recipient Criteria

A. In order to qualify for ABA-based therapy services, a Medicaid recipient must meet the following criteria. The recipient must:

1. be from birth up to 21 years of age;
2. exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to aggression, self-injury, elopement, impaired development in the areas of communication and/or social interaction, etc.);
3. be diagnosed by a qualified health care professional with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder; and

4. have a comprehensive diagnostic evaluation that prescribes and/or recommends ABA services that is conducted by a qualified health care professional.

B. All of the criteria in §103.A must be met to receive 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 41:

Chapter 3. Services

§301. Covered Services and Limitations

A. Medicaid covered ABA-based therapy services must be:

1. medically necessary;

2. prior authorized by the Medicaid Program or its designee; and

3. delivered in accordance with the recipient's treatment plan.

B. Services must be provided directly or billed by behavior analysts licensed by the Louisiana Behavior Analyst Board.

C. Medical necessity for ABA-based therapy services shall be determined according to the provisions of the *Louisiana Administrative Code* (LAC), Title 50, Part I, Chapter 11 (*Louisiana Register*, Volume 37, Number 1).

D. ABA-based therapy services may be prior authorized for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for reimbursement, except in the case of retroactive Medicaid eligibility.

E. Service Limitations

1. Services shall be based upon the individual needs of the child, and must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.

2. Services must be delivered in a natural setting (e.g., home and community-based settings, including schools and clinics).

a. Services delivered in a school setting must not duplicate services rendered under an individualized family service plan (IFSP) or an individualized educational program (IEP) as required under the federal Individuals with Disabilities Education Act (IDEA).

3. Any services delivered by direct line staff must be under the supervision of a lead behavior therapist who is a Louisiana licensed behavior analyst.

F. Not Medically Necessary/Non-Covered Services. The following services do not meet medical necessity criteria, nor qualify as Medicaid covered ABA-based therapy services:

1. therapy services rendered when measureable functional improvement or continued clinical benefit is not expected, and therapy is not necessary for maintenance of function or to prevent deterioration;

2. services that are primarily educational in nature;

3. services delivered outside of the school setting that are duplicative services under an individualized family service plan (IFSP) or an individualized educational program (IEP), as required under the federal Individuals with Disabilities Education Act (IDEA);

4. treatment whose purpose is vocationally- or recreationally-based;

5. custodial care;

a. for purposes of these provisions, custodial care:

i. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;

ii. is provided primarily for maintaining the recipient's or anyone else's safety; and

iii. could be provided by persons without professional skills or training; and

6. services, supplies, or procedures performed in a non-conventional setting including, but not limited:

a. resorts;

b. spas;

c. therapeutic programs; and

d. camps.

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 41:

§303. Treatment Plan

A. ABA-based therapy services shall be rendered in accordance with the individual's treatment plan. The treatment plan shall:

1. be person-centered and based upon individualized goals;

2. be developed by a licensed behavior analyst;

3. delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors;

4. identify long, intermediate, and short-term goals and objectives that are behaviorally defined;

5. identify the criteria that will be used to measure achievement of behavior objectives;

6. clearly identify the schedule of services planned and the individual providers responsible for delivering the services;

7. include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable;

8. include parent/caregiver training, support, and participation;

9. have objectives that are specific, measureable, based upon clinical observations, include outcome measurement assessment, and tailored to the individual; and

10. ensure that interventions are consistent with ABA techniques.

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 41:

Chapter 5. Provider Participation

§501. General Provisions

A. ABA-based therapy services must be provided by or under the supervision of a behavior analyst who is currently licensed by the Louisiana Behavior Analyst Board, or a licensed psychologist, or a licensed medical psychologist.

B. Licensed behavior analysts that render ABA-based therapy services shall meet the following provider qualifications:

1. be licensed by the Louisiana Behavior Analyst Board;

2. be covered by professional liability insurance to limits of $1,000,000 per occurrence, $1,000,000 aggregate;

3. have no sanctions or disciplinary actions on their Board Certified Behavior Analyst (BCBA®) or board certified behavior analyst-doctoral (BCBA-D) certification and/or state licensure;

4. not have Medicare/Medicaid sanctions, or be excluded from participation in federally funded programs (i.e., Office of Inspector General's list of excluded individuals/entities (OIG-LEIE), system for award management (SAM) listing and state Medicaid sanctions listings); and

5. have a completed criminal background check to include federal criminal, state criminal, parish criminal and sex offender reports for the state and parish in which the behavior analyst is currently working and residing.

a. Criminal background checks must be performed at the time of hire and at least five years thereafter.

b. Background checks must be current, within a year prior to the initial Medicaid enrollment application. Background checks must be performed at least every five years thereafter.

C. Certified assistant behavior analyst that render ABA-based therapy services shall meet the following provider qualifications:

1. must be certified by the Louisiana Behavior Analyst Board;

2. must work under the supervision of a licensed behavior analyst;

a. the supervisory relationship must be documented in writing;

3. must have no sanctions or disciplinary actions, if state-certified or board-certified by the BACB®;

4. may not have Medicaid or Medicare sanctions or be excluded from participation in federally funded programs (OIG-LEIE listing, SAM listing and state Medicaid sanctions listings); and

5. have a completed criminal background check to include federal criminal, state criminal, parish criminal and sex offender reports for the state and parish in which the certified assistant behavior analyst is currently working and residing.

a. Evidence of this background check must be provided by the employer.

b. Criminal background checks must be performed at the time of hire and an update performed at least every five years thereafter.

D. Registered line technicians that render ABA-based therapy services shall meet the following provider qualifications:

1. must be registered by the Louisiana Behavior Analyst Board;

2. must work under the supervision of a licensed behavior analyst;

a. the supervisory relationship must be documented in writing;

3. may not have Medicaid or Medicare sanctions or be excluded from participation in federally funded programs (OIG-LEIE listing, SAM listing and state Medicaid sanctions listings); and

4. have a completed criminal background check to include federal criminal, state criminal, parish criminal and sex offender reports for the state and parish in which the certified assistant behavior analyst is currently working and residing.

a. Evidence of this background check must be provided by the employer.

b. Criminal background checks must be performed at the time of hire and an update performed at least every five years thereafter.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Chapter 7. Reimbursements

§701. General Provisions

A. The Medicaid Program shall provide reimbursement for ABA-based therapy services to enrolled behavior analysts who are currently licensed and in good standing with the Louisiana Behavior Analyst Board. Reimbursement shall only be made for services billed by a licensed behavior analyst, licensed psychologist, or licensed medical psychologist.

B. Reimbursement for ABA services shall not be made to, or on behalf of services rendered by, a parent, a legal guardian or legally responsible person.

C. Reimbursement shall only be made for services authorized by the Medicaid Program or its designee.

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 41:

§703. Reimbursement Methodology

A. Reimbursement for ABA-based therapy services shall be based upon a percentage of the commercial rates for ABA-based therapy services in the state of Louisiana. The rates are based upon 15 minute units of service, with the exception of mental health services plan which shall be reimbursed at an hourly fee rate.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, 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 increasing access to critical behavioral health 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 a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by reducing the financial burden on families due to Medicaid coverage of applied behavior analysis-based therapy services.

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, March 31, 2015 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: Applied Behavior Analysis-Based Therapy Services

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

It is anticipated that the implementation of this proposed rule will result in estimated state general fund programmatic costs of $5,516,553 for FY 14-15, $5,664,799 for FY 15-16 and $5,834,743 for FY 16-17. It is anticipated that $1,512 ($756 SGF and $756 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.06 percent in FY 14-15 and 62.17 percent in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 15 is the federal rate for disaster-recovery FMAP adjustment states.

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

It is anticipated that the implementation of this proposed rule will increase federal revenue collections by approximately $9,023,169 for FY 14-15, $9,309,557 for FY 15-16 and $9,588,844 for FY 16-17. It is anticipated that $756 will be expended in FY 14-15 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.06 percent in FY 14-15 and 62.17 in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 15 is the federal rate for disaster-recovery FMAP adjustment states.

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

This proposed Rule continues the provisions of the October 20, 2014 Emergency Rule which amended the provisions of the February 1, 2014 Emergency Rule that adopted provisions which established coverage and reimbursement for applied behavior analysis (ABA)-based therapy services under the Medicaid State Plan for Chisholm class members in the Melanie Chisholm, et al vs. Kathy Kliebert class action litigation and other children under the age of 21. It is anticipated that implementation of this proposed rule will increase program expenditures in the Medicaid program for ABA-based therapy services by approximately $14,538,210 for FY 14-15, $14,974,356 for FY 15-16 and $15,423,587 for 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	Evan Brasseaux
Medicaid Director	Staff Director
1502#066	Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Behavioral Health Service Providers
Licensing Standards
(LAC 48:I.Chapters 56 and 74
and LAC 48.III.Chapter 5)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to repeal LAC 48:I.Chapter 74 governing licensing standards for substance abuse/addiction treatment facilities and LAC 48:III.Chapter 5 governing licensing standards for mental health clinics in their entirety, and proposes to adopt LAC 48:I.Chapters 56 and 57 governing the licensing standards for behavioral health service providers as authorized by R.S. 36:254 and R.S. 40:2151-2161 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.

Act 308 of the 2013 Regular Session of the Louisiana Legislature provides for the repeal of R.S. 28:567 through 573 and R.S. 40:1058.1-1058.10, the statutory authority for the current licensing standards governing mental health clinics and substance abuse/addiction treatment facilities, upon the promulgation and publication of these Chapters, and also resulted in the creation of R.S. 40:2151-2161, which requires the Department of Health and Hospitals, Bureau of Health Services Financing to adopt provisions governing the licensing standards for behavioral health service providers.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated a Notice of Intent which proposed to repeal LAC 48:I.Chapter 74, governing the licensing standards for substance abuse/addiction treatment facilities and LAC 48:III.Chapter 5 governing the licensing standards for mental health clinics and adopt provisions to establish licensing standards for behavior health service providers to comply with the directives of Act 308 *(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 LAC 48:I.Chapter 74 governing the licensing standards for substance

abuse/addiction treatment facilities and LAC 48.III.Chapter 5 governing the licensing standards for mental health clinics. In compliance with the directives of Act 308, the department also proposes to adopt provisions to establish licensing standards for behavioral health service providers.

Title 48

PUBLIC HEALTH—GENERAL

Part 1. General Administration

Subpart 3. Licensing

Chapter 56. Behavioral Health Service Providers

Subchapter A. General Provisions

§5601. Introduction

A. Pursuant to R.S. 40:2151-2161, the Department of Health and Hospitals (DHH) hereby establishes licensing standards for behavioral health service (BHS) providers. The purpose of these Chapters is to provide for the development, establishment and enforcement of statewide licensing standards for the care of clients receiving services from BHS providers, to ensure the maintenance of these standards, and to regulate conditions of these providers through a program of licensure that shall promote safe and adequate treatment of clients of BHS providers.

B. In addition to the requirements stated herein, all licensed BHS providers shall comply with applicable local, state, and federal laws and regulations.

C. The following providers shall be licensed under the BHS provider license:

1. substance abuse/addiction treatment facilities;
2. mental health clinics; and
3. any other entity that meets the definition of a BHS provider.

D. Licensed substance abuse/addiction treatment facilities and mental health clinics have one year from the date of promulgation of the final Rule to comply with all of the provisions herein.

NOTE: Existing licensed substance abuse/addiction treatment facilities and mental health clinics shall be required to apply for a BHS provider license at the time of renewal of their current license(s).

E. The following entities shall be exempt from the licensure requirements for BHS providers:

1. hospitals licensed under R.S. 40:2100 et seq.;
2. crisis receiving centers licensed under 40:2180.11 et seq.;
3. nursing homes licensed under R.S. 40:2009.3 et seq.;
4. psychiatric residential treatment facilities and therapeutic group homes licensed under R.S. 40:2009;
5. facilities or services operated by the federal government;
6. federally qualified health care centers (FQHCs) certified by the federal government;
7. community mental health centers (CMHCs) certified by the federal government, that provide CMHC services allowed by the federal government;
8. home and community-based service (HCBS) providers providing HCBS services under a license issued pursuant to R.S. 40:2120.1 et seq.;
9. an individual licensed mental health professional (LMHP), whether incorporated or unincorporated, or a group practice of LMHPs, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;
10. an individual licensed physician, or a group of licensed physicians, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;
11. an individual licensed physician assistant, or a group practice of licensed physician assistants, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;
12. school-based health clinics/centers that are certified by the Department of Health and Hospitals, Office of Public Health, and enrolled in the Medicaid Program;
13. a health care provider or entity solely providing case management or peer support services, or a combination thereof;
14. a health care provider that meets all of the following criteria:
    a. was an accredited mental health rehabilitation provider enrolled in the Medicaid Program as of February 28, 2012;
    b. was enrolled with the statewide management organization for the Louisiana Behavioral Health Partnership (LBHP) as of March 1, 2012;
    c. maintains continuous, uninterrupted accreditation through a DHH authorized accreditation organization;
    d. maintains continuous, uninterrupted enrollment with the statewide management organization for the LBHP;

NOTE: This exemption from licensure encompasses those mental health rehabilitation providers performing mental health rehabilitation services. It does not include a mental health rehabilitation provider that performs other services. If a mental health rehabilitation provider performs behavioral health services other than mental health rehabilitation services, the provider shall be licensed according to these licensing rules.

15. an individual licensed advanced practice registered nurse, or a group practice of licensed advanced practice registered nurses, providing services under the auspices of and pursuant to the scope of the individual's license or group's licenses;
16. rural health clinics (RHCs) providing RHC services under a license issued pursuant to R.S. 40:2197; and
17. facilities or services operated by the Department of Public Safety and Corrections, Corrections Services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5603. Definitions

Abuse—the infliction of physical or mental injury or the causing of the deterioration of an individual by means including, but not limited to, sexual *abuse*, or exploitation of funds or other things of value to such an extent that his health or mental or emotional well-being is endangered. Injury may include, but is not limited to: physical injury, mental disorientation, or emotional harm, whether it is caused by physical action or verbal statement or any other act or omission classified as abuse by Louisiana law, including, but not limited to, the *Louisiana Children's Code*.

Accredited—the process of review and acceptance by an accreditation body.

Active Client—a client that is being treated for addictive disorders at least every 90 days or a client that is being treated for mental health disorders at least every 180 days.

Addictionologist—a licensed physician who is either of the following:

1. certified by the American Board of Psychiatry and Neurology with a subspecialty in addiction psychiatry; or

2. certified by the American Board of Addiction Medicine.

Addiction Outpatient Treatment Program (ASAM Level I)—an outpatient program that offers comprehensive, coordinated, professionally directed and defined addiction treatment services that may vary in level of intensity and may be delivered in a wide variety of settings. Services are provided in regularly scheduled sessions of fewer than nine contact hours a week.

Administrative Procedure Act (APA)—R.S. 49:950 et seq.

Admission—the formal acceptance of an individual for assessment and/or therapeutic services provided by the BHS provider.

Adolescent—an individual 13 through 17 years of age.

ADRA—Addictive Disorder Regulatory Authority.

Adult—an individual 18 years of age or older.

Advance Practice Registered Nurse (APRN)—a licensed registered nurse who meets the criteria for an *advanced practice registered nurse* as established by the Louisiana State Board of Nursing and is licensed as an *APRN* and in good standing with the Louisiana State Board of Nursing.

Ambulatory Detoxification with Extended on-site Monitoring (ASAM Level II-D)—an organized outpatient addiction treatment service that may be delivered in an office setting or health care or behavioral health services provider by trained clinicians who provide medically supervised evaluation, detoxification and referral services. The services are designed to treat the client's level of clinical severity to achieve safe and comfortable withdrawal from mood-altering chemicals and to effectively facilitate the client's entry into ongoing treatment and recovery. The services are provided in conjunction with intensive outpatient treatment services (level II.1).

ASAM—American Society of Addiction Medicine.

Authorized Licensed Prescriber—a physician, physician assistant, nurse practitioner, or medical psychologist licensed in the state of Louisiana and with full prescriptive authority who is authorized by the BHS provider to prescribe treatment to clients of the specific BHS provider at which he/she practices.

Behavioral Health Service (BHS) Provider or *Provider*—a facility, agency, institution, person, society, corporation, partnership, unincorporated association, group, or other legal entity that provides behavioral health services, presents itself to the public as a *provider* of behavioral health services.

Behavioral Health Services—mental health services, substance abuse/addiction treatment services, or a combination of such services, for adults, adolescents and children. Such services may be provided in a residential setting, in a clinic setting on an outpatient basis, or in a home or community setting.

Building and Construction Guidelines—structural and design requirements applicable to the BHS provider which does not include occupancy requirements.

Business Location—the licensed location and office of the BHS provider that provides services only in the home and/or community.

Case Management—the coordination of services, agencies, resources, or people within a planned framework of action toward the achievement of goals established in the treatment plan that may involve liaison activities and collateral contracts with other providers.

Certified Addiction Counselor (CAC)—pursuant to R.S. 37:3387.1, any person who, by means of his specific knowledge acquired through formal education and practical experience, is qualified to provide addictive disorder counseling services and is certified by the ADRA as a *CAC*. The *CAC* may not practice independently and may not render a diagnostic impression.

Change of Ownership (CHOW)—the sale or transfer whether by purchase, lease, gift or otherwise of a BHS provider by a person/corporation of controlling interest that results in a change of ownership or control of 30 percent or greater of either the voting rights or assets of a BHS provider or that results in the acquiring person/corporation holding a 50 percent or greater interest in the ownership or control of the BHS provider.

Child—an individual under the age of 13.

Client—any person who has been accepted for treatment or services, including rehabilitation services, furnished by a provider licensed pursuant to this Chapter.

Client Education—information that is provided to clients and groups concerning alcoholism and other drug abuse, positive lifestyle changes, mental health promotion, suicide prevention and intervention, safety, recovery, relapse prevention, self-care, parenting, and the available services and resources. Educational group size is not restricted and may be offered as an outreach program.

Client Record—a single complete record kept by the provider which documents all treatment provided to the client and actions taken by the provider on behalf of the client. The record may be electronic, paper, magnetic material, film or other media.

Clinical Services—treatment services that include screening, assessment, treatment planning, counseling, crisis mitigation and education.

Clinically Managed High-Intensity Residential Treatment Program (ASAM Level III.5)—a residential program that offers continuous observation, monitoring, and treatment by clinical staff designed to treat clients experiencing substance-related disorders who have clinically-relevant social and psychological problems, such as criminal activity, impaired functioning and disaffiliation from mainstream values, with the goal of promoting abstinence from substance use and antisocial behavior and affecting a global change in clients' lifestyles, attitudes and values.

Clinically Managed Low Intensity Residential Treatment Program (ASAM Level III.1)—a residential program that offers at least five hours a week of a combination of low-intensity clinical and recovery-focused services for substance-related disorders. Services may include individual, group and family therapy, medication management and medication education, and treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the client into the worlds of work, education and family life (e.g., halfway house).

Clinically Managed Medium-Intensity Residential Treatment Program (ASAM Level III.3)—a residential program that offers at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services in a structured recovery environment to support recovery from substance-related disorders; is frequently referred to as extended or long term care.

Clinically Managed Residential Detoxification or Social Detoxification (ASAM LEVEL III.2D)—an organized residential program utilizing 24 hour active programming and containment provided in a non-medical setting that provides relatively extended, sub-acute treatments, medication monitoring observation, and support in a supervised environment for a client experiencing non-life threatening withdrawal symptoms from the effects of alcohol/drugs and impaired functioning and who is able to participate in daily residential activities.

Community Psychiatric Support and Treatment (CPST)—goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the client's individualized treatment plan. These supports and interventions are designed to improve behavioral health outcomes by utilizing evidence-based driven care.

Compulsive Gambling—persistent and recurrent maladaptive gambling behavior that disrupts personal, family, community, or vocational pursuits, and is so designated by a court, or diagnosed by a licensed physician or LMHP.

Controlled Dangerous Substance—any substance defined, enumerated, or included in federal or state statute or regulations or any substance which may hereafter be designated as a *controlled dangerous substance* by amendment of supplementation of such regulations or statute. The term shall not include distilled spirits, wine, malt beverages, or tobacco.

Core Services—the essential and necessary elements required of every BHS provider, when indicated, including assessment, orientation, client education, consultation with professionals, counseling services, referral, crisis mitigation, medication management, rehabilitation services, and treatment.

Counselor in Training (CIT)—a person currently registered with the Addictive Disorder Regulatory Authority (ADRA) and pursuing a course of training in substance abuse/addiction treatment counseling which includes educational hours, practicum hours, and direct, on-site supervision.

Crime of Violence—an offense listed as a *crime of violence* in R.S. 14:2.

Crisis Intervention—face to face intervention provided to a client who is experiencing a psychiatric crisis. The services are designed to interrupt and/or ameliorate a crisis experience, via a preliminary assessment, immediate crisis resolution and de-escalation with referral and linkage to appropriate community services to avoid more restrictive levels of treatment.

Crisis Mitigation Services—a BHS provider's assistance to clients during a crisis that provides 24-hour on call telephone assistance to prevent relapse or harm to self or others, to provide referral to other services, and to provide support during related crises. Referral to 911 or a hospital's emergency department alone does not constitute crisis mitigation services.

Deemed Status—following the issuance of an initial license, the department's acceptance of the BHS provider's accreditation as compliance with this Chapter in lieu of on-site licensing surveys.

Department—the Louisiana Department of Health and Hospitals (DHH) or any office or agency thereof designated by the secretary to administer the provisions of this Chapter.

Dependent Children—any child/adolescent under the age of 18 that relies on the care of a parent or legal guardian.

DHH Authorized Accreditation Organization—any organization authorized by DHH to accredit behavioral health providers.

Diagnosis—the act of identifying a disease or behavioral health disorder as defined by the current version of the diagnostic and statistical manual (DSM). A *diagnosis* is determined by a qualified LMHP or physician based on comprehensive assessment of physical evidence (if related to diagnosis), signs and symptoms, clinical and psycho-social evidence, and individual/family history.

Direct Care Staff—any member of the staff, including an employee, contractor or volunteer, that provides the services delineated in the comprehensive treatment plan. Food services, maintenance, and clerical staff are not considered as *direct care staff*.

Disaster or *Emergency*—a local, community-wide, regional or statewide declared health crisis or event.

Dispense or *Dispensing*—the interpretation, evaluation, and implementation of a prescription drug order, including the preparation and delivery of a drug or device to a patient or patient's agent in a suitable container appropriately labeled for subsequent administration to, or use by, a patient. *Dispense* necessarily includes a transfer of possession of a drug or device to the patient or the patient's agent.

Dispensing Physician—any physician in the state of Louisiana who is registered as a *dispensing physician* with the Louisiana State Board of Medical Examiners and who dispenses to his/her patients any drug, chemical, or medication, except a bona fide medication sample.

Division of Administrative Law (DAL)—the Louisiana Department of State Civil Service, *Division of Administrative Law* or its successor.

Exploitation—act or process to use (either directly or indirectly) the labor or resources of an individual or organization for monetary or personal benefit, profit, or gain.

Facility Need Review (FNR)—a process that requires licensure applicants to prove the need for the services prior to applying for licensure. Opioid treatment programs are required to obtain *FNR* approval prior to applying for a BHS provider license.

FDA—the United States Food and Drug Administration.

Financial Viability—the provider seeking licensure is able to provide verification and continuous maintenance of all of the following pursuant to R.S. 40:2153:

1. a line of credit issued from a federally insured, licensed lending institution in the amount of at least $50,000;
2. general and professional liability insurance of at least $500,000; and
3. workers' compensation insurance.

Grievance—a formal or informal written or verbal complaint that is made to the provider by a client or the client's family or representative regarding the client's care, abuse or neglect when the complaint is not resolved by staff present at the time of the complaint.

Health Standards Section (HSS)—the licensing and certification section of the Department of Health and Hospitals.

High Risk Behavior—includes substance abuse, gambling, violence, academic failure, delinquency behavior, and mental health issues such as depression, anxiety, and suicidal ideations.

Human Services District or Authority—an existing or newly created local governmental entity with local accountability and management of behavioral health and developmental disabilities services as well as any public health or other services contracted to the district by the department.

Human Services Field—an academic program with a curriculum content in which at least 70 percent of the required courses are in the study of behavioral health or human behavior.

Intensive Outpatient Treatment Program (ASAM Level II.1)—professionally directed assessment, diagnosis, treatment and recovery services provided in an organized non-residential treatment setting, including individual, group, family counseling and psycho-education on recovery as well as monitoring of drug use, medication management, medical and psychiatric examinations, crisis mitigation coverage and orientation to community-based support groups. Services may be offered during the day, before or after work or school, in the evening or on a weekend, and the program must provide nine or more hours of structured programming per week for adults and six or more hours of structured programming per week for children/adolescents.

Level of Care—intensity of services provided by the provider.

Licensed Addiction Counselor (LAC)—any person who, by means of his specific knowledge, acquired through formal education and practical experience, is qualified to provide addiction counseling services and is licensed by the ADRA as a licensed addiction counsel or pursuant to R.S. 37:3387.

Licensed Clinical Social Worker (LCSW)—a person duly licensed to independently practice clinical social work under R.S. 37:2702 et seq.

Licensed Marriage and Family Therapist (LMFT)—a person to whom a license has been issued and who is licensed to perform the professional application of psychotherapeutic and family systems theories and techniques in the assessment and treatment of individuals, couples and families. An *LMFT* is not permitted to diagnose a behavioral health disorder under his/her scope of practice under state law.

Licensed Mental Health Professional (LMHP)—an individual who is currently licensed and in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts and the individual's professional license, as one of the following:

1. medical psychologist;
2. licensed psychologist;
3. licensed clinical social worker (LCSW);
4. licensed professional counselor (LPC);
5. licensed marriage and family therapist (LMFT);
6. licensed addiction counselor (LAC);
7. advance practice registered nurse (APRN); or
8. licensed rehabilitation counselor (LRC).

Licensed Professional Counselor—any person who holds himself out to the public for a fee or other personal gain, by any title or description of services incorporating the words "*licensed professional counselor*" or any similar term, and who offers to render professional mental health counseling services denoting a client-counselor relationship in which the counselor assumes responsibility for knowledge, skill and ethical considerations needed to assist individuals, groups, organizations, or the general public, and who implies that he is licensed to practice mental health counseling.

Licensed Psychologist—any person licensed as a psychologist pursuant to R.S. 37:2352.

Licensed Rehabilitation Counselor (LRC)—any person who holds himself out to the public, for a fee or other personal gain, by any title or description of services incorporating the words "licensed professional vocational rehabilitation counselor" or any similar terms, and who offers to render professional rehabilitation counseling services denoting a client-counselor relationship in which the counselor assumes responsibility for knowledge, skill, and ethical considerations needed to assist individuals, groups, organizations, or the general public, and who implies that he is licensed to engage in the practice of rehabilitation counseling. An *LRC* is also known as a licensed professional vocational rehabilitation counselor. An *LRC* is not permitted to provide assessment or treatment services for substance abuse/addiction, mental health or co-occurring disorders under his/her scope of practice under state law.

Master's-Prepared—an individual who has completed a master's degree in social work or counseling, but has not met the requirements for licensing by the appropriate state board.

Medical Psychologist—a licensed psychological practitioner who has undergone specialized training in clinical psychopharmacology and has passed a national proficiency examination in psychopharmacology approved by the Louisiana State Board of Medical Examiners.

Medically Managed Residential Detoxification (Medically Supported Detoxification) (ASAM Level III.7D)—a residential program that provides 24-hour observation, monitoring and treatment delivered by medical and nursing professionals to clients whose withdrawal signs and symptoms are moderate to severe and thus require residential care, but do not need the full resources of an acute care hospital.

Medically Monitored Intensive Residential Treatment Program (ASAM Level III.7)—a residential program that provides a planned regimen of 24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment to clients with co-occurring psychiatric and substance disorders whose disorders are so severe that they require a residential level of care but do not need the full resources of an acute care hospital. The program provides 24 hours of structured treatment activities per week, including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, and habilitative and rehabilitation services.

Medication Administration—preparation and/or giving of a legally prescribed individual dose of medication to a client by qualified staff including observation and monitoring of a client's response to medication.

Mental Health Service—a service related to the screening, diagnosis, management, or treatment of a mental disorder, mental illness, or other psychological or psychiatric condition or problem.

Minor—any person under the age of 18.

Mothers with Dependent Children Program or *Dependent Care Program*—a program that is designed to provide substance abuse/addiction treatment to mothers with dependent children who remain with the parent while the parent is in treatment.

Neglect—the failure to provide the proper or necessary medical care, nutrition or other care necessary for a client's well-being or any other act or omission classified as *neglect* by Louisiana law.

Non-Ambulatory—unable to walk or accomplish mobility without assistance.

Non-Prescription Medication—medication that can be purchased over-the-counter without an order from a licensed practitioner.

Nurse—any registered *nurse* licensed and in good standing with the Louisiana State Board of Nursing or any practical *nurse* licensed and in good standing with the Louisiana State Board of Practical Nurse Examiners.

OBH—the DHH Office of Behavioral Health.

Off-Site—a parent facility's alternate program that provides behavioral health services on a routine basis in a geographic location that:

1. is detached from the parent provider;
2. is owned by, leased by or donated or loaned to the parent provider for the purpose of providing behavioral health services; and
3. has a sub-license issued under the parent facility's license.

OHSEP—Office of Homeland Security and Emergency Preparedness.

On Call—immediately available for telephone consultation and less than one hour from ability to be on duty.

On Duty—scheduled, present and awake at the site to perform job duties.

OPH—the DHH Office of Public Health.

Opioid Treatment Program—a program that engages in medication-assisted opioid treatment of clients with an opioid agonist treatment medication.

OSFM—the Louisiana Department of Public Safety and Corrections, Office of State Fire Marshal.

Outpatient Clinic—a BHS provider that provides behavioral health services on-site at the provider's geographic location but is not a residential provider.

Outpatient Services—behavioral health services offered in an accessible non-residential setting to clients whose physical and emotional status allows them to function in their usual environment.

Parent Facility—the main building or premises of a behavioral health service provider where services are provided on-site and administrative records are maintained.

Physical Environment—the BHS provider's licensed exterior and interior space where BH services are rendered.

Physician—an individual who is currently licensed and in good standing in the state of Louisiana to practice medicine in Louisiana and who is acting within the scope of all applicable state laws and the individual's professional license.

Physician Assistant—an individual who is currently approved and licensed by and in good standing with the Louisiana State Board of Medical Examiners to perform medical services under the supervision of a physician or group of physicians who are licensed by and registered with the Louisiana State Board of Medical Examiners to supervise a *physician assistant*, and who is acting within the scope of all applicable state laws and the individual's professional license.

Plan Review—the process of obtaining approval for construction plans and specifications for the BHS provider.

Prescription Medication—medication that requires an order from a licensed practitioner and that can only be dispensed by a pharmacist on the order of a licensed practitioner or a dispensing physician and requires labeling in accordance with R.S. 37:1161 et seq.

Professional Board(s)—the entity responsible for licensure or certification for specific professions (e.g., nursing, counselors, social workers, physicians, etc.).

Psychosocial Rehabilitation (PSR)—face to face intervention with the client designed to assist with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with his/her mental illness.

Qualifying Experience—experience used to qualify for any position that is counted by using 1 year equals 12 months of full-time work.

Recovery Focused Services—services such as life skills training, job readiness, self-help meetings, parenting skills, training and recreation activities that should be coordinated with clinical services.

Referral—the BHS provider identifies needed services not provided by the provider and assists the client/family to optimally utilize the available support systems and community resources to meet the client's needs.

Registered Addiction Counselor (RAC)—pursuant to R.S. 37:3387.2, any person who, by means of his/her specific knowledge acquired through formal education and practical experience, is qualified to provide addictive disorder counseling services and is registered by the ADRA as a *RAC*. The CAC may not practice independently and may not render a diagnostic impression.

Rehabilitative Services—services intended to promote the maximum reduction of symptoms and/or restoration of the client to his/her best age-appropriate functional level according to an individualized treatment plan.

Residential Treatment Program—a planned regimen of 24-hour professionally-directed evaluation, observation, monitoring and treatment of behavioral health conditions according to a treatment plan.

Secretary—the *secretary* of the Department of Health and Hospitals or his/her designee.

Self-Administration—the client's preparation and direct application of a medication to his/her own body by injection, inhalation, ingestion or any other means.

Shelter in Place—a provider's decision to stay on-site rather than evacuate during a disaster or emergency.

Site/Premises—a single identifiable geographical location owned, leased, or controlled by a provider where any element of treatment is offered or provided. Multiple buildings may be contained in the license only if they are connected by walk-ways and not separated by public streets, or have different geographical addresses.

Staff—individuals who provide services for the provider including employees, contractors, consultants and volunteers.

State Opioid Authority (SOA)—the agency or other appropriate officials designated by the governor or his/her designee, to exercise the responsibility and authority within the state for governing the treatment of opiate addiction with an opioid drug. The *state opioid authority* for the state of Louisiana is the Office of Behavioral Health.

Stock Medication—any medication obtained through a pharmacy or pharmacy contract that is not designated for a specific client.

Substance Abuse/Addiction Treatment Service—a service related to the screening, diagnosis, management, or treatment for the abuse of or addiction to controlled dangerous substances, drugs or inhalants, alcohol, problem gambling or a combination thereof; may also be referred to as *substance use disorder service*.

Take-Home Dose(s)—a dose of opioid agonist treatment medication dispensed by a dispensing physician or pharmacist to a client for unsupervised use.

Therapeutic Counseling Services or Sessions—individual or group therapeutic treatment that teaches skills to assist clients, families, or groups in achieving objectives through exploration of a problem and its ramifications, examination of attitudes and feelings, consideration of alternative solutions and decision making and problem solving. *Therapeutic counseling sessions* consist of no more than 15 clients and last at least 15 minutes.

Treatment—the application of planned procedures to identify and change patterns of behaviors that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning.

Treatment Plan—the provider's documentation of the client's issues, needs, ongoing goals and objectives of care based on admission information and updated based on the client's response to treatment.

Unlicensed Professional (UP)—for purposes of this Rule, any unlicensed behavioral health professional who cannot practice independently or without supervision by a LHMP. This includes but is not limited to CACs, RACs and unlicensed addiction counselors, social workers or psychologists.

Volunteer—an individual who offers services on behalf of the provider for the benefit of the provider willingly and without pay.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter B. Licensing

§5605. General Provisions

A. All BHS providers shall be licensed by the DHH. It shall be unlawful to operate as a BHS provider without a license issued by the department.

B. A BHS provider license authorizes the provider to provide behavioral health services.

C. A BHS provider license shall:

1. be issued only for the person/entity and premises named in the license application;

2. be valid only for the BHS provider to which it is issued and only for one geographic address of that provider approved by DHH;

3. be valid for up to one year from the date of issuance, unless revoked, suspended, or modified prior to that date, or unless a provisional license is issued;

4. expire on the expiration date listed on the license, unless timely renewed by the BHS provider;

5. be invalid if sold, assigned, donated or transferred, whether voluntary or involuntary; and

6. be posted in a conspicuous place on the licensed premises at all times.

D. To be considered operational and retain licensed status, the BHS provider shall meet the following applicable operational requirements.

1. A BHS provider providing on-site services shall:

a. have established operational hours for a minimum of 20 hours per week, as indicated on the license application or change notification approved by DHH;

b. have services available and the required direct care staff on duty at all times during operational hours to meet the needs of the clients; and

c. be able to accept referrals during operational hours.

2. A BHS provider providing services only in the home and community shall:

a. have a business location which conforms to the provisions of §5691.B of this Chapter;

b. have at least one employee on duty at the business location during stated hours of operation; and

c. have direct care staff and professional services staff employed and available to be assigned to provide services to persons in their homes or in the community upon referral for services.

E. The licensed BHS provider shall abide by any state and/or federal law, rule, policy, procedure, manual or memorandum pertaining to BHS providers.

F. Provider Names. A BHS provider is prohibited from using:

1. the same name as another provider;

2. a name that resembles the name of another provider;

3. a name that may mislead the client or public into believing it is owned, endorsed or operated by the state of Louisiana when it is not.

G. Off-Sites. A licensed BHS provider may have an off-site location with the approval of HSS that meets the following requirements.

1. The off-site may share a name with the parent facility if a geographic indicator (e.g. street, city or parish) is added to the end of the off-site name.

2. Each off-site shall be licensed as an off-site under the parent facility's license.

3. The off-site shall have written established operating hours.

4. The off-site shall operate either:

a. in the same or adjacent parish as the parent facility; or

b. for providers operated by a human service district or authority, within the jurisdiction of the district or authority.

5. A residential off-site shall be reviewed under the plan review process.

6. An initial survey may be required prior to opening a residential off-site.

7. An off-site shall have staff to comply with all requirements in this Chapter and who are present during established operating hours to meet the needs of the clients.

8. Personnel records and client records may be housed at the parent facility.

9. Clients who do not receive all treatment services at an off-site may receive the services at the parent facility or be referred to another licensed provider that provides those services.

10. The off-site may offer fewer services than the parent facility and/or may have less staff than the parent facility.

11. The off-site together with the parent facility provides all core functions of a BHS provider and meets all licensing requirements of a BHS provider.

H. Plan Review

1. Plan review is required for outpatient clinics and residential BHS provider locations where direct care services or treatment will be provided, except for the physical environment of a substance abuse/addiction treatment facility or licensed mental health clinic at the time of this Chapter's promulgation.

2. Notwithstanding the provisions in this Section, any entity that will operate as a BHS provider and is required to go through plan review shall complete the plan review process and obtain approval for its construction documents in accordance with:

a. R.S. 40:1574;

b. the current *Louisiana Administrative Code* provisions;

c. OSFM requirements; and

d. the requirements for the provider's physical environment in Subchapter H of this Chapter.

3. Any change in the type of the license shall require review for requirements applicable at the time of licensing change.

4. Upon plan review approval, the provider shall submit the following to the department:

a. a copy of the final construction documents approved by OSFM; and

b. OSFM's approval letter.

I. Waivers

1. The secretary of the DHH may, within his/her sole discretion, grant waivers to building and construction guidelines which are not part of or otherwise required under the provisions of the state *Sanitary Code* or the OSFM.

2. In order to request a waiver, the provider shall submit a written request to HSS that demonstrates:

a. how patient safety and quality of care are not compromised by the waiver;

b. the undue hardship imposed on the provider if the waiver is not granted; and

c. the provider's ability to completely fulfill all other requirements of service.

3. The department will make a written determination of each waiver request.

4. Waivers are not transferable in a change of ownership or geographic change of location, and are subject to review or revocation upon any change in circumstances related to the waiver.

J. The BHS provider shall maintain and make available to the department any information or records related to compliance with this Chapter.

K. The BHS provider shall permit designated representatives of the department, in performance of their duties, to:

1. inspect all areas of the BHS provider's operations; and

2. conduct interviews with any provider staff member, client or other person as necessary.

L. An owner, officer, member, manager, administrator, medical director, managing employee or clinical supervisor is prohibited from being a BHS provider, who has been convicted of or entered a guilty or nolo contendere plea to a felony related to:

1. violence, abuse or neglect against a person;

2. sexual misconduct and/or any crimes that requires the person to register pursuant to the Sex Offenders Registration Act;

3. cruelty, exploitation or the sexual battery of a juvenile or the infirmed;

4. the misappropriation of property belonging to another person;

5. a crime of violence;

6. an alcohol or drug offense, unless the offender has:

a. completed his/her sentence, including the terms of probation or parole, at least five years prior to the ownership of or working relationship with the provider; and

b. been sober per personal attestation for the last two years;

7. possession or use of a firearm or deadly weapon;

8. Medicare or Medicaid fraud; or

9. fraud or misappropriation of federal or state funds.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5607. Initial Licensure Application Process

A. Any entity, organization or person seeking to operate as a BHS provider must submit a completed initial license application packet to the department for approval. Initial BHS provider licensure application packets are available from HSS.

B. The completed initial licensing application packet shall include:

1. a completed BHS provider licensure application;

2. the non-refundable licensing fee established by statute;

3. the plan review approval letter from OSFM, if applicable;

4. the on-site inspection report with approval for occupancy by the OSFM, if applicable;

5. the health inspection report with recommendation for licensure from the Office of Public Health;

6. a statewide criminal background check, including sex offender registry status, on all owners and managing employees;

7. except for governmental entities, proof of financial viability;

8. an organizational chart and names, including position titles of key administrative personnel and governing body;

9. a legible floor sketch or drawing of the premises to be licensed;

10. a letter of intent detailing the type of BHS provider operated by the licensee and the types of services or specializations that will be provided by the BHS provider (e.g. addiction treatment program, mental health program, residential provider, outpatient provider, opioid treatment program);

11. if operated by a corporate entity, such as a corporation or a limited liability company, current proof of registration and status with the Louisiana Secretary of State; and

12. any other documentation or information required by the department for licensure.

C. Deadline for Submitting Initial Licensure Application for Unlicensed Agencies with the OBH Certification

1. Any unlicensed agency that was certified by OBH as a provider of any psychosocial rehabilitation, crisis intervention and/or community psychiatric support and treatment services prior to the promulgation of this Rule and is required to be licensed as a BHS provider has 180 days from the promulgation of this Rule to submit an initial licensing application packet to HSS.

2. Any such unlicensed agency with OBH certification may continue to operate without a license during the licensing process until the department acts upon the initial license application and any and all appeal processes associated with the initial licensure is complete or the delay for taking an appeal has expired, whichever is later.

3. The department has the authority to issue a cease and desist order and pursue legal action for failure to comply with the deadline for submitting an initial licensure application. The cease and desist order shall require immediate discharge of all current clients and no new clients shall be admitted.

D. If the initial licensing packet is incomplete, the applicant shall:

1. be notified of the missing information; and

2. have 90 days from receipt of the notification to submit the additional requested information; if not submitted, the application shall be closed.

E. Once the initial licensing application is approved by the department, notification of such approval shall be forwarded to the applicant.

F. The applicant shall notify the department of initial licensing survey readiness within the required 90 days of receipt of application approval. If an applicant fails to notify the department of initial licensing survey readiness within 90 days, the application shall be closed.

G. If an initial licensing application is closed, an applicant who seeks to operate as a BHS provider shall submit:

1. a new initial licensing packet;

2. non-refundable licensing fee; and

3. facility need review approval, if applicable.

H. Applicants shall be in compliance with all applicable federal, state, departmental or local statutes, laws, ordinances, rules, regulations and fees before the BHS provider will be issued an initial license to operate.

I. A BHS provider is prohibited from providing behavioral health services to clients during the initial application process and prior to obtaining a license, unless the applicant qualifies as one of the following facilities:

1. a licensed mental health clinic;

2. a licensed substance abuse/addiction treatment facility; or

3. an agency that is certified by OBH as a provider of psychosocial rehabilitation, community psychiatric support and treatment, and/or crisis intervention services.

J. Off-Sites. In order to operate an off-site, the provider must submit:

1. a request for opening an off-site location;

2. a completed application, including established operational hours;

3. payment of applicable fees;

4. current on-site inspection reports from OSFM and OPH; and

5. for any residential off-site, plan review approval from OSFM.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5609. Initial Licensing Surveys

A. Prior to the initial license being issued, an initial licensing survey shall be announced and conducted on-site to ensure compliance with the licensing laws and standards.

B. In the event that the initial licensing survey finds that the provider is compliant with all licensing laws, regulations and other required statutes, laws, ordinances, rules, regulations, and fees, the department may issue a full license to the provider.

C. In the event that the initial licensing survey finds that the provider is noncompliant with any licensing laws or regulations, or any other required rules or regulations, that present a potential threat to the health, safety, or welfare of the clients, the department shall deny the initial license. If the department denies an initial license, the applicant for a BHS provider license shall discharge the clients receiving services.

D. In the event that the initial licensing survey finds that the BHS provider is noncompliant with any licensing laws or regulations, or any other required rules or regulations, and the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients, the department may:

1. issue a provisional initial license for a period not to exceed six months; and/or

2. conduct a follow-up survey following the initial licensing survey to ensure correction of the deficiencies.

a. Follow-up surveys to the initial licensing surveys are unannounced surveys.

b. If all deficiencies are corrected on the follow-up survey, a full license may be issued.

c. If the provider fails to correct the deficiencies, the initial license may be denied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5611. Types of Licenses

A. The department has the authority to issue the following types of licenses.

1. Initial License

a. The department may issue a full license to the BHS provider when the initial licensing survey indicates the provider is compliant with:

i. all licensing laws and regulations;

ii. all other required statutes, laws, ordinances, rules, regulations; and

iii. fees.

b. The license shall be valid until the expiration date shown on the license, unless the license is modified, revoked, or suspended.

2. Provisional Initial License. The department may issue a provisional initial license to the BHS provider when the initial licensing survey finds that the BHS provider is noncompliant with any licensing laws or regulations or any other required statutes, laws, ordinances, rules, regulations or fees, but the department determines that the noncompliance does not present a threat to the health, safety or welfare of the clients.

a. The provider shall submit a plan of correction to the department for approval, and the provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

b. If all such noncompliance or deficiencies are corrected on the follow-up survey, a full license may be issued.

c. If all such noncompliance or deficiencies are not corrected on the follow-up survey, or new deficiencies affecting the health, safety or welfare of a client are cited, the provisional license may expire and the provider shall be required to begin the initial licensing process again by submitting a new initial license application packet and the appropriate licensing fees.

3. Renewal License. The department may issue a renewal license to a licensed BHS provider that 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.

4. Provisional License. The department may issue a provisional license to a licensed BHS provider for a period not to exceed six months.

a. A provisional license may be issued for one of the following reasons:

i. more than five deficiencies cited during any one survey;

ii. four or more validated complaints in a consecutive 12-month period;

iii. a deficiency resulting from placing a client at risk for serious harm or death;

iv. failure to correct deficiencies within 60 days of notification of such deficiencies or at the time of a follow-up survey; or

v. failure to be 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. The department may extend the provisional license for an additional period not to exceed 90 days in order for the provider to correct the deficiencies.

c. The provider shall:

i. submit a plan of correction to the department for approval; and

ii. correct all noncompliance or deficiencies prior to the expiration of the provisional license.

d. The department may conduct a follow-up survey, either on-site or by administrative review, of the BHS provider prior to the expiration of the provisional license.

e. If the follow-up survey determines that the BHS provider has corrected the deficiencies and has maintained compliance during the period of the provisional license, the department may issue a license that will expire on the expiration date of the most recent renewal or initial license.

f. The provisional license may expire if:

i. the provider fails to correct the deficiencies by the follow-up survey; or

ii. the provider is cited with new deficiencies at the follow-up survey indicating a risk to the health, safety or welfare of a client.

g. If the provisional license expires, the provider shall be required to begin the initial licensing process by submitting the following:

i. a new initial licensing application packet;

ii. a non-refundable licensing fee; and

iii. facility need review approval, if applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5613. Changes in Licensee Information or Personnel

A. A BHS provider shall report in writing to HSS within five days of any change of the following:

1. BHS provider's entity name;
2. business name;
3. mailing address;
4. telephone number; or
5. email address of the administrator.

B. Any change to the BHS provider's name or doing business as name requires the nonrefundable fee for the issuance of an amended license with the new name.

C. A BHS provider shall report in writing to the HSS any change in the provider's key administrative personnel within five days of the change.

1. Key administrative personnel include the following:

a. administrator;

b. medical director; and

c. clinical supervisor.

2. The BHS provider's written notice to HSS shall include the individual's:

a. name;

b. hire date; and

c. qualifications.

D. Change of Ownerships

1. A BHS provider shall report a change of ownership (CHOW) in writing to HSS within five days following the change. The new owner shall submit the following:

a. the legal CHOW document;
b. all documents required for a new license; and
c. the applicable nonrefundable licensing fee.

2. A BHS provider that is under license revocation, provisional licensure or denial of license renewal may not undergo a CHOW.

3. If there are any outstanding fees, fines or monies owed to the department by the existing licensed entity, the CHOW will be suspended until payment of all outstanding amounts.

4. Once all application requirements are completed and approved by the department, a new license may be issued to the new owner.

E. Change in Geographic Location

1. A BHS provider that seeks to change its geographic location shall submit:

a. written notice to HSS of its intent to relocate;
b. a plan review request, if applicable;
c. a new license application;
d. the nonrefundable license fee; and
e. other applicable licensing requirements.

2. In order to receive approval for the change of geographic location, the BHS provider shall have:

a. plan review approval, if required;
b. approval from the OSFM and the OPH recommendation for licensure of the new geographic location;
c. an approved license application packet;
d. compliance with other applicable licensing requirements; and
e. an on-site licensing survey prior to relocation of the provider.

3. Upon approval of the requirements for a change in geographic location, the department may issue a new license to the BHS provider.

F. Any request for a duplicate license shall be accompanied by the required fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5615. Renewal of License

A. A BHS provider license shall expire on the expiration date listed on the license, unless timely renewed by the BHS provider.

B. To renew a license, the BHS provider shall submit a completed license renewal application packet to the department at least 30 days prior to the expiration of the current license. The license renewal application packet shall include:

1. the license renewal application;
2. a current OSFM report;
3. a current OPH inspection report;
4. the non-refundable license renewal fee as established by statute;
5. except for governmental entities, proof of financial viability;
6. payment of any outstanding fees, fines or monies owed to the department; and
7. any other documentation required by the department.

C. The department may perform an on-site survey and inspection of the provider upon renewal.

D. Failure to submit a completed license renewal application packet prior to the expiration of the current license may result in the voluntary non-renewal of the BHS provider license upon the license expiration.

E. The renewal of a license does not affect any sanction, civil monetary penalty or other action imposed by the department against the provider.

F. If a licensed BHS provider has been issued a notice of license revocation or suspension, and the provider's license is due for annual renewal, the department shall deny the license renewal application and shall not issue a renewal license.

G. Voluntary Non-Renewal of a License

1. If a provider fails to timely renew its license, the license:

a. expires on the license's expiration date; and
b. is considered a non-renewal and voluntarily surrendered.

2. There is no right to an administrative reconsideration or appeal for a voluntary surrender or non-renewal of the license.

3. If a provider fails to timely renew its license, the provider shall immediately cease providing services. If the provider is actively treating clients, the provider shall:

a. within two days of voluntary non-renewal, provide written notice to HSS of the number of clients receiving treatment;
b. within two days of voluntary non-renewal, provide written notice to each active client's prescribing physician and to every client, or, if applicable, the client's parent or legal guardian, of the following:
i. voluntary non-renewal of license;
ii. date of closure; and
iii. plans for the transition of the client;
c. discharge and transition each client in accordance with this Chapter within 15 days of the license's expiration date; and
d. provide written notice to HSS of the location where client and personnel records will be stored and the name, address and telephone number of the person responsible for the records.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5617. Deemed Status

A. A licensed BHS provider may request deemed status once it becomes accredited by the DHH authorized accreditation organization.

B. The department may approve the deemed status request and accept accreditation in lieu of an on-site licensing survey when the provider provides documentation to the department that shows:

1. the accreditation is current and was obtained through the DHH authorized accreditation organization;
2. all behavioral health services provided under the BHS provider license are accredited; and
3. the accrediting organization's findings.

C. If deemed status is approved, accreditation will be accepted as evidence of satisfactory compliance with this Chapter in lieu of conducting a licensing survey.

D. To maintain deemed status, the provider shall submit a copy of current accreditation documentation with its annual license renewal application.

E. The department may rescind deemed status and conduct a licensing survey for the following:

1. any valid complaint within the preceding 12 months;

2. an addition of services;

3. a change of ownership;

4. issuance of a provisional license in the preceding 12-month period;

5. deficiencies identified in the preceding 12-month period that placed clients at risk for harm;

6. treatment or service resulting in death or serious injury; or

7. a change in geographic location.

F. The provider shall notify HSS upon change in accreditation status within two business days.

G. The department shall rescind deemed status when the provider loses its accreditation.

H. A BHS provider approved for deemed status is subject to and shall comply with all provisions of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5619. Licensing Surveys

A. The department may conduct periodic licensing surveys and other surveys as deemed necessary to ensure compliance with all laws, rules and regulations governing behavioral health providers and to ensure client health, safety and welfare. These surveys may be conducted on-site or by administrative review and shall be unannounced.

B. If deficiencies are cited, the department may require the provider to submit an acceptable plan of correction.

C. The department may conduct a follow-up survey following any survey in which deficiencies were cited to ensure correction of the deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5621. Complaint Investigations

A. Pursuant to R.S. 40:2009.13 et seq., the department may conduct unannounced complaint investigations on all behavioral health providers, including those with deemed status.

B. The department shall issue a statement of deficiencies to the provider if deficient practice is cited as a result of the complaint investigation.

C. Upon issuance a statement of deficiencies, the department may require the provider to submit an acceptable plan of correction.

D. The department may conduct a follow-up survey following a complaint investigation in which deficiencies were cited to ensure correction of the deficient practices.

E. Informal Reconsiderations of Complaint Investigations

1. A provider that is cited with deficiencies found during a complaint investigation has the right to request an informal reconsideration of the deficiencies. The provider's written request for an informal reconsideration must be received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies and must identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

2. An informal reconsideration for a complaint investigation shall be conducted by HSS as a desk review.

3. Correction of the violation or deficiency shall not be the basis for the reconsideration.

4. The provider shall be notified in writing of the results of the informal reconsideration.

5. Except for the right to an administrative appeal provided in R.S. 40:2009.16(A), the informal reconsideration shall constitute final action by the department regarding the complaint investigation, and there shall be no further right to an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5623. Statement of Deficiencies

A. The BHS provider shall post the following statements of deficiencies issued by the department in a readily accessible place on the licensed premises:

1. the most recent annual survey statement of deficiencies; and

2. each of the complaint survey statements of deficiencies, including the plans of correction, issued after the most recent annual survey.

B. The BHS provider shall make its statements of deficiencies available to the public 30 days after the provider submits an acceptable plan of correction of the deficiencies or 90 days after the statement of deficiencies is issued to the provider, whichever occurs first.

C. Informal Dispute Resolution

1. Unless otherwise provided in statute or in this Chapter, a BHS provider has the right to an informal dispute resolution (IDR) of any deficiencies cited as a result of a survey.

2. Correction of the violation, noncompliance or deficiency shall not be the basis for the IDR.

3. The BHS provider's written request for IDR must be received by HSS within 10 calendar days of the provider's receipt of the statement of deficiencies and must identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

4. If a timely request for an IDR is received, the department shall schedule and conduct the IDR.

5. HSS shall notify the provider in writing of the results of the IDR.

6. Except as provided for complaint surveys and as provided in this Chapter:

a. the IDR decision is the final administrative decision regarding the deficiencies; and

b. there is no right to an administrative appeal of such deficiencies.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5625. Cessation of Business

A. Except as provided in §5677 of these licensing regulations, a license shall be immediately null and void if a BHS provider ceases to operate.

B. A cessation of business is deemed to be effective the date on which the BHS provider stopped offering or providing services to the community.

C. Upon the cessation of business, the BHS 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 BHS 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 BHS provider shall:

1. give 30 days advance written notice to:

a. HSS;

b. the prescribing physician; and

c. the client, legal guardian or legal representative, if applicable, of each client; and

2. provide for an orderly discharge and transition of all of the clients in accordance with the provisions of this chapter.

F. In addition to the advance notice of voluntary closure, the BHS provider shall submit a written plan for the disposition of client 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 BHS provider fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a BHS provider for a period of two years.

H. Once the BHS provider has ceased doing business, the BHS provider 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. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5627. Sanctions

A. The department may issue sanctions for deficiencies and violations of law, rules and regulations that include:

1. civil fines;

2. license revocation or denial of license renewal; and

3. any sanctions allowed under state law or regulation.

B. The department may deny an application for an initial license or a license renewal, or may revoke a license in accordance with the Administrative Procedure Act.

C. The department may deny an initial license, revoke a license or deny a license renewal for any of the following reasons, including, but not limited to:

1. failure to be in compliance with the BHS licensing laws, rules and regulations;

2. failure to be in 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. cruelty or indifference to the welfare of the clients;

5. misappropriation or conversion of the property of the clients;

6. permitting, aiding or abetting the unlawful, illicit or unauthorized use of drugs or alcohol within the provider of a program;

7. documented information of past or present conduct or practices of BHS provider personnel which are detrimental to the welfare of the clients, including but not limited to illegal or criminal activities, or coercion;

8. failure to protect a client from a harmful act of an employee or other client including, but not limited to:

a. mental or physical abuse, neglect, exploitation or extortion;

b. any action posing a threat to a client's health and safety;

c. coercion;

d. threat or intimidation;

e. harassment; or

f. illegal or criminal activities;

9. failure to notify the proper authorities, as required by federal or state law or regulations, of all suspected cases of the acts outlined in Paragraph C.8 above;

10. 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, client records or provider records;

d. matters under investigation by the department or authorized law enforcement agencies; or

e. information submitted for reimbursement from any payment source;

11. knowingly making a false statement or providing false, forged or altered information or documentation to DHH employees or to law enforcement agencies;

12. the use of false, fraudulent or misleading advertising; or

13. the BHS provider, an owner, officer, member, manager, administrator, medical director, managing employee, or clinical supervisor that has pled guilty or nolo contendere to a felony, or is convicted of a felony, as documented by a certified copy of the record of the court, related to:

a. violence, abuse or neglect against a person;

b. sexual misconduct and/or any crimes that requires the person to register pursuant to the Sex Offenders Registration Act;

c. cruelty, exploitation or the sexual battery of a juvenile or the infirmed;

d. the misappropriation of property belonging to another person;

e. a crime of violence;

f. an alcohol or drug offense, unless the offender has:

i. completed his/her sentence, including the terms of probation or parole, at least five years prior to the ownership of or working relationship with the provider; and

ii. been sober per personal attestation for at least the last two years;

g. a firearm or deadly weapon;

h. Medicare or Medicaid fraud; or

i. fraud or misappropriation of federal or state funds;

14. failure to comply with all reporting requirements in a timely manner, as required by the department;

15. failure to allow or refusal to allow the department to conduct an investigation or survey or to interview BHS provider staff or clients;

16. interference with the survey process, including but not limited to, harassment, intimidation, or threats against the survey staff;

17. failure to allow or refusal to allow access to BHS provider or client records by authorized departmental personnel;

18. bribery, harassment, intimidation or solicitation of any client designed to cause that client to use or retain the services of any particular BHS provider;

19. failure to repay an identified overpayment to the department or failure to enter into a payment agreement to repay such overpayment;

20. failure to timely pay outstanding fees, fines, sanctions or other debts owed to the department;

21. failure to maintain accreditation, if accreditation is a federal or state requirement for participation in the program; or

22. failure to uphold client rights that may have resulted or may result in harm, injury or death of a client.

D. Any owner, officer, member, manager, director or administrator of such BHS provider is prohibited from owning, managing, directing or operating another BHS provider for a period of two years from the date of the final disposition of any of the following:

1. license revocation;
2. denial of license renewal; or
3. the license is surrendered in lieu of adverse action.

E. If the secretary of the department determines that the health and safety of a client or the community may be at risk, 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. The department will provide written notification to the BHS provider if the imposition of the action will be immediate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5629. Notice and Appeal of License Denial, License Revocation and Denial of License Renewal

A. The department shall provide written notice to the provider of the following:

1. initial license denial;
2. license revocation; or
3. denial of license renewal.

B. The BHS provider has the right to an administrative reconsideration of the initial license denial, license revocation or denial of license renewal.

1. If the BHS provider chooses to request an administrative reconsideration, the request must:

a. be in writing addressed to HSS;

b. be received by HSS within 15 calendar days of the BHS provider's receipt of the notice of the initial license denial, license revocation or denial of license renewal; and

c. include any documentation that demonstrates that the determination was made in error.

2. If a timely request for an administrative reconsideration is received, HSS shall provide the BHS provider with written notification of the date of the administrative reconsideration.

3. The HSS shall conduct the administrative reconsideration. The BHS provider may request to present an oral presentation and be represented by counsel.

4. The HSS shall not consider correction of a deficiency or violation as a basis for the reconsideration.

5. The BHS provider will be notified in writing of the results of the administrative reconsideration.

C. The administrative reconsideration process is not in lieu of the administrative appeals process.

D. The BHS provider has a right to an administrative appeal of the initial license denial, license revocation or denial of license renewal.

1. If the BHS provider chooses to request an administrative appeal, the request must be received:

a. by the DAL or its successor, within 30 days of the BHS provider's receipt of the results of the administrative reconsideration; or

b. within 30 days of the BHS provider's receipt of the notice of the initial license denial, revocation or denial of license renewal if the BHS provider chooses to forego its rights to an administrative reconsideration;

2. The provider's request for administrative appeal shall:

a. be in writing;

b. include any documentation that demonstrates that the determination was made in error; and

c. include the basis and specific reasons for the appeal.

3. The DAL shall not consider correction of a violation or a deficiency as a basis for the administrative appeal.

4. If a timely request for an administrative appeal is received by the DAL, the BHS provider shall be allowed to continue to operate and provide services until the DAL issues a final administrative decision, unless the imposition of the revocation or denial of license renewal is immediate based on the secretary's determination that the health and safety of a client or the community may be at risk.

E. If a licensed BHS provider has been issued notice of license revocation by the department, and the license is due for annual renewal, the department shall deny the license renewal application. The denial of the license renewal application does not affect, in any manner, the license revocation.

F. Administrative Hearings of Initial License Denials, Denial of License Renewals and License Revocations

1. If a timely administrative appeal is submitted by the BHS provider, the DAL or its successor, shall conduct the hearing in accordance with the APA.

2. If the final DAL decision is to reverse the initial license denial, denial of license renewal or license revocation, the BHS provider's license will be re-instated upon the payment of any outstanding fees or sanctions fees due to the department.

3. If the final DAL decision is to affirm the denial of license renewal or license revocation, the BHS provider shall:

a. discharge and transition any and all clients receiving services according to the provisions of this Chapter; and

b. notify HSS in writing of the secure and confidential location where the client records will be stored and the name, address and phone number of the contact person responsible for the records.

G. There is no right to an administrative reconsideration or an administrative appeal of the issuance of a provisional initial license to a new BHS provider, or the issuance of a provisional license to a licensed BHS provider.

H. Administrative Reconsiderations from the Expiration of a Provisional Initial License or Provisional License

1. A BHS provider with a provisional initial license or a provisional license that expires due to deficiencies cited at the follow-up survey has the right to request an administrative reconsideration of the validity of the deficiencies cited at the follow up survey.

2. The BHS provider's request for an administrative reconsideration must:

a. be in writing;

b. 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; and

c. identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

3. Correction of a violation or deficiency after the follow-up survey will not be considered as the basis for the administrative reconsideration.

4. A BHS provider with a provisional initial license or a provisional license that expires under the provisions of this Chapter, shall cease providing services and discharge or transition clients, unless the DAL or successor issues a stay of the expiration.

a. To request a stay, the BHS provider must submit its written application to the DAL at the time the administrative appeal is filed.

b. The DAL shall hold a contradictory hearing on the stay application. If the BHS provider shows that there is no potential harm to its clients, then the DAL shall grant the stay.

I. Administrative Hearing of the Expiration of a Provisional Initial License or Provisional License

1. A BHS provider with a provisional initial license or a provisional license that expires due to deficiencies cited at the follow-up survey has the right to request an administrative appeal of the validity of the deficiencies cited at the follow up survey.

2. Correction of a violation or deficiency after the follow-up survey will not be considered as the basis for the administrative appeal.

3. The BHS provider's request for an administrative appeal shall:

a. be in writing;

b. be submitted to the DAL within 15 calendar days of receipt of the notice of the results of the follow-up survey from the department; and

c. identify each disputed deficiency or deficiencies and the reason for the dispute that demonstrates the findings were cited in error.

4. If the BHS provider submits a timely request for an administrative hearing, the DAL shall conduct the hearing in accordance with the APA.

a. If the final DAL decision is to remove all disputed deficiencies, the department will reinstate the BHS provider's license upon the payment of any outstanding fees and settlement of any outstanding sanctions due to the department.

b. If the final DAL decision is to uphold the disputed deficiencies thereby affirming the expiration of the provisional license, the BHS provider shall discharge any and all clients receiving services and comply with the cessation of business requirements in accordance with this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter C. Organization and Administration

§5631. General Provisions

A. Purpose and Organizational Structure. The BHS provider shall develop and maintain a written statement that clearly defines the purpose and organization of the provider. The statement shall include:

1. the program philosophy;

2. the program goals and objectives;

3. the ages, sex and characteristics of clients accepted for care;

4. the geographical area served;

5. the types of services provided;

6. the admission criteria;

7. the needs, problems, situations or patterns addressed by the BHS provider's program; and

8. the BHS provider's organizational chart which clearly delineates the line of authority.

B. The BHS provider shall provide supervision and services that:

1. conform to the department's rules and regulations;

2. meet the needs of the client as identified and addressed in the client's treatment plan;

3. protect each client's rights; and

4. promote the social and physical well-being and behavioral health of clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5633. Governing Body

A. A BHS provider shall have the following:

1. an identifiable governing body with responsibility for and authority over the policies and operations of the BHS provider;

2. documentation identifying the governing body's:

a. members;

b. contact information for each member;

c. terms of membership;

d. officers; and

e. terms of office for each officer.

B. The governing body of a BHS provider shall:

1. be comprised of one or more persons;

2. hold formal meetings at least twice a year;

3. maintain written minutes of all formal meetings of the governing body; and

4. maintain by-laws specifying frequency of meetings and quorum requirements.

C. The responsibilities of a BHS provider's governing body, include, but are not limited to:

1. ensuring the BHS provider's compliance with all federal, state, local and municipal laws and regulations as applicable;

2. maintaining funding and fiscal resources to ensure the provision of services and compliance with this Chapter;

3. reviewing and approving the BHS provider's annual budget;

4. designating a qualified person to act as administrator, and delegating this person the authority to manage the BHS provider;

5. at least once a year, formulating and reviewing, in consultation with the administrator, the clinical supervisor and/or medical director, written policies concerning:

a. the BHS provider's philosophy and goals;

b. current services;

c. personnel practices and job descriptions; and

d. fiscal management;

6. evaluating the performance of the administrator at least once a year;

7. meeting with designated representatives of the department whenever required to do so;

8. informing the department, or its designee, prior to initiating any substantial changes in the services provided by the BHS provider; and

9. ensuring statewide criminal background checks are conducted as required in this Chapter and state law.

D. A governing body shall ensure that the BHS provider maintains the following documents:

1. minutes of formal meetings and by-laws of the governing body;

2. documentation of the BHS provider's authority to operate under state law;

3. all leases, contracts and purchases-of-service agreements to which the BHS provider is a party;

4. insurance policies;

5. annual operating budgets;

6. a master list of all the community resources used by the BHS provider;

7. documentation of ownership of the BHS provider;

8. documentation of all accidents, incidents, and abuse/neglect allegations; and

9. daily census log of clients receiving services.

E. Service Agreements. The governing body of a BHS provider shall ensure the following with regards to agreements to provide services for the provider:

1. the agreement for services is in writing;

2. the provider reviews all written agreements at least once a year;

3. the deliverables are being provided as per the agreement;

4. the BHS provider retains full responsibility for all services provided by the agreement;

5. all services provided by the agreement shall:

a. meet the requirements of all laws, rules and regulations applicable to a BHS provider; and

b. be provided only by qualified providers and personnel in accordance with this Chapter; and

6. if the agreement is for the provision of direct care services, the written agreement specifies the party responsible for screening, orientation, ongoing training and development of and supervision of the personnel providing services pursuant to the agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5635. Policies and Procedures

A. Each BHS provider shall develop, implement and comply with provider-specific written policies and procedures related to compliance with this Chapter, including, but not limited to policies and procedures that address:

1. the protection of the health, safety, and well-being of each client;

2. the provision of treatment in order for clients to achieve recovery;

3. access to care that is medically necessary;

4. uniform screening for patient placement and quality assessment, diagnosis, evaluation, and referral to appropriate level of care;

5. operational capability and compliance;

6. delivery of services that are cost-effective and in conformity with current standards of practice;

7. confidentiality and security of client records and files;

8. client rights;

9. grievance procedures;

10. emergency preparedness;

11. abuse, neglect and exploitation of clients;

12. incidents and accidents, including medical emergencies and reporting requirements, if applicable;

13. universal precautions and infection control;

14. documentation of services;

15. admission, including screening procedures, emergency care, client orientation, walk-in services or other brief or short-term services provided.

16. transfer and discharge procedures;

17. behavior management;

18. transportation;

19. quality Improvement;

20. medical and nursing services;

21. research or non-traditional treatment approaches and approval thereof, in accordance with federal and state guidelines;

22. access to and usage of laundry and kitchen facilities;

23. the BHS provider's exterior location where smoking, if allowed, may occur;

24. domestic animals, if permitted on premises that, at a minimum, include:

a. required animal vaccinations and updates, as indicated; and

b. management of the animals' care and presence consistent with the goals of the program and clients' needs, including those with allergies;

25. privacy and security of laboratory testing and screenings, if performed on-site;

26. what constitutes the authorized and necessary use of force and least restrictive measures by uniformed security as related to client behaviors and safety; and

27. compliance with applicable federal and state laws and regulations.

B. A BHS provider shall develop, implement and comply with written personnel policies that address the following:

1. recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of employees;

2. written job descriptions for each staff position, including volunteers;

3. an employee grievance procedure;

4. abuse reporting procedures that require staff to report:

a. any allegations of abuse or mistreatment of clients according to state and federal laws; and

b. any allegations of abuse, neglect, exploitation or misappropriation of a client to the HSS;

5. a nondiscrimination policy;

6. the requirement that all employees report any signs or symptoms of a communicable disease or contagious illness to their supervisor or the clinical supervisor as soon as possible;

7. procedures to ensure that only qualified personnel are providing care within the scope of the core functions of the provider's services;

8. the governing of staff conduct and procedures for reporting violations of laws, rules, and professional and ethical codes of conduct;

9. procedures to ensure that the staff's credentials are verified, legal and from accredited institutions; and

10. procedure to obtain statewide criminal background checks, ensuring no staff is providing unsupervised direct care prior to obtaining the results of the statewide criminal background check and addressing the results of the background check, if applicable.

C. A BHS provider shall comply with all federal and state laws, rules and regulations in the development and implementation of its policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter D. Provider Operations

§5637. Client Records

A. The BHS provider shall ensure that:

1. a client record is maintained for each client according to current professional standards;

2. policies and procedures regarding confidentiality, maintenance, safeguarding and storage of records are developed and implemented;

3. records are stored in a place or area where safeguards are in place to prevent unauthorized access, loss, and destruction of client records;

4. when electronic health records are used, the most current technologies and practices are used to prevent unauthorized access;

5. records are kept confidential according to federal and state law and regulations;

6. records are maintained at the provider where the client is currently active and for six months after discharge;

7. six months post-discharge, records may be transferred to a centralized location for maintenance;

8. client records are directly and readily accessible to the direct care staff caring for the client;

9. a system of identification and filing is maintained to facilitate the prompt location of the client's records;

10. all record entries are dated, legible and authenticated by the staff person providing the service or treatment, as appropriate to the media used;

11. records are disposed of in a manner that protects client confidentiality;

12. a procedure for modifying a client record in accordance with accepted standards of practice is developed, implemented and followed;

13. an employee is designated as responsible for the client records;

14. disclosures are made in accordance with applicable state and federal laws and regulations;

15. client records are maintained at least 6 years from discharge, and for minors, client records are maintained at least 10 years.

B. Contents. The provider shall ensure that a client record, at a minimum, contains the following:

1. the treatment provided to the client;

2. the client's response to the treatment;

3. all pertinent medical, psychological, social and other therapeutic information, including:

a. initial assessment;

b. admission diagnosis;

c. referral information;

d. client information/data such as name, race, sex, birth date, address, telephone number, social security number, school/employer, and authorized representative, if applicable;

e. screenings;

f. medical limitations such as major illnesses, allergies;

g. treatment plan that includes the initial treatment plan plus any updates or revisions;

h. lab work including diagnostic, laboratory and other pertinent information, when indicated;

i. legible written progress notes or equivalent documentation;

j. documentation of the services delivered for each client signed by the client or responsible person for services provided in the home or community;

k. documentation related to incidents;

l. consent forms;

m. physicians' orders;

n. a record of all medicines administered by the BHS provider or self-administered by the client, including medication name and type, dosage, frequency of administration, route and person who administered each dose;

o. discharge summary; and

p. other pertinent information related to client as appropriate;

4. progress notes that are documented in accordance with professional standards of practice and that:

a. document implementation of the treatment plan and results;

b. document the client's level of participation; and

c. are completed upon delivery of services by the direct care staff to document progress toward stated treatment plan goals.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5639. Quality Improvement Plan

A. A BHS provider shall develop, implement and maintain a quality improvement (QI) plan that:

1. assures that the provider is in compliance with federal, state, and local laws;

2. meets the needs of the provider's clients;

3. is attaining the goals and objectives established by the provider;

4. maintains systems to effectively identify issues that require quality monitoring, remediation and improvement activities;

5. improves individual outcomes and individual satisfaction;

6. includes plans of action to correct identified issues that:

a. monitor the effects of implemented changes; and

b. result in revisions to the action plan;

7. is updated on an ongoing basis to reflect changes, corrections and other modifications.

B. The QI plan shall include:

1. a process for obtaining input from the client, or client's parents or legal guardian, as applicable, at least once a year that may include, but not be limited to:

a. satisfaction surveys conducted by a secure method that maintains the client's privacy;

b. focus groups; and

c. other processes for receiving input regarding the quality of services received;

2. a sample review of client case records on a quarterly basis to ensure that:

a. individual treatment plans are up to date;

b. records are accurate, complete and current;

c. the treatment plans have been developed and implemented as ordered; and

d. the program involves all services and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors;

3. a process for identifying on a quarterly basis the risk factors that affect or may affect the health, safety and/or welfare of the clients of the BHS provider receiving services, that includes, but is not limited to:

a. review and resolution of complaints;

b. review and resolution of incidents; and

c. incidents of abuse, neglect and exploitation;

4. a process to review and resolve individual client issues that are identified;

5. a process to review and develop action plans to resolve all system wide issues identified as a result of the processes above;

6. a process to correct problems that are identified through the program that actually or potentially affect the health and safety of the clients;

7. a process of evaluation to identify or trigger further opportunities for improvement, such as:

a. identification of individual care and service components;

b. application of performance measures; and

c. continuous use of a method of data collection and evaluation;

8. a methodology for determining the amount of client case records in the quarterly sample review that will involve all services and produce accurate data to guide the provider toward performance improvement.

C. The QI program shall establish and implement an internal evaluation procedure to:

1. collect necessary data to formulate a plan; and

2. hold quarterly committee meetings comprised of at least three individuals who:

a. assess and choose which QI plan activities are necessary and set goals for the quarter;

b. evaluate the activities of the previous quarter; and

c. implement any changes that protect the clients from potential harm or injury.

D. The QI plan committee shall:

1. be comprised of at least three persons, one of whom is a LMHP and the others are staff with the qualifying experience to contribute to the committee's purpose; and

2. develop and implement the QI plan.

E. The QI program outcomes shall be documented and reported to the administrator and medical director for action, as necessary, for any identified systemic problems.

F. The BHS provider shall maintain documentation of the most recent 12 months of the QI plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter E. Personnel

§5641. General Requirements

A. The BHS provider shall maintain an organized professional staff who is accountable to the governing body for the overall responsibility of:

1. the quality of all clinical care provided to clients;

2. the ethical conduct and professional practices of its members;

3. compliance with policies and procedures; and

4. the documented staff organization that pertains to the provider's setting and location.

B. The direct care staff of a BHS provider shall:

1. have the qualifying experience to provide the services required by its clients' treatment plans; and

2. not practice beyond the scope of his/her license, certification and/or training.

C. The provider shall ensure that:

1. Qualified direct care staff members are present with the clients as necessary to ensure the health, safety and well-being of clients;

2. Staff coverage is maintained in consideration of:

a. acuity of the clients being serviced;

b. the time of day;

c. the size, location, physical environment and nature of the provider;

d. the ages and needs of the clients;

e. ensuring the continual safety, protection, direct care and supervision of clients;

3. applicable staffing requirements in this Chapter are maintained;

4. mechanisms are developed for tracking staff attendance and hours worked during operational hours whether onsite or off-site;

5. there is adequate justification for the provider's assigned staffing patterns at any point in time.

D. Criminal Background Checks

1. For any provider that is treating children and/or adolescents, the provider shall either:

a. obtain a statewide criminal background check by an agency authorized by the Office of State Police to conduct criminal background checks on all staff that was conducted within 90 days prior to hire or employment; or

b. request a criminal background check on all staff prior to hire or employment in the manner required by R.S. 15:587.1 et seq.

2. For any provider that is treating adults, the provider shall obtain a statewide criminal background check on all unlicensed direct care staff within 90 days prior to hire or employment by an agency authorized by the Office of State Police to conduct criminal background checks. The background check shall be conducted within 90 days prior to hire or employment.

3. A provider that hires a contractor to perform work which does not involve any contact with clients is not required to conduct a criminal background check on the contractor if accompanied at all times by a staff person when clients are present in the provider.

E. Prior to hiring the unlicensed direct care staff member, and once employed, at least every six months thereafter or more often, the provider shall review the Louisiana state nurse aide registry and the Louisiana direct service worker registry to ensure that each unlicensed direct care staff member does not have a negative finding on either registry.

F. Prohibitions

1. The provider is prohibited from knowingly employing or contracting with, or retaining the employment of or contract with, a member of the direct care staff who:

a. has entered a plea of guilty or nolo contendere, no contest, or has been convicted of a felony involving:

i. abuse or neglect of a person;

ii. an alcohol or drug offense, unless the employee or contractor has:

(a). completed his/her court-ordered sentence, including community service, probation and/or parole; and

(b). been sober per personal attestation for at least the last two years;

iii. any crimes that requires the person to register pursuant to the Sex Offenders Registration Act;

iv. misappropriation of property belonging to another person when:

(a). the offense was within the last five years; or

(b). the employee/contractor has not completed his/her sentence, including, if applicable, probation or parole;

v. a crime of violence;

b. has a finding placed on the Louisiana state nurse aide registry or the Louisiana direct service worker registry.

G. Orientation and Training

1. All staff shall receive orientation. All direct care staff shall receive orientation prior to providing direct client care without supervision.

2. All staff shall receive in-service training:

a. at least once a year;

b. that complies with the provider's policies and procedures;

c. that is necessary depending on the needs of the clients; and

d. that is specific to the age of the provider's population.

3. The content of the orientation and in-service training shall include the following:

a. confidentiality in accordance with federal and state laws and regulations;

b. grievance process;

c. fire and disaster plans;

d. emergency medical procedures;

e. organizational structure and reporting relationships;

f. program philosophy;

g. policies and procedures;

h. detecting and mandatory reporting of client abuse, neglect or misappropriation;

i. detecting signs of illness or dysfunction that warrant medical or nursing intervention;

j. basic skills required to meet the health needs and challenges of the client;

k. crisis intervention and the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening and verbal and observational methods to prevent emergency safety situations;

l. telephone crisis mitigation for those staff members who provide such services;

m. client's rights;

n. duties and responsibilities of each employee;

o. standards of conduct required by the provider;

p. information on the disease process and expected behaviors of clients;

q. maintaining a clean, healthy and safe environment;

r. infectious diseases and universal precautions; and

s. basic emergency care for accidents and emergencies until emergency medical personnel can arrive at provider.

4. The orientation and in-service training shall:

a. be provided only by staff who are qualified by education, training, and qualifying experience; and

b. includes documentation of demonstrated competency of direct care staff, ongoing and prior to providing services to clients.

5. The in-service trainings shall serve as a refresher for subjects covered in orientation or training as indicated through the QI process.

I. The provider shall document an annual staff performance evaluation of all employees.

J. The provider shall report violations of laws, rules, and professional and ethical codes of conduct by provider staff and volunteers to the appropriate professional board or licensing authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5643. Core Staffing Personnel Qualifications and Responsibilities

A. All BHS providers shall abide by the following minimum core staffing requirements and shall meet the additional requirements. All BHS providers shall also meet the additional requirements for each specialized program or module pursuant to the provisions of this Chapter as applicable to each BHS provider.

B. Professional Staffing Standards. All BHS providers shall, at a minimum, have the following staff:

1. a medical director who:

a. is a physician with a current, unrestricted license to practice medicine in the state of Louisiana;

b. has the following assigned responsibilities:

i. ensures that the necessary services are provided to meet the needs of the clients;

ii. provides oversight for provider policy/procedure and staff regarding the medical needs of the clients according to the current standards of medical practice;

iii. directs the specific course of medical treatment for all clients;

iv. reviews reports of all medically related accidents/incidents occurring on the premises and identify hazards to the administrator;

v. participates in the development and implementation of policies and procedures for the delivery of services;

vi. periodically reviews delivery of services to ensure care meets the current standards of practice; and

vii. participates in the development of new programs and modifications;

c. has the following responsibilities or designates the duties to a qualified practitioner:

i. writes the admission and discharge orders;

ii. writes and approves all prescription medication orders;

iii. develops, implements and provides education regarding the protocols for administering prescription and non-prescription medications on-site;

iv. provides consultative and on-call coverage to ensure the health and safety of clients; and

v. collaborates with the client's primary care physician and psychiatrists as needed for continuity of the client's care;

2. an administrator who:

a. has either a bachelor's degree from an accredited college or university or one year of qualifying experience that demonstrates adequate knowledge, experience and expertise in business management;

b. is responsible for the on-site day to day operations of the BHS provider and supervision of the overall BHS provider's operation commensurate with the authority conferred by the governing body; and

c. shall not perform any programmatic duties and /or make clinical decisions unless licensed to do so;

3. with the exception of opioid treatment programs, a clinical supervisor who:

a. is an LMHP that maintains a current and unrestricted license with its respective professional board or licensing authority in the state of Louisiana;

b. shall be on duty and on call as needed;

c. has two years of qualifying clinical experience as an LMHP in the provision of services provided by the provider;

d. shall have the following responsibilities:

i. provide supervision utilizing evidenced-based techniques related to the practice of behavioral health counseling;

ii. serve as resource person for other professionals counseling persons with behavioral health disorders;

iii. attend and participate in care conferences, treatment planning activities, and discharge planning;

iv. provide oversight and supervision of such activities as recreation, art/music, or vocational education;

v. function as client advocate in treatment decisions;

vi. ensure the provider adheres to rules and regulations regarding all behavioral health treatment, such as group size, caseload, and referrals;

vii. provide only those services that are within the person's scope of practice; and

viii. assist the medical director and governing body with the development and implementation of policies and procedures;

4. nursing staff who:

a. provide the nursing care and services under the direction of a registered nurse necessary to meet the needs of the clients; and

b. have a valid current nursing license in the State of Louisiana.

i. A BHS provider with clients who are unable to self-administer medication shall have a sufficient number of nurses on staff to meet the medication needs of its clients.

ii. Nursing services may be provided directly by the BHS or may be provided or arranged via written contract, agreement, policy, or other document. The BHS shall maintain documentation of such arrangement.

C. Other Staffing Requirements. The provider shall abide by the following staffing requirements that are applicable to its provider.

1. Licensed Mental Health Professionals

a. The provider shall maintain a sufficient number of LMHPs to meet the needs of its clients.

b. The LMHP has the following responsibilities:

i. provide direct care to clients utilizing the core competencies of addiction counseling and/or mental health counseling and may serve as primary counselor to specified caseload;

ii. serve as resource person for other professionals in their specific area of expertise;

iii. attend and participate in individual care conferences, treatment planning activities, and discharge planning;

iv. provide on-site and direct professional supervision of any unlicensed professional or inexperienced professional;

v. function as the client's advocate in all treatment decisions affecting the client; and

vi. prepare and write notes or other documents related to recovery (e.g. assessment, progress notes, treatment plans, discharge, etc.).

2. Unlicensed Professionals

a. The provider shall maintain a sufficient number of unlicensed professionals (UPs) to meet the needs of its clients.

b. The UP shall:

i. provide direct care to clients and may serve as primary counselor to specified caseload under clinical supervision;

ii. serve as resource person for other professionals and paraprofessionals in their specific area of expertise;

iii. attend and participate in individual care conferences, treatment planning activities and discharge planning;

iv. function as the client's advocate in all treatment decisions affecting the client; and

v. prepare and write notes or other documents related to recovery (e.g. assessment, progress notes, treatment plans, etc.).

3. Direct Care Aides

a. A residential provider shall have a sufficient number of direct care aides to meet the needs of the clients.

b. A provider that provides outpatient services shall use direct care aides as needed.

c. Direct care aides shall meet the following minimum qualifications:

i. has obtained a high school diploma or equivalent;

ii. be at least 18 years old in an adult provider and 21 years old in a provider that treats children and/or adolescents.

d. Direct care aides shall have the following responsibilities:

i. ensure a safe environment for clients;

ii. exercise therapeutic communication skills;

iii. take steps to de-escalate distressed clients;

iv. observe and document client behavior;

v. assist with therapeutic and recreational activities;

vi. monitor clients' physical well-being;

vii. provide input regarding patient progress to the interdisciplinary team;

viii. oversee the activities of the facility when there is no professional staff on duty;

ix. possess adequate orientation and skills to assess situations related to relapse and to provide access to appropriate medical care when needed; and

x. function as client advocate.

4. Volunteers

a. If a BHS provider utilizes volunteers, the provider shall ensure that each volunteer is:

i. supervised to protect clients and staff;

ii. oriented to the provider, job duties, and other pertinent information;

iii. trained to meet requirements of duties assigned;

iv. given a written job description or written agreement;

v. identified as a volunteer;

vi. trained in privacy measures;

vii. required to sign a written confidentiality agreement; and

viii. required to submit to a statewide criminal background check by an agency authorized by the Office of the State Police to conduct criminal background checks prior to providing direct care.

b. If a BHS provider utilizes student volunteers, it shall ensure that each student volunteer:

i. has current registration with the applicable Louisiana professional board, when required, and is in good standing at all times that is verified by the provider;

ii. is actively pursuing a degree in a human service field or professional level licensure or certification at all times;

iii. provides direct client care utilizing the standards developed by the professional board;

iv. provides care only under the direct supervision of the appropriate supervisor; and

v. provides only those services for which the student has been trained and deemed competent to perform.

c. A volunteer's duties may include:

i. direct care activities only when qualified provider personnel are present;

ii. errands, recreational activities; and

iii. individual assistance to support services.

d. The provider shall designate a volunteer coordinator who:

i. has the experience and training to supervise the volunteers and their activities; and

ii. is responsible for selecting, evaluating and supervising the volunteers and their activities.

5. Care Coordinator

a. The provider shall ensure that each care coordinator:

i. has a high school diploma or equivalent;

ii. is at least 18 years old in an adult provider and 21 years old in provider that treats children and/or adolescents; and

iii. has been trained to perform assigned job duties.

E. Multiple Positions. If a BHS provider employs a staff member in more than one position, the provider shall ensure that:

1. the person is qualified to function in both capacities; and

2. one person is able to perform the responsibilities of both jobs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5645. Personnel Records

A. A BHS provider shall maintain a personnel file for each employee and direct care staff member. Each record shall contain:

1. the application for employment and/or resume, including contact information and employment history for the preceding five years, if applicable;

2. reference letters from former employer(s) and personal references or written documentation based on telephone contact with such references;

3. any required medical examinations or health screens;

4. evidence of current applicable credentials/certifications for the position;

5. annual performance evaluations;

6. personnel actions, other appropriate materials, reports and notes relating to allegations of abuse, neglect and misappropriation of clients' funds;

7. the employee's starting and termination dates;

8. proof of attendance of orientation, training and in-services;

9. results of statewide criminal background checks by an agency authorized by the Office of State Police to conduct criminal background checks on all direct care staff;

10. job descriptions and performance expectations;

11. prior to hiring the unlicensed direct care staff member, and once employed, at least every six months thereafter or more often, the provider shall have documentation of reviewing the Louisiana state nurse aide registry and the Louisiana direct service worker registry to ensure that each unlicensed direct care staff member does not have a negative finding on either registry; and

12. a written confidentiality agreement signed by the staff upon hire and subsequently per provider's policy.

B. A BHS provider shall retain personnel files for at least three years following termination of employment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter F. Admission, Transfer and Discharge

§5647. Admission Requirements

A. A BHS provider shall not refuse admission to any individual on the grounds of race, religion, national origin, sexual orientation, ethnicity or disability.

B. A BHS provider shall admit only those individuals whose behavioral health needs, pursuant to the Initial Admission Assessment, can be fully met by the provider.

C. Pre-Admission Requirements

1. Prior to admission, the provider shall either:

a. conduct an initial admission assessment; or

b. obtain a current assessment conducted within the past year that determines the individual's diagnosis and update the assessment to represent the client's current presentation.

2. If the client is disoriented due to psychological or physiological complications or conditions, the initial admission assessment shall be completed as soon as the client is capable of participating in the process.

3. The BHS provider shall include client participation in the assessment process to the extent appropriate.

4. The initial admission assessment shall contain the following:

a. a screening to determine eligibility and appropriateness for admission and referral;

b. a biopsycho-social evaluation that includes:

i. circumstances leading to admission;

ii. past and present behavioral health concerns;

iii. past and present psychiatric and addictive disorders treatment;

iv. significant medical history and current health status;

v. family and social history;

vi. current living situation;

vii. relationships with family of origin, nuclear family, and significant others;

viii. education and vocational training;

ix. employment history and current status;

x. military service history and current status;

xi. legal history and current legal status;

xii. emotional state and behavioral functioning, past and present; and

xiii. strengths, weaknesses, and needs;

c. physical examination or appropriate referral within 72 hours if indicated by the physician, nursing assessment or screening process;

d. drug screening when history is inconclusive or unreliable;

e. appropriate assignment to level of care with referral to other appropriate services as indicated;

f. signature and date by the LMHP; and

g. for residential facilities, diagnostic laboratory tests or appropriate referral as required to prevent spread of contagious/communicable disease, or as indicated by physical examination or nursing assessment.

D. Admission Requirements

1. A provider shall establish admission requirements that include:

a. availability of appropriate physical accommodations;

b. legal authority or voluntary admission;

c. availability of professionals to provide services needed as indicated by the initial assessment and diagnosis; and

d. written documentation that client and family, if applicable, consents to treatment and understands the diagnosis and level of care.

2. Client/Family Orientation. Each provider shall ensure that a confidential and efficient orientation is provided to the client and the client's family, if applicable, concerning:

a. visitation in a residential facility, if applicable;

b. family involvement;

c. safety;

d. the rules governing individual conduct;

e. authorization to provide treatment;

f. adverse reactions to treatment;

g. the general nature and goals of the program;

h. proposed treatment to include treatment methodology, duration, goals and services;

i. risks and consequences of non-compliance;

j. treatment alternatives;

k. clients rights and responsibilities; and

l. all other pertinent information, including fees and consequences of non-payment of fees.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5649. Transfer and Discharge Requirements

A. Each provider shall develop, implement and comply with policies and procedures that address:

1. discharge;

2. transition to another level of care; and

3. transfer to another licensed provider.

B. The BHS provider shall ensure that a client is discharged:

1. when the client's treatment goals are achieved, as documented in the client's treatment plan;

2. when the client's issues or treatment needs are not consistent with the services the provider is authorized or able to provide;

3. according to the provider's established written discharge criteria; or

4. when the voluntarily-admitted client, or client's parent or legal guardian, if applicable, requests discharge.

C. Discharge planning shall begin upon admission.

D. Discharge Plan. The provider shall submit a written discharge plan to each client upon discharge or, if unable to submit at discharge, within seven days after discharge. The discharge plan shall provide reasonable protection of continuity of services that includes:

1. the client's transfer or referral to outside resources, continuing care appointments, and crisis intervention assistance;

2. documented attempts to involve family or an alternate support system in the discharge planning process;

3. the client's goals or activities to sustain recovery;

4. signature of the client or, if applicable, the client's parent or guardian;

5. name, dosage, route and frequency of client's medications ordered at the time of discharge; and

6. the disposition of the client's possessions, funds and/or medications, if applicable.

E. Discharge Summary. The BHS provider shall ensure that each client record contains a written discharge summary that includes:

1. the client's presenting needs and issues identified at the time of admission;

2. the services provided to the client;

3. the provider's assessment of the client's progress towards goals;

4. the discharge disposition; and

5. the continuity of care recommended following discharge, supporting documentation and referral or transfer information.

F. When a request for discharge is received or when the client leaves the provider against the provider's advice, the provider shall:

1. have and comply with written procedures for handling discharges and discharge requests;

2. document the circumstances surrounding the leave;

3. complete the discharge summary within 30 days of the client's leaving the program or sooner for continuity of care.

G. Transitions. When a client undergoes a transition to another level of care, the provider shall ensure that:

1. the transition to a different level of care is documented in the client's record by a member of the direct care staff;

2. the client is notified of the transition; and

3. if transitioning to a different provider, the staff coordinates transition to next level of care.

H. Transfer Process

1. If a residential provider decides to transfer a client, the provider shall ensure that there is an agreement with the receiving provider to provide continuity of care based on:

a. the compilation of client data; or

b. the medical history/examination/physician orders, psycho-social assessment, treatment plan, discharge summary and other pertinent information provided upon admission to inpatient or outpatient care.

2. The residential provider responsible for the transfer and discharge of the client shall:

a. request and receive approval from the receiving provider prior to the transfer;

b. notify the receiving provider prior to the arrival of the client of any significant medical and/or psychiatric conditions and complications or any other pertinent information that will be needed to care for the client prior to arrival;

c. transfer all requested client information and documents upon request; and

d. ensure that the client has consented to the transfer.

I. If a client is involuntarily committed to a provider, the provider shall:

1. maintain the care of the client until an appropriate level of care becomes available; and

2. comply with the transfer and discharge requirements in this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter G. Services

§5651. Treatment Protocols

A. A BHS provider shall deliver all services according to a written plan that:

1. is age and culturally appropriate for the population served;

2. demonstrates effective communication and coordination;

3. provides utilization of services at the appropriate level of care;

4. is an environment that promotes positive well-being and preserves the client's human dignity; and

5. utilizes evidence-based counseling techniques and practices.

B. The provider shall make available a variety of services, including group and/or individual treatment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5653. Treatment Plan

A. Each client of the BHS provider shall have a treatment plan linked to the assessment that contains:

1. documented input from the counselor and client within 72 hours after admission to a residential facility, with information from other disciplines added as the client is evaluated and treated;

2. client-specific, measurable goals that are clearly stated in behavioral terms;

3. the treatment modalities to be utilized;

4. realistic and specific expected achievement dates;

5. the strategies and activities to be used to help the client achieve the goals;

6. information specifically related to the mental, physical, and social needs of the client; and

7. the identification of staff assigned to carry out the treatment.

B. The BHS provider shall ensure that the treatment plan is in writing and is:

1. developed in collaboration with the client and when appropriate, the client's family and is signed by the client or the client's family, when appropriate;

2. reviewed and revised as required by this Chapter or more frequently as indicated by the client's needs;

3. consistently implemented by all staff members;

4. signed by the LMHP or physician responsible for developing the treatment plan; and

5. is in language easily understandable to the client and to the client's family, when applicable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5655. Core Services

A. A BHS provider shall provide the following services to its clients when needed:

1. assessment;
2. orientation;
3. treatment;
4. client education;
5. consultation with professionals;
6. counseling services;
7. referral;
8. medication management;
9. rehabilitation services; and
10. crisis mitigation.

B. Crisis Mitigation Services

1. The BHS provider's crisis mitigation plan shall:

a. identify steps to take when a client suffers from a medical, psychiatric, medication or relapse crisis; and

b. specify names and telephone numbers of staff or organizations to assist clients in crisis.

2. If the provider contracts with another entity to provide crisis mitigation services, the BHS provider shall have a written contract with the entity providing the crisis mitigation services.

3. The qualified individual, whether contracted or employed by the BHS provider, shall call the client within 30 minutes of receiving notice of the client's call.

C. Referral

1. The provider shall provide:

a. appropriate resource information regarding local agencies to client and family, if applicable, upon need or request; and

b. procedures to access vocational services, community services, transitional living services and transportation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5657. Laboratory Services

A. Each BHS provider that provides medication management and/or addiction treatment services shall:

1. have a written agreement for laboratory services off-site or provide laboratory services on-site;

2. ensure that the laboratory providing the services has current clinical laboratories improvement amendments (CLIA) certification when necessary;

3. ensure diagnostic laboratory services are available to meet the behavioral health needs of the clients; and

4. maintain responsibility for all laboratory services provided on-site or off-site via contractual agreement.

B. If collection is performed on-site, the provider shall develop, implement and comply with written policies and procedures for the collection of specimens in accordance with current standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5659. Medications

A. A BHS provider that stores stock medications of scheduled controlled dangerous substances shall maintain:

1. a site-specific Louisiana controlled dangerous substance license in accordance with the Louisiana Uniform Controlled Dangerous Substance Act; and

2. a United States Drug Enforcement Administration controlled substance registration for the provider in accordance with title 21 of the *United States Code*.

B. The provider, when applicable, shall develop, implement and comply with written policies and procedures that govern:

1. the safe administration and handling of all prescription and nonprescription medications;

2. identification of medications being brought into the premises when the provider is responsible for administering medications;

3. the storage, dispensing, if applicable, and recording and control of all medications;

4. The self-administration of all medications, that includes:

a. age limitations for self-administration;

b. order from the authorized licensed prescriber;

c. parental consent, if applicable; and

d. the manner in which the client is monitored by staff to ensure medication is taken as prescribed in the treatment plan;

5. the disposal of all discontinued and/or expired medications and containers with worn, illegible or missing labels in accordance with state and federal law and regulations;

6. the use of prescription medications including:

a. when medication is administered and monitoring of the effectiveness of the medication administered;

b. a procedure to inform clients, staff, and where appropriate, client's parent(s) or legal guardian(s) of each medication's anticipated results, the potential benefits and side-effects as well as the potential adverse reaction that could result from not taking the medication as prescribed;

c. involving clients and, when appropriate, their parent(s) or legal guardian(s) in decisions concerning medication; and

d. staff training to ensure the recognition of the potential side effects of the medication;

7. recording of medication errors and adverse drug reactions and reporting them to the client's physician or authorized prescriber;

8. the reporting of and steps to be taken to resolve discrepancies in inventory, misuse and abuse of controlled dangerous substances in accordance with federal and state law; and

9. reconciliation of all controlled dangerous substances to guard against diversion.

C. The provider shall ensure that:

1. any medication administered to a client is administered as prescribed;

2. all medications are kept in a locked cabinet, closet or room and under recommended temperature controls;

3. all controlled dangerous substances shall be kept separately from other medications in a locked cabinet or compartment accessible only to individuals authorized to administer medications;

4. current and accurate records are maintained on the receipt and disposition of all scheduled drugs;

5. schedule II, III and IV of the provider's controlled dangerous substances are reconciled at least twice a day by different shifts of staff authorized to administer controlled dangerous substances;

6. medications are administered only upon receipt of written orders by paper, facsimile, or electronic transmission, or verbal orders from an authorized licensed prescriber;

7. all verbal orders are signed by the authorized licensed prescriber within 10 calendar days;

8. medications that require refrigeration are stored in a refrigerator or refrigeration unit separate from food, beverages, blood, and laboratory specimens;

9. all prescription medications are labeled to identify:

a. the client's full name;

b. the name of the medication;

c. dosage;

d. quantity and date dispensed;

e. directions for taking the medication;

f. required accessory and cautionary statements;

g. prescriber's name; and

h. the expiration date, if applicable;

10. medication errors, adverse drug reactions, and interactions with other medications, food or beverages taken by the client are immediately reported to the medical director with an entry in the client's record; and

11. discrepancies in inventory of controlled dangerous substances are reported to the pharmacist.

D. BHS Providers that Dispense Medications

1. If the BHS provider dispenses medications to its clients, the provider shall:

a. provide pharmaceutical services on-site at the center; or

b. have a written agreement with a pharmaceutical provider to dispense the medications.

2. The provider shall ensure that all compounding, packaging, and dispensing of medications is:

a. accomplished in accordance with Louisiana law and Board of Pharmacy regulations; and

b. performed by or under the direct supervision of a registered pharmacist currently licensed to practice in Louisiana.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter H. Client Rights

§5661. Client Rights

A. The BHS provider shall develop, implement and comply with policies and procedures that:

1. protect its client's rights;

2. respond to questions and grievances pertaining to these rights;

3. ensure compliance with client's rights enumerated in R.S. 28:171; and

4. ensure compliance with minor's rights enumerated in the *Louisiana Children's Code* article 1409.

B. A BHS provider's client and, if applicable, the client's parent(s) or legal guardian, have the following rights:

1. to be informed of the client's rights and responsibilities at the time of admission or within 24 hours of admission;

2. to have a family member, chosen representative and/or his or her own physician notified of admission to the BHS provider at the request of the client;

3. to receive treatment and medical services without discrimination based on race, age, religion, national origin, gender, sexual orientation, or disability;

4. to maintain the personal dignity of each client;

5. to be free from abuse, neglect, exploitation and harassment;

6. to receive care in a safe setting;

7. to receive the services of a translator or interpreter, if applicable, to facilitate communication between the client and the staff;

8. to be informed of the client's own health status and to participate in the development, implementation and updating of the client's treatment plan;

9. to make informed decisions regarding the client's care by the client or the client's parent or guardian, if applicable, in accordance with federal and state laws and regulations;

10. to participate or refuse to participate in experimental research when the client gives informed, written consent to such participation, or when a client's parent or legal guardian provides such consent, when

applicable, in accordance with federal and state laws and regulations;

11. for clients in residential facilities, to consult freely and privately with the client's legal counsel or to contact an attorney at any reasonable time;

12. to be informed, in writing, of the policies and procedures for filing a grievance and their review and resolution;

13. to submit complaints or grievances without fear of reprisal;

14. for clients in residential facilities, to possess and use personal money and belongings, including personal clothing, subject to rules and restrictions imposed by the BHS provider;

15. for clients in residential facilities, to visit or be visited by family and friends subject to rules imposed by the provider and to any specific restrictions documented in the client's treatment plan;

16. to have the client's information and medical records, including all computerized medical information, kept confidential in accordance with federal and state statutes and rules/regulations;

17. for clients in residential facilities, access to indoor and outdoor recreational and leisure opportunities;

18. for clients in residential facilities, to attend or refuse to attend religious services in accordance with his/her faith;

19. to be given a copy of the program's rules and regulations upon admission;

20. to receive treatment in the least restrictive environment that meets the client's needs;

21. to not be restrained or secluded in violation of federal and state laws, rules and regulations;

22. to be informed in advance of all estimated charges and any limitations on the length of services at the time of admission or within 72 hours;

23. to receive an explanation of treatment or rights while in treatment;

24. to be informed of the:

a. nature and purpose of any services rendered;

b. the title of personnel providing that service;

c. the risks, benefits, and side effects of all proposed treatment and medications;

d. the probable health and mental health consequences of refusing treatment; and

e. other available treatments which may be appropriate;

25. to accept or refuse all or part of treatment, unless prohibited by court order or a physician deems the client to be a danger to self or others or gravely disabled;

26. for children and adolescents in residential BH facilities, to access educational services consistent with the client's abilities and needs, relative to the client's age and level of functioning; and

27. to have a copy of these rights, which includes the information to contact HSS during routine business hours.

C. The residential or outpatient clinic provider shall

1. post a copy of the clients' rights on the premises that is accessible to all clients; and

2. give a copy of the clients' rights to each client upon admission and upon revision.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5663. Grievances

A. The provider shall develop, implement and comply with a written grievance procedure for clients designed to allow clients to submit a grievance without fear of retaliation. The procedure shall include, but not be limited to:

1. a procedure for filing a grievance;

2. a time line for responding to the grievance;

3. a method for responding to a grievance; and

4. the staff's responsibilities for addressing grievances.

B. The provider shall ensure that:

1. the client and, if applicable, the client's parent(s) or legal guardian(s), is informed of the grievance procedure; and

2. all grievances are addressed and resolved to the best of the provider's ability.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter I. Physical Environment

§5665. Exterior Space Requirements

A. The provider shall maintain its exterior areas that are accessible to the clients, including the grounds and structures on the grounds, in good repair and free from potential hazards to health or safety.

B. The provider shall ensure the following:

1. garbage stored outside is secured in noncombustible, covered containers and removed on a regular basis;

2. trash collection receptacles and incinerators are separate from recreation areas;

3. unsafe areas have safeguards to protect clients from potential hazards;

4. fences are in good repair;

5. exterior areas are well lit; and

6. the provider has signage that indicates the provider's:

a. legal or trade name;

b. address;

c. hours of operation; and

d. telephone number(s).

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5667. Interior Space for Residential Facilities and Outpatient Clinics

A. The BHS provider that provides services on-site shall:

1. have a physical environment that ensures the health, safety and security of the clients;

2. have routine maintenance and cleaning services;

3. be well-lit, clean, safe and ventilated;

4. maintain its physical environment, including, but not limited to, all equipment, fixtures, plumbing, electrical, furnishings, doors and windows, in good order and safe condition and in accordance with manufacturer's recommendations; and

5. maintain heating, ventilation and cooling systems in good order and safe condition to ensure a temperature controlled environment.

B. The provider shall have designated space for the secure storage of the staff's personal belongings.

C. Furnishings. The BHS provider shall ensure that the provider's furnishings for all living and treatment areas are designed to meet the needs of the clients.

D. Medication Storage and Preparation. The provider shall have an area for medication preparation, administration and storage that meets one of the following:

1. a secured medication room that contains sufficient space for a work counter, sink, refrigerator, locked storage for controlled dangerous substances; or

2. a secured self-contained medication distribution unit located in a clean workroom, alcove or other staff work area with an easily accessible hand washing station.

E. Administrative and Counseling Area

1. The provider shall provide a space that is distinct from the client living and/or treatment areas that serves as an administrative office.

2. The provider shall have a designated space(s) to allow for private and group discussions and counseling sessions.

F. Smoking. The provider shall prohibit smoking in the interior of its licensed space.

G. Bathrooms

1. There shall be at least one bathroom for use by clients and staff and meets the requirements of the Louisiana *Sanitary Code*.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5669. Interior Space for Residential Facilities

A. The provider shall evaluate each client's physical, emotional and medical needs and the physical environment of the facility in order to ensure the safety and well-being of all admitted clients.

B. Common Area. The facility's physical environment shall have a designated space accessible to the clients:

1. to be used for group meetings, dining, visitation, leisure and recreational activities;

2. that is at least 25 square feet per client and no less than 150 square feet, exclusive of bedrooms or sleeping areas, bathrooms, areas restricted to staff, laundry rooms and office areas; and

3. that contains a sufficient number of tables and chairs for eating meals.

C. The facility's physical environment shall have a designated room(s) or area(s) to allow for private and group discussions and counseling sessions that:

1. safely accommodates the clients being served;

2. has adequate space to meet the client's needs in the therapeutic process; and

3. is exclusive of bedrooms, bathrooms and common areas.

D. Client Bedrooms. The provider shall ensure that each client bedroom in the facility:

1. contains at least 80 square feet for single bedrooms, exclusive of fixed cabinets, fixtures and equipment;

2. contains at least 60 square feet per bed for multi-bedrooms, exclusive of fixed cabinets, fixtures, and equipment;

3. has at least a 7 1/2 foot ceiling height over the required area except in a room with varying ceiling height, only portions of the room with a ceiling height of at least 7 1/2 feet are allowed in determining usable space;

4. has at least 2 foot minimum clearance at the foot of each bed; and

5. contains no more than four beds;

a. exception. Providers licensed as substance abuse/addiction treatment residential facilities at the time this Rule is promulgated that have more than four clients per bedroom, may maintain the existing bedroom space that allows more than four clients per bedroom provided that the bedroom space has been previously approved by DHH waiver. This exception applies only to the currently licensed physical location;

6. has at least three feet between beds;

7. has designated storage space for the client's:

a. clothes;

b. toiletries; and

c. personal belongings;

8. has a screened window that opens to the outside;

9. has sheets, pillow, bedspread and blankets for each client that are clean and in good repair and discarded when no longer usable;

10. has sufficient headroom to allow the occupant to sit up; and

11. contains a bed(s) that:

a. is longer than the client is tall;

b. is no less than 30 inches wide;

c. is of solid construction;

d. has a clean, comfortable, nontoxic fire retardant mattress; and

e. is appropriate to the size and age of the client.

E. The provider shall:

1. prohibit any client over the age of five years to occupy a bedroom with a member of the opposite sex who is not in the client's immediate family;

2. require separate bedrooms and bathrooms for adults, and children/adolescents, except in the Mothers with Dependent Children Program, and for males and females;

3. prohibit adults and children/adolescents from sharing the same space, except in the Mothers with Dependent Children Program;

4. require sight and sound barriers between adult area/wing and the adolescent area/wing;

5. for facilities with child/adolescent clients, ensure that the age of clients sharing bedroom space is not greater than four years in difference unless contraindicated based on diagnosis, the treatment plan or the behavioral health assessment of the client;

6. ensure that each client has his/her own bed;

7. prohibit mobile homes from being used as client sleeping areas; and

8. prohibit bunk beds in the following programs:

a. clinically managed residential detoxification (ASAM level III.2D);

b. Clinically Managed High Intensity Residential Program (ASAM level III.5);

c. medically monitored intensive residential treatment (ASAM level III.7); and

d. medically monitored residential detoxification (ASAM level III.7D).

F. Bathrooms

1. In accordance with the Louisiana state *Sanitary Code*, a provider shall have bathrooms equipped with lavatories, toilets, tubs and/or showers for use by the clients located within the provider and the following:

a. shatterproof mirrors secured to the walls at convenient heights; and

b. other furnishings necessary to meet the clients' basic hygienic needs.

2. The provider shall have the ratio of lavatories, toilets, tubs and/or showers to clients required by the Louisiana state *Sanitary Code*.

3. A provider shall have at least one separate toilet, lavatory, and bathing facility for the staff located within the provider.

4. In a multi-level facility, there shall be at least one a full bathroom with bathing facility reserved for client use on each client floor.

5. Each bathroom shall be located so that it opens into a hallway, common area or directly into the bedroom. If the bathroom only opens directly into a bedroom, it shall be for the use of the occupants of that bedroom only.

6. The provider shall ensure that each client has personal hygiene items, such as a toothbrush, toothpaste, shampoo, and soap as needed.

H. Kitchen

1. If a BHS provider prepares meals on-site, the BHS provider shall have a full service kitchen that meets the requirements of the Louisiana state *Sanitary Code* and:

a. includes a cooktop, oven, refrigerator, freezer, hand washing station, storage and space for meal preparation;

b. is inspected and approved annually by OPH;

c. has the equipment necessary for the preparation, serving, storage and clean-up of all meals regularly served to all of the clients and staff; and

d. contains trash containers covered and made of metal or United Laboratories-approved plastic;

2. A BHS provider that does not prepare meals on-site shall have a nourishment station or a kitchenette, that includes:

a. a sink;

b. a work counter;

c. a refrigerator;

d. storage cabinets;

e. equipment for preparing hot and cold nourishments between scheduled meals; and

f. space for trays and dishes used for nonscheduled meal service.

I. Laundry. The provider shall have a laundry space complete with a ratio of 1:20 washers and dryers to meet the needs of the clients.

J. Staff Quarters. The provider utilizing live-in staff shall provide adequate, separate living space with a private bathroom for staff usage only.

K. The provider shall ensure that all closets, bedrooms and bathrooms are equipped with doors that can be readily opened from both sides.

L. The provider shall ensure that outside doors and windows prohibit an outsider from gaining unauthorized ingress.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter J. Safety and Emergency Preparedness

§5671. Safety Provisions for Outpatient Clinics and Residential Facilities

A. The provider shall provide additional supervision when necessary to provide for the safety of all individuals.

B. The provider shall:

1. prohibit weapons of any kind on-site unless possessed by security or law enforcement official or hired security while in uniform and on official business;

2. ensure that its equipment, furnishings, accessories and any other items that are in a state of disrepair or defects are removed and inaccessible until replaced or repaired;

3. ensure that all poisonous, toxic and flammable materials are:

a. maintained in appropriate containers and labeled as to the contents;

b. securely stored in a separate and locked storage area that is inaccessible to clients;

c. maintained only as necessary; and

d. are used in such a manner as to ensure the safety of clients, staff and visitors;

4. ensure that supervision and training is provided to any staff member or client exposed to or that may come in contact with potentially harmful materials such as cleaning solvents and/or detergents;

5. ensure that a first aid kit is readily available in the provider and in all vehicles used to transport clients.

C. Required Inspections. The provider shall be in compliance with all required inspections and shall have documentation to demonstrate compliance with applicable laws and regulations.

D. The provider shall have an on-going safety program in any facility where clients, staff and others may be, that includes:

1. continuous inspection of the provider for possible hazards;

2. continuous monitoring of safety equipment and maintenance or repair when needed;

3. investigation and documentation of all accidents or emergencies; and

4. fire control and evacuation planning with documentation of all emergency drills.

E. Required BHS Provider Reporting. The provider shall report the following incidents in writing to HSS on the HSS approved form within 24 hours of discovery:

1. any disaster or emergency or other unexpected event that causes significant disruption to program operations and an inability to provide services for greater than 24 hours;

2. any death or serious injury of a client that:

a. may potentially be related to program activities; or

b. at the time of his/her death or serious injury, was on-site at the BHS provider's premises or a resident of the provider's facility; and

3. allegations of client abuse, neglect and/or exploitation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5673. Infection Control

A. The provider shall provide a sanitary environment to avoid source(s) and transmission of infections and communicable diseases.

B. The provider shall have an active Infection Control Program that requires:

1. reporting of infectious disease in accordance with CDC and state OPH guidelines;

2. monitoring of:

a. the spread of infectious disease;

b. hand washing;

c. staff and client education; and

d. incidents of specific infections in accordance with OPH guidelines;

3. corrective actions; and

4. a designated infection control coordinator who:

a. develops and implements policies and procedures related to infection control; and

b. has training and/or experience in infection control;

5. universal precautions; and

6. strict adherence to all sanitation requirements.

C. The provider shall maintain a clean and sanitary environment and shall ensure that:

1. supplies and equipment are available to staff;

2. consistent ongoing monitoring and cleaning of all areas of the provider;

3. methods used for cleaning, sanitizing, handling and storing of all supplies and equipment prevent the transmission of infection;

4. procedures are posted for sanitizing kitchen, kitchen, bathroom and laundry areas in accordance with the *Louisiana Sanitary Code*; and

5. storage, handling, and removal of food and waste will not spread disease, cause noxious odor, or provide a breeding place for pests.

D. The provider may enter into a written contract for housekeeping services necessary to maintain a clean and neat environment.

E. The provider shall have an effective pest control plan.

F. After discharge of a client, the residential provider shall:

1. clean the bed, mattress, cover, bedside furniture and equipment;

2. ensure that mattresses, blankets and pillows assigned to clients are in sanitary condition; and

3. ensure that the mattress, blankets and pillows used for a client with an infection is sanitized before assigned to another client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5675. Emergency Preparedness

A. The BHS provider shall have a written emergency preparedness plan:

1. to maintain continuity of the provider's operations in preparation for, during and after an emergency or disaster;

2. to manage the consequences of all disasters or emergencies that disrupt the provider's ability to render care and treatment, or threaten the lives or safety of the clients; and

3. that is prepared in coordination with the provider's local and/or parish Office of Homeland Security and Emergency Preparedness (OHSEP).

B. The residential facility or outpatient clinic provider shall:

1. post floor plans with diagrams giving clear directions on how to exit the building safely and in a timely manner at all times;

2. post emergency numbers by all telephones;

3. have a separate floor plan or diagram with designated safe zones or sheltering areas for non-fire emergencies; and

4. train its employees in emergency or disaster preparedness. Training shall include orientation, ongoing training and participation in planned drills for each employee and on each shift.

C. The residential BHS provider's emergency preparedness plan shall include, at a minimum:

1. in the event of an emergency, an assessment of all clients to determine the clients:

a. who continue to require services and should remain in the care of the provider; or

b. who may be discharged to receive services from another provider;

2. the determination as to when the facility will shelter in place and when the facility will evacuate for a disaster or emergency and the conditions that guide these determinations in accordance with local or parish OHSEP;

3. provisions for when the provider shelters-in-place that include:

a. the decision to take this action is made after reviewing all available and required information on the emergency/disaster, the provider, the provider's surroundings, and consultation with the local or parish OHSEP;

b. provisions for seven days of necessary supplies to be provided by the provider prior to the emergency, including drinking water or fluids and non-perishable food; and

c. the delivery of essential services to each client;

4. provisions for when the provider evacuates with clients:

a. the delivery of essential provisions and services to each client, whether the client is in a shelter or other location;

b. the provider's method of notifying the client's family or caregiver, including:

i. the date and approximate time that the Provider or client is evacuating;

ii. the place or location to which the client(s) is evacuating which includes the name, address and telephone number; and

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

c. provisions for ensuring that supplies, medications, clothing and a copy of the treatment plan are sent with the client, if the client is evacuated;

d. the procedure or methods that will be used to ensure that identification accompanies the client. The identification shall include the following information:

i. current and active diagnosis;

ii. all medication, including dosage and times administered;

iii. allergies;

iv. special dietary needs or restrictions; and

v. legal representative, if applicable, including contact information;

e. transportation or arrangements for transportation for an evacuation that is adequate for the current census;

5. provisions for staff to maintain continuity of care during an emergency; and

6. staff distribution and assignment of responsibilities and functions during an emergency.

D. The outpatient clinic's emergency preparedness plan shall include, at a minimum:

1. in the event of an emergency or disaster, an assessment of all clients to determine the clients:

a. who continue to require services; or

b. who may be discharged to receive services from another provider;

2. a plan for each client to continue to receive needed services during a disaster or emergency either by the provider or referral to another program; and

3. measures to be taken to locate clients after an emergency or disaster and determine the need for continued services and/or referral to other programs.

E. The provider shall:

1. follow and execute its emergency preparedness plan in the event of the occurrence of a declared disaster or other emergency;

2. if the state, parish or local OHSEP orders a mandatory evacuation of the parish or the area in which the agency is serving, ensure that all clients are evacuated according to the provider's emergency preparedness plan;

3. review and update its emergency preparedness plan at least once a year;

4. cooperate with the department and with the local or parish OHSEP in the event of an emergency or disaster and provide information as requested;

5. monitor weather warnings and watches as well as evacuation orders from local and state emergency preparedness officials;

6. upon request by the department, submit a copy of its emergency preparedness plan for review; and

7. upon request by the department, submit a written summary attesting how the emergency plan was followed and executed. The summary shall contain, at a minimum:

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

b. plan provisions that were not followed;

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

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

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

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5677. Inactivation of License due to a Declared Disaster or Emergency

A. A licensed BHS provider located in a parish which is the subject of an executive order or proclamation of emergency or disaster issued, may seek to inactivate its license for a period not to exceed one year, provided that the provider:

1. submits written notification to HSS within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the BHS provider has experienced an interruption in the provisions of services and an inability to resume services as a result of events that are the subject of such executive order or proclamation of emergency or;

b. the BHS provider intends to resume operation as a BHS provider in the same service area;

c. includes an attestation that the emergency or disaster is the sole casual factor in the interruption of the provision of services;

d. includes an attestation that all clients have been properly discharged or transferred to another provider; and

e. lists the clients and the location of the discharged or transferred clients;

2. submits documentation of the provider's interruption in services and inability to resume services as a result of the emergency or disaster;

3. resumes operating as a BHS provider in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with state statute;

4. continues to pay all fees and cost due and owed to the department including, but not limited to, annual licensing fees and outstanding civil fines; and

5. continues to submit required documentation and information to the department.

B. Upon receiving a completed request to inactivate a BHS provider license, the department may issue a notice of inactivation of license to the BHS provider.

C. In order to obtain license reinstatement, a BHS provider with a department-issued notice of inactivation of license shall:

1. submit a written license reinstatement request to HSS 60 days prior to the anticipated date of reopening that includes:

a. the anticipated date of opening, which is within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with state statute;

b. a request to schedule a licensing survey; and

c. a completed licensing application with appropriate licensing fees and other required documents, if applicable;

2. submit written approvals for occupancy from OSFM and OPH.

D. Upon receiving a completed written request to reinstate a BHS provider license, the department shall conduct a licensing survey.

E. If the BHS provider meets the requirements for licensure and the requirements under this subsection, the department shall issue a notice of reinstatement of the BHS provider license.

F. During the period of inactivation, the department prohibits change of ownership of the provider.

G. The provisions of this Section shall not apply to a BHS provider which has voluntarily surrendered its license.

H. Failure to request inactive status when the license becomes nonoperational due to a disaster or emergency and/or failure to comply with any of the provisions of this subsection shall be deemed a voluntary surrender of the BHS provider license.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter K. Additional Requirements for Children/Adolescent Programs

NOTE: In addition to the requirements applicable to all Behavioral Health Service providers, programs that treat children and/or adolescents must meet the applicable requirements below.

§5679. General Provisions

A. The BHS provider that provides services to children and/or adolescents shall:

1. provide program lectures and written materials to the clients that are age-appropriate and commensurate with their education and skill-level;

2. involve the client's family or an alternate support system in the process or document why this is not appropriate;

3. prohibit staff from:

a. providing, distributing or facilitating access to tobacco products, alcohol or illegal drugs; and

b. using tobacco products in the presence of adolescent clients;

4. prohibit clients from using tobacco products on the program site or during structured program activities;

5. address the special needs of its clients and comply with all applicable standards, laws and protocols to protect their rights;

6. develop and implement policies and procedures for obtaining consent in accordance with state statutes; and

7. prohibit adults and children/adolescents from attending the same group counseling sessions and activities unless it is therapeutically indicated.

B. Staffing

1. All direct care employees shall have training in adolescent development, family systems, adolescent psycho-pathology and mental health, substance use in adolescents, and adolescent socialization issues.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5681. Residential Programs for Children and/or Adolescents

A. Staffing

1. While the clients are on-site, the staff shall:

a. directly supervise and be readily available within hearing distance of the clients at all times; and

b. conduct visual checks, including bed checks, at least once every hour, or more frequently as indicated in the treatment plan.

2. The clients who are off-site but under the responsibility of the provider shall be within eyesight of the staff at all times. While off-site, there shall be a ratio of one staff member to five clients.

B. Educational Resources. The provider shall provide a Department of Education-approved opportunity for clients to maintain grade level and continuity of education during any treatment lasting longer than 14 days unless the treatment occurs during school vacation.

C. Family Communications. The provider shall allow regular communication between a client and the client's family and shall not arbitrarily restrict any communications without clear, written, individualized clinical justification documented in the client record.

D. Recreational Space. Clients shall have access to safe, suitable outdoor recreational space and age appropriate equipment that is located, installed and maintained to ensure the safety of the clients.

E. The provider shall provide a tobacco cessation program to assist client's with nicotine dependency.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter L. Additional Requirements for Mental Health Programs

NOTE: In addition to the requirements applicable to all BHS providers, a provider that provides mental health services must meet the requirements of Subchapter L.

§5683. Staffing Requirements

A. Medical Director. The provider with a mental health program shall ensure that its medical director:

1. is a physician with two years of qualifying experience in treating psychiatric disorders; or

2. is a board-certified psychiatrist.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5685. Psychosocial Rehabilitation Services

A. The provider that provides psychosocial rehabilitation services (PSR) shall:

1. provide PSR either individually or in a group setting;

2. provide services in community locations where the client lives, works, attends school and/or socializes in addition to or instead of at the licensed entity;

3. assist the client in developing social and interpersonal skills to:

a. increase community tenure;

b. enhance personal relationships;

c. establish support networks;

d. increase community awareness; and

e. develop coping strategies and effective functioning in the individual's social environment;

4. assist the client with developing daily living skills to improve self-management of the negative effects of

psychiatric or emotional symptoms that interfere with a person's daily living;

5. implement learned skills so the client can remain in a natural community location and achieve developmentally appropriate functioning; and

6. assist the client with effectively responding to or avoiding identified precursors or triggers that result in functional impairments.

B. Staffing. The provider shall ensure that:

1. the unlicensed professionals providing PSR receive regularly scheduled clinical supervision from an LMHP;

2. The size of group therapy does not exceed 15 adults or 8 adolescents or children;

3. its staff providing PSR services:

a. is at least 18 years old;

b. has a high school diploma or equivalent; and

c. is at least three years older than any individual served under the age of 18.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5687. Crisis Intervention

A. Crisis intervention services may occur in a variety of locations including a health care provider or the community.

B. The provider shall ensure that:

1. a preliminary screening of risk, mental status and stability and the need for further evaluation or other mental health services is conducted by an UP that:

a. includes contact with the client, family members or other collateral sources with pertinent information; and

b. includes a referral to other alternative mental health services at an appropriate level if necessary;

2. an assessment of risk, mental status and psychiatric stability is conducted by a LMHP.

C. Staffing

1. Unlicensed Professionals

a. Unlicensed professionals (UPs) shall:

i. be at least 20 years old and be at least three years older than a client under the age of 18; and

ii. have either:

(a). an associate's degree in social work, counseling, psychology or a related human services field;

(b). two years of course work in a human services field; or

(c). two years of qualifying experience working with clients who have behavioral health disorders.

b. The responsibilities of the UP include:

i. performing the preliminary screening;

ii. assisting the program's LMHP in conducting the assessment;

iii. developing and implementing an individualized written crisis plan from the assessment that provides procedures to reduce the risks of harm to the client and others as well as follow-up procedures;

iv. consulting with physician or the program's LMHP when necessary;

v. providing short term crisis intervention, including crisis resolution and debriefing with the client;

vi. contacting family members when necessary; and

vii. following up with the client and as necessary, with family members and/or caretaker.

2. Licensed Mental Health Professionals

a. The licensed mental health professional (LMHP) shall have experience in administering crisis intervention techniques that work to minimize the risk of harm to self or others.

b. The responsibilities of the LMHP are:

i. to conduct the assessment of risk, mental status and medical stability;

ii. to be available for consultation and support; and

iii. to supervise the development and implementation of each crisis plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5689. Community Psychiatric Support and Treatment

A. The provider that provides community psychiatric support and treatment (CPST) services shall:

1. provide services in community locations where the client lives, works, attends school and/or socializes in addition to or instead of at the licensed entity;

2. provide CPST services with the client present;

3. provide services to minimize the negative effects of the symptoms, emotional disturbances or associated environmental stressors which interfere with the client's daily living;

4. provide individual supportive counseling, solution-focused interventions, emotional and behavioral management and problem behavior analysis with the client;

5. participates in and utilizes strengths-based planning and treatments, that includes identifying strengths and needs, resources, natural supports and developing goals and objectives to address functional deficits associated with the client's mental illness; and

6. provides restoration, rehabilitation and support to develop skills to locate, rent and keep a home.

B. Staffing Requirements

1. Unlicensed Professionals Providing CPST Services

a. The program's UPs that provide CPST, except counseling, shall have one of the following:

i. a bachelor's degree in social work, counseling, psychology or a related human services field; ~~or~~

ii. four years of equivalent education in a human service field; or

iii. four years of qualifying experience working with clients who have behavioral health disorders.

b. The program's UPs that provide counseling services shall have a master's degree in social work, counseling, psychology or a related human services field.

c. The responsibilities of the UPs, when providing CPST services include:

i. assisting the client with effectively responding to or avoiding identified precursors or triggers that would risk the client remaining in a natural community location;

ii. assisting in the development of daily living skills specific to managing a home; and

iii. assisting the client and family members to identify strategies or treatment options associated with the client's mental illness.

2. Licensed Mental Health Professionals

a. The LMHP shall have experience in CPST services.

b. The LMHP is responsible for providing clinical supervision of the CPST staff.

3. The provider shall ensure that the direct care staff's caseload size:

a. is based on the needs of the clients and their families with emphasis on successful outcomes and individual satisfaction; and

b. meets the needs identified in the individual treatment plan.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5691. Behavioral Health Service Providers with a Mental Health Program that Provide Services Only in the Home and Community

A. The BHS provider with only a home and community-based mental health program shall notify HSS of the parishes in the state of Louisiana in which it will provide services. The parishes shall be contiguous.

B. Business Office. The provider offering behavioral health services only in the home or community shall have a business location that:

1. is part of the licensed location of the BHS provider;

2. is located in a parish where the provider offers services;

3. has at least one employee on duty in the business office during hours of operation listed on the approved license application;

4. stores the administrative files, including governing body documents, contracts to which the provider is a party, insurance policies, budgets and audit reports, personnel files, client records, policies and procedures, and other files or documents the BHS provider is required to maintain; and

5. is not located in an occupied personal residence.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter M. Additional Requirements for Substance Abuse/Addiction Treatment Programs

NOTE: In addition to the requirements applicable to all BHS providers, a provider that provides substance abuse/addiction treatment services must meet the requirements of Subchapter M.

§5693. General Requirements

A. The BHS provider shall provide, either directly or through referral:

1. access to HIV counseling and testing services;

2. access to testing for pregnancy, tuberculosis and sexually transmitted diseases; and

3. appropriate follow-up referral and care.

B. Staffing

1. Medical Director

a. The provider shall ensure that its medical director is a licensed physician who:

i. is an addictionologist; or

ii. meets all of the following:

(a). is board-eligible or board-certified;

(b). has two years of qualifying experience in treating addictive disorders; and

(c). maintains a consulting relationship with an addictionologist.

b. A PA may perform duties as designated by the supervising physician in accordance with the Louisiana State Board of Medical Examiners.

c. The APRN shall be in collaborative practice with a physician in accordance with the Louisiana State Board of Nursing.

2. LMHPs. The LMHP providing addiction treatment services shall have documented credentials, experience and/or training in working with clients who have addictive disorders.

3. UPs. A UP providing addiction treatment services shall meet one of the following qualifications:

a. a master's-prepared behavioral health professional that has not obtained full licensure privileges and is participating in ongoing professional supervision. When working in addiction treatment settings, the master's prepared UP shall be supervised by a LMHP who meets the requirements of this Section;

b. be a registered addiction counselor;

c. be a certified addiction counselor; or

d. be a counselor in training (CIT) that is registered with ADRA and is currently participating in a supervisory relationship with a ADRA-registered certified clinical supervisor (CCS).

C. Policies and Procedures. The BHS provider shall have a policy and procedure that addresses drug screen tests and collections.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5695. Addiction Outpatient Treatment Program (ASAM Level I)

A. The BHS provider shall:

1. only admit clients clinically appropriate for ASAM level I into this program;

2. provide fewer than nine contact hours per week for adults and fewer than six hours per week for children/adolescents; and

3. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 90 days.

B. Staffing. The provider shall ensure that:

1. there are physician services available as needed for the management of psychiatric and medical needs of the clients;

a. physician services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement;

2. there is a clinical supervisor available on site for supervision as needed, and available on call at all times;

3. there is at least one LMHP or UP on-site when clinical services are being provided;

4. each LMHP/UP's caseload does not exceed 1:50 active clients; and

5. there are nursing services available as needed to meet the nursing needs of the clients.

a. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5697. Intensive Outpatient Treatment Programs (ASAM Level II.1)

A. The provider shall:

1. only admit clients clinically appropriate for ASAM level II.1 into this program;

2. maintain a minimum of 9 contact hours per week for adults, at a minimum of three days per week, with a maximum of 19 hours per week;

3. maintain a minimum of 6 hours per week for children/adolescents, at a minimum of three days per week, with a maximum of 19 hours per week; and

4. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 30 days.

B. Staffing. The provider shall ensure that:

1. a physician is on site as needed for the management of psychiatric and medical needs and on call 24 hours per day, seven days per week;

2. there is a clinical supervisor on-site 10 hours a week and on call 24 hours per day, seven days per week;

3. there is at least one LMHP or UP on site when clinical services are being provided;

4. each LMHP/UP caseload does not exceed 1:25 active clients; and

5. there are nursing services available as needed to meet the nursing needs of the clients.

a. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5699. Ambulatory Detoxification with Extended On-Site Monitoring (ASAM Level II-D) (Adults Only)

A. The BHS provider shall:

1. only admit clients clinically appropriate for ASAM level II-D into this program;

2. review and update the treatment plan in collaboration with the client as needed or at a minimum of every 30 days; and

3. ensure that level II-D services are offered in conjunction with intensive outpatient treatment services (ASAM level II.1);

B. Staffing. The provider shall ensure that:

1. a physician is on-site at least 10 hours per week during operational hours and on-call 24 hours per day, seven days per week;

2. there is a LMHP or UP on site 40 hours per week;

3. each LMHP/UP caseload does not exceed 1:25 active clients;

4. there is a licensed nurse on call 24 hours per day, seven days per week and on site no less than 40 hours a week; and

5. there is a RN on-site as needed to perform nursing assessments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Chapter 57. Behavioral Health Services

§5701. Clinically Managed Low-Intensity Residential Treatment Program (ASAM Level III.1)

A. The BHS provider shall:

1. only admit clients clinically appropriate for ASAM level III.1 into its Clinically Managed Low-Intensity Residential Treatment Program;

2. offer at least five hours per week of a combination of low-intensity clinical and recovery focused services, including:

a. individual therapy;

b. group and family therapy;

c. medication management; and

d. medication education;

3. ensure that the treatment plan is reviewed in collaboration with the client at least every 90 days;

4. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing

1. The provider shall have a clinical supervisor available for clinical supervision and by telephone for consultation.

2. There shall be at least one LMHP or UP on duty at least 40 hours a week.

3. Adult Staffing Patterns

a. The LMHP/UP caseload shall not exceed 1:25 active clients.

b. There shall be at least one direct care aide on duty during each shift.

4. Children/Adolescent Staffing Patterns

a. The UP caseload shall not exceed 1:8 active clients.

b. The provider shall have at least two direct care aides on duty during each shift.

c. There shall be a ratio of 1:8 direct care aides during all shifts and a ratio of 1:5 direct care aides on therapy outings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5703. Clinically Managed Residential Detoxification (Social Detoxification) (ASAM Level III.2D)

A. The provider shall:

1. only admit clients clinically appropriate for ASAM level III.2D into its Clinically Managed Residential Detoxification Program;

2. screen each client upon arrival for at least the following to ensure proper placement:

a. withdrawal potential;

b. biomedical conditions; and

c. cognitive/emotional complications;

3. have at least one staff member on each shift trained in cardiopulmonary resuscitation (CPR);

4. develop and implement an individualized stabilization/treatment plan in collaboration with the client that:

a. shall be reviewed and signed by the UP and the client; and

b. shall be filed in the client's record within 24 hours of admission;

5. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Emergency Admissions

1. If a client is admitted under emergency circumstances, the admission process may be delayed until the client can be interviewed, but no longer than 24 hours unless assessed and evaluated by a physician.

2. The provider shall orient the direct care staff to monitor, observe and recognize early symptoms of serious illness associated with detoxification and to access emergency services promptly.

C. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day, seven days per week and on duty as needed for management of psychiatric and medical needs of the clients;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. there is at least one LMHP or UP available on site at least 40 hours per week; and

4. for adults:

a. each LMHP/UP's caseload shall not exceed 1:25;

b. there is at least one direct care aide per shift with additional as needed;

5. for children/adolescents:

a. each LMHP/UP's caseload shall not exceed 1:16;

b. there are at least two direct care aides per shift with additional as needed; and

c. the ratio of aides to clients shall not exceed 1:10.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5705. Clinically Managed Medium-Intensity Residential Treatment (ASAM Level III.3) (Adult Only)

A. The provider shall:

1. only admit clients clinically appropriate for ASAM level III.3 into its Clinically Managed Medium-Intensity Residential Program;

2. offer at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services;

3. ensure that the treatment plan is reviewed in collaboration with the client as needed or at a minimum of every 90 days and documented accordingly; and

4. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day and on duty as needed for management of psychiatric and medical needs;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. there is 24 hour on-call availability by an RN plus a licensed nurse on duty whenever needed to meet the professional nursing requirements;

4. there is a LMHP or UP on site 40 hours a week to provide direct client care;

5. each LMHP/UP caseload shall not exceed 1:12; and

6. there is at least one direct care aide on duty for each shift plus additional aides as needed.

C. Mothers with Dependent Children Program (Dependent Care Program)

1. A provider's Mothers with Dependent Children Program shall:

a. meet the requirements of ASAM level III.3;

b. provide weekly parenting classes where attendance is required;

c. address the specialized needs of the parent;

d. provide education, counseling, and rehabilitation services for the parent that further addresses:

i. the effects of chemical dependency on a woman's health and pregnancy;

ii. parenting skills; and

iii. health and nutrition;

e. regularly assess parent-child interactions and address any identified needs in treatment; and

f. provide access to family planning services.

2. Child Supervision

a. The provider shall ensure that it provides child supervision appropriate to the age of each child when the mother is not available to supervise her child.

b. The provider shall ensure that its child supervision is provided by either:

i. the provider's on-site program with all staff members who:

(a). are at least 18 years old;

(b). have infant CPR certification; and

(c). have at least eight hours of training in the following areas prior to supervising children independently:

(i). chemical dependency and its impact on the family;

(ii). child development and age-appropriate activities;

(iii). child health and safety;

(iv). universal precautions;

(v). appropriate child supervision techniques; and

(vi). signs of child abuse; or

ii. a licensed day care provider pursuant to a written agreement with the provider.

c. The provider shall maintain a staff-to-child ratio that does not exceed 1:3 for infants (18 months and younger) and 1:6 for toddlers and children.

d. Child Specialist. The provider shall have a child specialist who:

i. is available to provide staff training, evaluate effectiveness of direct care staff, and plan activities, for at least one hour per week per child;

ii. has 90 clock hours of education and training in child development and/or early childhood education; and

iii. has one year of documented experience providing services to children.

e. Clients shall not supervise another parent's child or children without written consent from the legal guardian and staff approval.

f. Staff shall check all diapers frequently and change as needed, dispose of the diapers in a sealed container and sanitize the changing area.

3. Clinical Care for Children. The provider shall:

a. address the specialized and therapeutic needs and care for the dependent children and develop an individualized plan of care to address those needs, to include goals, objectives and target dates;

b. provide age-appropriate education, counseling, and rehabilitation services for children that address or include:

i. the emotional and social effects of living with a chemically dependent care-giver;

ii. early screening and intervention of high risk behavior and when indicated provide or make appropriate referrals for services;

iii. screening for developmental delays; and

iv. health and nutrition;

c. ensure that all children have access to medical care when needed;

d. ensure that children are administered medication according to the label by the parent or licensed staff qualified to administer medications; and

e. ensure that if licensed staff will be administering medications, the provider:

i. obtains written consent from the parent to administer the prescribed and over the counter medications, including identifying information relative to dosage, route, etc.;

ii. assumes full responsibility for the proper administration and documentation of the medications; and

iii. ensures original labeled medication containers with name, dosage, route, etc. are obtained prior to medication administration.

f. maintain current immunization records and allergy records for each child at the program site; and

g. obtain consent for emergency medical care for each child at admission.

4. Child Services

a. The daily activity schedule for the children shall include a variety of structured and unstructured age-appropriate activities.

b. School age children shall have access to school.

c. The health, safety, and welfare of the children shall be protected at all times.

d. Behavior management shall be fair, reasonable, consistent, and related to the child's behavior. Physical discipline is prohibited.

e. The children shall be well-groomed and dressed weather-appropriate.

f. An adequate diet for childhood growth and development, including two snacks per day, shall be provided to each child.

5. The program shall develop, implement and comply with written policies and procedures that:

a. address abuse and/or neglect of a child;

b. prohibit children under the age of 18 months from sleeping in bed with their mothers;

c. require a current schedule showing who is responsible for the children at all times;

d. address isolating parents and children who have communicable diseases and providing them with appropriate care and supervision; and

e. identify those persons authorized to remove a child from the facility other than legal guardian or parent.

6. Safety and Emergency Preparedness

a. The program shall develop and implement an emergency preparedness plan that includes provisions and services for the clients and children.

b. The program shall ensure that all toys and equipment are age appropriate, in good order and safe condition, and in accordance with manufacturer's recommendations.

c. Staff, volunteers, and parents shall use universal precautions at all times.

d. The provider shall ensure that only the legal guardian or a person authorized by the legal guardian may remove a child from the provider.

e. If an individual shows documentation of legal custody, staff shall record the person's identification before releasing the child.

7. Physical Environment

a. The program shall provide potty chairs for small children and sanitize them after each use.

b. The program shall provide age-appropriate bathing facilities. Infants shall not be bathed in sinks.

c. Each child shall be provided with his/her own bed.

d. Infants up to 18 months shall sleep in either a bassinet or cribs appropriate to the size of the child.

e. The provider shall provide a variety of age-appropriate equipment, toys, and learning materials for the children/adolescents.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5707. Clinically Managed High-Intensity Residential (ASAM Level III.5)

A. The provider shall:

1. admit only clients clinically appropriate for ASAM level III.5 into its Clinically Managed High Intensity Residential Treatment Program;

2. the treatment plan is reviewed in collaboration with the client as needed, or at a minimum of every 30 days and documented accordingly;

3. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. the provider shall have one licensed RN on call 24/7 to perform nursing duties for the provider; and

4. there shall be at least one LMHP or UP on duty at least 40 hours per week;

5. for adult staffing patterns:

a. each LMHP/UP's caseload shall not exceed 1:12;

b. there shall be at least one direct care aide on duty on all shifts with additional as needed; and

c. there shall be at least one licensed nurse on duty during the day and evening shifts to meet the nursing needs of the clients. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement;

6. for children/adolescent staffing patterns:

a. each LMHP/UP's caseload shall not exceed 1:8; and

b. there shall be at least two direct care aides on duty during all shifts with additional as needed. The ratio of aides to clients shall not exceed 1:8. On therapy outings, the ratio shall be at least 1:5;

c. there shall be a psychologist available when needed; and

d. there shall be a licensed nurse on duty to meet the nursing needs of the clients.

i. Nursing services may be provided directly by the BHS provider or may be provided or arranged via written contract, agreement, policy, or other document. The BHS provider shall maintain documentation of such arrangement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5709. Medically Monitored Intensive Residential (ASAM Level III.7) (Adults only)

A. The provider shall:

1. admit only clients clinically appropriate for ASAM level III.7 into its Medically Monitored Intensive Residential Treatment Program; and

2. the treatment plan is reviewed and updated in collaboration with the client as needed, or at a minimum of every 30 days and documented accordingly;

3. provide case management that is:

a. provided by a care coordinator who is on duty as needed; or

b. assumed by the clinical staff.

B. Staffing. The provider shall ensure that:

1. there is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs;

2. there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation;

3. there is at least one LMHP or UP on duty at least 40 hours/week;

4. there is at least one RN on call 24 hours per day, seven days per week to perform nursing duties and at least one licensed nurse is on duty during all shifts with additional licensed nursing staff to meet the nursing needs of the clients;

5. its on-site nursing staff is solely responsible for III.7 program and does not provide services for other levels of care at the same time;

6. each LMHP/UP caseload shall not exceed 1:10;

7. there is at least one direct care aide on duty on all shifts with additional as needed;

8. there is an activity or recreational therapist on duty at least 15 hours per week.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5711. Medically Managed Residential Detoxification (Medical Detoxification) (ASAM Level III.7D) (Adults Only)

A. The provider shall:

1. admit only clients clinically appropriate for ASAM level III.7D into its Medically Managed Residential Detoxification Program;

2. ensure that:

a. a physical examination is conducted by a physician, PA or APRN within 24 hours of admission; or

b. the provider's admitting physician reviews and approves a physical examination conducted by a physician, PA or APRN within 24 hours prior to admission;

3. ensure that each client's progress is assessed at least daily;

4. ensure that each client's physical condition, including vital signs, is assessed at least daily, or more frequently as indicated by physician's order or change in the client's status;

5. have a reliable, adequately sized emergency power system to provide power during an interruption of normal electrical service;

6. provide case management that is conducted:

a. by a care coordinator who is on duty as needed; or

b. by the clinical staff.

B. Emergency Admissions

1. If a client is admitted under emergency circumstances, the admission process may be delayed until the client can be interviewed, but no longer than 24 hours unless seen by a physician.

2. The provider shall orient the direct care staff to monitor, observe and recognize early symptoms of serious illness and to access emergency services promptly.

C. Staffing

1. The provider shall have a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients.

2. Nursing

a. The provider shall have at least one RN on call 24 hours per day, seven days per week to perform nursing duties.

b. There shall be at least one licensed nurse on duty during all shifts with additional as needed based upon the provider's census and the clients' acuity levels.

c. There shall be a RN on-site no less than 40 hours per week who is responsible for conducting nursing assessments upon admission and delegating staffing assignments to the nursing staff based on the assessments and the acuity levels of the clients.

d. The provider shall ensure that its on-site nursing staff is solely responsible for III.7D program and does not provide services for other levels of care at the same time.

e. The nursing staff is responsible for:

i. monitoring client's progress; and

ii. administering medications in accordance with physician orders.

3. Clinical Supervisor and Unlicensed Professionals

a. The provider shall have a clinical supervisor available for clinical supervision when needed and by telephone for consultation.

b. The LMHP/UP caseload shall not exceed 1:10.

4. There shall be at least one direct care aide on all shifts with additional as needed based upon the provider's census and the clients' acuity levels.

5. The provider shall have at least one employee on duty certified in CPR.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter N. Additional Requirement for Substance Abuse/Addictive Residential Treatment Programs

NOTE: In addition to the requirements applicable to all BHS providers, residential programs that treat substance abuse/addiction must meet the applicable requirements below.

§5713. Client Funds and Assets

A. If a BHS provider manages clients' personal funds accounts, the BHS provider shall develop and implement written policies and procedures governing the maintenance and protection of the client fund accounts that include, but are not limited to:

1. the maximum amount each client may entrust with the provider;

2. the criteria by which clients can access money;

3. the disbursement procedure, including the maximum amount that may be disbursed to the client;

4. staff members who may access such funds; and

5. the method for protecting and maintaining the funds.

B. The BHS provider that manages a client's personal funds shall:

1. furnish a copy of the provider's policy and procedures governing the maintenance and protection of client funds to the client or the client's parents or legal guardian, if applicable;

2. obtain written authorization from the client or the client's parent or legal guardian, if applicable, for the safekeeping and management of the funds;

3. provide each client with an account statement upon request with a receipt listing the amount of money the provider is holding in trust for the client;

4. maintain a current balance sheet containing all financial transactions to include the signatures of staff and the client for each transaction;

5. provide a list or account statement regarding personal funds upon request of the client; and

6. be prohibited from commingling the clients' funds with the provider's operating account.

C. If the BHS provider manages funds for a client, the provider shall ensure that:

1. any remaining funds shall be refunded to the client or his/her legal guardian within five business days of notification of discharge; and

2. in the event of the death of a client, any remaining funds are refunded to the client's legal representative within five business days of the client's death.

D. The BHS provider shall develop, implement and comply with a policies and procedures that address:

1. the maintenance and safeguard of client possessions, including money, brought to the provider by its clients;

2. maintaining an inventory of each client's possessions from the date of admission;

3. returning all possessions to the client upon the client's discharge; and

4. requiring the client and one staff member to sign documentation indicating that the client's possessions have been placed with the provider and the return of possessions to the client.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5715. Dietary Services

A. The residential BHS provider shall ensure that:

1. all dietary services are provided under the direction of a Louisiana licensed dietician;

2. menus are approved by a licensed dietician;

3. meals are of sufficient quantity and quality to meet the nutritional needs of clients, including religious and dietary restrictions;

4. meals are in accordance with FDA dietary guidelines and the orders of the authorized licensed prescriber;

5. at least three meals plus an evening snack are provided daily with no more than 14 hours between any two meals;

6. all food is stored, prepared, distributed, and served under safe and sanitary conditions in accordance with the Louisiana state *Sanitary Code*;

7. all equipment and utensils used in the preparation and serving of food are properly cleaned, sanitized and stored in accordance with the Louisiana state *Sanitary Code*; and

8. if meals are prepared on-site, they are prepared in an OPH approved kitchen.

B. The BHS provider may provide meal service and preparation pursuant to a written agreement with an outside food management company. If provided pursuant to a written agreement, the provider shall:

1. maintain responsibility for ensuring compliance with this Chapter;

2. ensure that the outside food management company possesses a valid OPH retail food permit; and

3. ensure that, if the provider does not employ or directly contract with a licensed dietician, the food management company employs or contracts with a licensed dietician who serves the provider as needed to ensure that the nutritional needs of the clients are met in accordance with the authorized licensed prescriber's orders and acceptable standards of practice.

C. The licensed dietician shall:

1. approve therapeutic menus; and

2. be available for consultation when necessary.

D. If the BHS provider has a program that allows menu planning and preparation by clients, the provider shall develop and implement a policy with guidelines for the participating clients that:

1. ensures that meal preparation/service, with client participation, meets all requirements listed above; and

2. defines client's participation in writing and has written instructions posted or easily accessible to clients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5717. Transportation

A. A residential BHS provider shall assist in arranging for or provide transportation necessary for implementing the client's treatment plan, including but not limited to, court-ordered hearings and medically necessary appointments with a health care provider.

B. The BHS provider may provide transportation pursuant to a written agreement with an outside transportation service. If provided pursuant to a written agreement, the provider shall maintain responsibility for ensuring compliance with this Chapter.

C. Any vehicle used to transport a BHS provider's client shall be:

1. properly licensed and inspected in accordance with state law;

2. maintained in a safe condition;

3. operated at a climate controlled temperature that does not compromise the health, safety or needs of the client; and

4. operated in conformity with all of the applicable motor vehicle laws, including but not limited to, utilization of seat belts and vehicular child restraint systems.

D. The provider shall ensure that it or its contracted transportation service:

1. has documentation of current liability insurance coverage for all owned and non-owned vehicles used to transport clients. The personal liability insurance of a provider's employee shall not be substituted for the required coverage;

2. utilizes only drivers who are properly licensed and insured to operate that class of vehicle in accordance with state laws, rules and regulations;

3. obtains a driving history record from the state Office of Motor Vehicles for each employee upon hire and annually thereafter;

4. prohibits the number of persons in any vehicle used to transport clients to exceed the number of available seats with seatbelts in the vehicle; and

5. determines the nature of any need or problem of a client which might cause difficulties during transportation. This information shall be communicated to agency staff responsible for transporting clients.

E. The provider shall comply with the following when transporting disabled non-ambulatory clients in a wheelchair:

1. a ramp to permit entry and exit of a client from the vehicle;

2. wheelchairs used in transit shall be securely fastened inside the vehicle utilizing approved wheelchair fasteners; and

3. the client is securely fastened in the wheelchair.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5719. Staffing

A. The provider shall ensure that there are at least two staff persons on site at all times when a client is present.

B. House Manager

1. A residential provider shall have a house manager.

2. The house manager shall:

a. be at least 21 years old;

b. have at least two years qualifying experience working for a provider that treats clients with mental illness and/or addiction disorders;

c. supervise the activities of the facility when the professional staff is not on duty;

d. perform clinical duties only if licensed to do so;

e. report incidents of abuse, neglect and misappropriation to the medical director;

f. identify and respond to and report any crisis situation to the clinical supervisor when it occurs; and

g. coordinate and consult with the clinical staff as needed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 41:

§5721. Policies and Procedures

A. House Rules and Regulations. A residential provider shall:

1. have a clearly written list of house rules and regulations governing client conduct and behavior management;

2. provide a copy of the house rules and regulations to all clients and, where appropriate, the client's parent(s) or legal guardian(s) upon admission;

3. post the rules and regulations in an easily accessible location in the provider and make them available when requested; and

4. have a policy and procedure that pertains to the bedroom assignment of its clients, with consideration given to age, client's diagnosis and severity of client's medical condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

Subchapter O. Additional Requirements for Opioid Treatment Programs

NOTE: In addition to the requirements applicable to all BHS providers, opioid treatment programs must also meet the requirements of Subchapter O.

§5723. General Provisions

A. A provider with an opioid treatment program shall:

1. meet the requirements of the protocols established by OBH/state opioid authority;

2. update the Louisiana methadone central registry daily and as needed;

3. upon the death of a client:

a. report the death of a client enrolled in their clinic to the SOA within 24 hours of the discovery of the client's death;

b. report the death of a client to HSS within 24 hours of discovery if the death is related to program activity;

c. submit documentation on the cause and/or circumstances to SOA and to HSS, if applicable, within 24 hours of the provider's receipt of the documentation; and

d. adhere to all protocols established by DHH on the death of a patient; and

4. conduct at least eight random monthly drug screen tests on each client per year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5725. Treatment

A. Client Admission Criteria. The program shall only admit clients that:

1. are at least 18 years old, unless the client has consent from a parent, or legal guardian, if applicable;

2. meet the federal requirements regarding the determination that the client is currently addicted to opiates and has been addicted to opiates for at least one year prior to admission or the exceptions;

3. are verified by a physician that treatment is medically necessary;

4. have had a complete physical evaluation by the client's or program's physician before admission to the opioid treatment program;

5. have had a full medical exam, including results of serology and other tests, completed within 14 days of admission; and

6. have a documented history of opiate addiction.

B. Treatment Phases

1. Initial Treatment. During the initial treatment phase that lasts from three to seven days in duration, the provider shall:

a. conduct client orientation;

b. provide individual counseling; and

c. develop the initial treatment plan including initial dose of medication and plan for treatment of critical health or social issues.

2. Early Stabilization. In the early stabilization period that begins on the third to seventh day following initial treatment through 90 days duration, the provider shall:

a. conduct weekly monitoring by a nurse of the client's response to medication;

b. provide at least four individual counseling sessions;

c. revise the treatment plan within 30 days to include input by all disciplines, the client and significant others; and

d. conduct random monthly drug screen tests.

3. Maintenance Treatment. In the maintenance treatment phase that follows the end of early stabilization and lasts for an indefinite period of time, the provider shall provide:

a. random monthly drug screen tests until the client has negative drug screen tests for 90 consecutive days. Thereafter, the provider shall conduct at least eight random drug screen tests per year as well as random testing for alcohol when indicated;

b. monthly testing to clients who are allowed six days of take-home doses;

c. continuous evaluation by the nurse of the client's use of medication and treatment from the program and from other sources;

d. documented reviews of the treatment plan every 90 days in the first 2 years of treatment by the treatment team; and

e. documentation of response to treatment in a progress note at least every 30 days.

4. Medically Supervised Withdrawal from Synthetic Narcotic with Continuing Care. Medically supervised withdrawal is provided if and when appropriate. If provided, the provider shall:

a. decrease the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, as medically tolerated by the client;

b. provide counseling of the type and quantity determined by the indicators and the reason for the medically supervised withdrawal from the synthetic narcotic; and

c. conduct discharge planning with continuity of care to assist client to function without support of the medication and treatment activities.

5. Required Withdrawal. The provider shall provide medically-approved and medically-supervised assistance to withdrawal from the synthetic narcotic when:

a. the client requests withdrawal;

b. quality indicators predict successful withdrawal; or

c. client or payer source suspends payment of fees.

C. Counseling. The provider shall ensure that:

1. counseling is provided when requested by the client or client's family;

2. written criteria are used to determine when a client will receive additional counseling;

3. the type and quantity of counseling is based on the assessment and recommendations of the treatment team;

4. written documentation supports the decisions of the treatment team, including indicators such as positive drug screens, maladjustment to new situations, inappropriate behavior, criminal activity, and detoxification procedure; and

5. all counseling is provided individually or in homogenous groups, not to exceed 12 clients.

D. Physical Evaluations/Examinations. The provider shall ensure that each client has a documented physical evaluation and examination by a physician or advanced practice registered nurse as follows:

1. upon admission;

2. every other week until the client becomes physically stable;

3. as warranted by client's response to medication during the initial stabilization period or any other subsequent stabilization period;

4. after the first year and annually thereafter; and

5. any time that the client is medically unstable.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5727. Additional Staffing Requirements

A. The provider's opioid treatment program shall have the following staff in addition to the general staffing requirements.

1. Pharmacist or Dispensing Physician

a. An opioid treatment program that dispenses prescription medication on-site shall employ or contract with a pharmacist or dispensing physician to assure that any prescription medication dispensed on-site meets the requirements of applicable state statutes and regulations.

b. The pharmacist or dispensing physician shall have a current, valid unrestricted license to practice in the state of Louisiana.

c. The provider's pharmacist or dispensing physician shall:

i. provide on-site services;

ii. dispense all medications;

iii. consult with the provider as needed;

iv. evaluate medication policy and procedure of provider to dispense medications;

v. reconcile inventories of medications that were dispensed and/or administered at least every 30 days;

vi. maintain medication records for at least three years in accordance with state laws, rules and regulations; and

vii. approve all transport devices for take-home medications in accordance with the program's diversion control policy.

2. Nursing

a. The provider shall maintain a nursing staff sufficient to meet the needs of the clients.

b. Each nurse shall have a current unrestricted license to practice nursing in the state of Louisiana.

c. The responsibilities of the nurse(s) include but are not limited to:

i. administering medications; and

ii. monitoring the client's response to medications.

3. Licensed Mental Health Professionals

a. The provider shall maintain a sufficient number of LMHPs to meet the needs of its clients and there is at least one LMHP or UP on site when clinical services are being provided.

b. The provider shall ensure that:

i. the caseload of the LMHP shall not exceed 75 active clients; and

ii. there is an LMHP on site at least five hours/week.

4. Unlicensed Professionals

a. The provider shall have UPs sufficient to meet the needs of the clients.

b. The caseload of the UP shall not exceed 75 active clients.

5. Physician or APRN. There shall be a physician or APRN who is on-site as needed or on-call as needed during hours of operation.

B. Training. All direct care employees shall receive orientation and training for and demonstrate knowledge of the following, including, but not limited to:

1. symptoms of opiate withdrawal;

2. drug screen testing and collections;

3. current standards of practice regarding opiate addiction treatment;

4. poly-drug addiction; and

5. information necessary to ensure care is provided within accepted standards of practice.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5729. Medications

A. The provider shall ensure that all medications are administered by a nurse, pharmacist or other practitioner licensed under state law and authorized by federal and state law to administer or dispense opioid drugs.

B. Take-Home Dose(s)

1. The provider shall ensure that:

a. determinations for take-home dose(s) and the factors considered are made by the client's treatment team and are documented in the client's record when each take-home dose is authorized;

b. date and recommended dosage are documented in the client's record; and

c. take-home dose(s) are ordered by the medical director.

2. The provider shall ensure that the following factors are considered by the medical director and treatment team before a take-home dose is authorized by the treatment team:

a. a negative drug/alcohol screen for at least 30 days;

b. documented regularity of clinic attendance relative to treatment plan;

c. absence of serious behavioral problems;

d. absence of known criminal activity;

e. absence of known drug related criminal activity during treatment;

f. stability of home environment and social relationships;

g. assurance that take-home medication can be safely stored; and

h. whether the benefit to the client outweighs the risk of diversion.

3. Standard Schedule. The provider shall abide by the following schedule of take-home, therapeutic doses when a take-home dose is authorized:

a. after the first 30 days of treatment, and during the remainder of the first 90 days of treatment, one take-home, therapeutic dose per week;

b. in the second 90 days of treatment, two doses, consisting of take-home, therapeutic doses, may be allowed per week;

c. in the third 90 days of treatment, three doses consisting of take-home, therapeutic doses may be allowed per week;

d. in the final 90 days of treatment during the first year, four doses consisting of take-home, therapeutic doses may be allowed per week;

e. after one year in treatment, a six-day dose supply consisting of take-home, therapeutic doses may be allowed once a week;

f. after two years in treatment, a 13-day dose supply consisting of take-home, therapeutic doses may be allowed once every two weeks.

4. Loss of Privilege. Positive drug screens at any time for any drug other than those prescribed shall require a new determination to be made by the treatment team regarding take-home doses.

5. Exceptions to the Standard Schedule. The provider must request and obtain approval for an exception to the

standard schedule from the state opioid authority. Any exception must be for an emergency or severe travel hardship.

B. Temporary Transfers or Guest Dosing. The providers involved in a temporary transfer or guest dosing shall ensure the following:

1. the receiving provider shall verify dosage prior to dispensing and administering medication;

2. the sending provider shall verify dosage and obtain approval and acceptance from receiving provider prior to client's transfer; and

3. that documentation to support all temporary transfers and guest dosing is maintained.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:

§5731. Client Records

A. In addition to the general requirements for client records, each client record shall contain:

1. recording of medication administration and dispensing in accordance with federal and state requirements;

2. results of five most recent drug screen tests with action taken for positive results;

3. physical status and use of additional prescription medication;

4. monthly or more frequently, as indicated by needs of client, contact notes and progress notes which include employment/vocational needs, legal and social status, and overall individual stability;

5. documentation and confirmation of the factors to be considered in determining whether a take-home dose is appropriate;

6. documentation of approval of any exception to the standard schedule of take-home doses and the physician's justification for such exception; and

7. any other pertinent information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2151-2161.

HISTORICAL NOTE: Promulgated 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 or autonomy as described in R.S. 49:972 by assuring the safe operation of facilities that behavioral health providers 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 or 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 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 Comment

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, March 31, 2015 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 Service 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 $24,624 (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 increase revenue collections to the department by approximately $36,000 FY 14-15, $36,000 for FY 15-16, and $36,000 for FY 16-17 as a result of the collection of annual licensing fees from behavioral health service providers.

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

This proposed rule adopts provisions in order to establish licensing standards governing behavioral health service (BHS)

providers to comply with the directives of Act 308 of the 2013 Regular Session of the Louisiana Legislature (anticipate approximately 60 BHS providers). It is anticipated that implementation of this proposed rule will have economic costs to behavioral health service providers of approximately $600 annually, and will benefit all behavioral health service providers by providing up-to-date licensing requirements for operation in the state of Louisiana.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

Cecile Castello Director 1502#067	Evan Brasseaux Staff Director Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Hospital Licensing Standards
Therapeutic Recreational Therapists
(LAC 48:I.9501)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 48:I.9501 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2100-2115. 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 that established new regulations governing the licensing of hospitals *(Louisiana Register,* Volume 29, Number 11). The department subsequently promulgated a Rule which amended the provisions of the November 20, 2003 Rule governing hospital licensing standards to establish provisions for crisis receiving centers (*Louisiana Register,* Volume 36, Number 3).

The Department of Health and Hospitals, Bureau of Health Services Financing now proposes to amend the provisions governing hospital licensing standards to revise the qualification requirements for therapeutic recreational therapists and to establish the qualifications of an individual who shall clinically supervise therapeutic recreational services.

Title 48
PUBLIC HEALTH—GENERAL
Part I. General Administration
Subpart 3. Licensing and Certification
Chapter 93. Hospitals
Subchapter R. Psychiatric Services (Optional)
§9501. Staffing

A. - F. ...

G. Therapeutic activities such as art leisure counseling, recreational therapy, etc., shall be clinically supervised and provided by certified therapeutic recreational therapists or degreed individuals, adequate in number to respond to the therapeutic activity needs of the patient population being served.

1. An individual who clinically supervises therapeutic recreation activities shall meet the following qualifications:

a. have a degree in therapeutic recreation therapy from an accredited post-secondary institution and be certified in accordance with the National Council for Therapeutic Recreation Certification requirements; or

b. have a degree in another field of study and has also attained certification in accordance with the National Council for Therapeutic Recreation Certification requirements.

2. An individual who provides therapeutic recreational services shall have the following qualifications:

a. a degree in therapeutic recreation from an accredited post-secondary institution; or

b. a degree in another field of study and has also attained certification in accordance with the National Council for Therapeutic Recreation Certification requirements; or

c. a minimum of 10 years' experience providing therapeutic recreational services; or

d. be currently employed as a therapeutic recreational specialist 2 per Louisiana Civil Service requirements.

3. Individuals currently providing therapeutic recreational services who do not meet the qualifications of §9501.G.1-2.d, shall have two years from the effective date of this Rule to qualify as therapeutic recreational therapists.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2100-2115.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 29:2427 (November 2003), amended 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 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 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 meet the requirements for therapeutic recreation therapist and may increase 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, March 31, 2015 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: Hospital Licensing Standards Therapeutic Recreational Therapists

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 $540 (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 proposed Rule amends the provisions governing hospital licensing standards to revise the qualification requirements for therapeutic recreational therapists and to establish the qualifications of an individual who shall clinically supervise therapeutic recreational services. It is anticipated that implementation of this proposed rule will not have economic costs to hospitals 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 Castillo	Evan Brasseaux
Section Director	Staff Director
1502#068	Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Medicaid Eligibility
Children Supplemental Security Income (SSI)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to repeal the October 20, 1998 Rule governing the Medicaid eligibility of children receiving Supplemental Security Income (SSI) in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to title XIX of the Social Security Act. This proposed Rule is 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 to adopt the provisions of section 4913 of the Balanced Budget Act of 1997 to establish a new mandatory eligibility group for eligible children whom on August 22, 1996 were receiving supplemental security income (SSI) but who effective July 1, 1997, or later, lost SSI payment because of a disability determination under the rules enacted by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193). Medicaid benefits for children whose eligibility was reinstated under this provision applied to medical assistance furnished on or after July 1, 1997. (*Louisiana Register*, Volume 24, Number 10).

The Department of Health and Hospitals, Bureau of Health Services Financing now proposes to repeal the October 20, 1998 Rule governing the provisions for Medicaid eligibility of children receiving supplemental security income (SSI) since children born August 22, 1996 or prior would have reached age 18 by August 22, 2014 and are no longer eligible under this provision. Due to the provisions governing coverage of the section 4913 children, there cannot be any new children to qualify for this coverage group as these children have aged out.

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, March 31, 2015 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: Medicaid Eligibility
Children Supplemental Security Income (SSI)

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

It is anticipated that the implementation of this proposed rule will have no programmatic fiscal impact to the state other than the cost of promulgation for FY 14-15. It is anticipated that $324 ($162 SGF and $162 FED) will be expended in FY 14-15 for the state's administrative expense for the promulgation of this proposed rule and the final rule.

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

It is anticipated that the implementation of this proposed rule will not affect federal revenue collections other than the federal share of the promulgation costs for FY 14-15. It is anticipated that $162 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 repeals the October 20, 1998 rule governing the Medicaid eligibility of children receiving Supplemental Security Income provisions since children born August 22, 1996 or prior would have reached age 18 by August 22, 2014 and are no longer eligible under this provision. It is anticipated that the implementation of this proposed rule will not have economic cost or benefits 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	Evan Brasseaux
Medicaid Director	Staff Director
1502#069	Legislative Fiscal Office

NOTICE OF INTENT

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 proposes to amend LAC 50:III.10705 and adopt §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 proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

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 proposed Rule is being promulgated in order to continue the provisions of the April 20, 2014 Emergency Rule.

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 caretaker 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 Relatives 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 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 the 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. Former Foster Care Children. Former 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. Former 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. Former foster care children must:

a. be at least age 18, but under age 26;

b. currently live 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 41:

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 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 41:

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 subsides;

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 41:

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 by the Department of Health and Hospitals, Bureau of Health Services Finance, LR 36:2867 (December 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 may have a positive impact on family functioning, stability or autonomy as described in R.S. 49:972 by reducing the financial burden for health care costs for certain families who will now meet the new income standards.

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 may have a positive impact on child, individual, or family poverty in relation to individual or community asset development as described in R.S. 49:973 by reducing the financial burden for health care costs for certain families who will now meet the new income standards.

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, March 31, 2015 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: Medicaid Eligibility
Modified Adjusted Gross Income

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

It is anticipated that implementation of this proposed rule may result in an increase in programmatic expenditures in the Medicaid Program by an indeterminable amount for FY 14-15, FY 15-16, and FY 16-17. It is anticipated that $2,808($1,404 SGF and $1,404 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 have an indeterminable increase in federal revenue collections for FY 14-15, FY 15-16, and FY 16-17. It is anticipated that $1,404 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 December 31, 2013 and April 20, 2014 Emergency Rules which amended the provisions governing Medicaid eligibility to adopt the Modified Adjusted Gross Income (MAGI) eligibility methodology and provisions which allowed qualified hospitals to make determinations of presumptive eligibility for individuals who are not currently enrolled in Medicaid. It is anticipated that implementation of this proposed rule may increase Medicaid costs by an indeterminable amount for FY 14-15, FY 15-16, and FY 16-17 as the potential change in enrollment is unknown but is expected to be nominal.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule has no known effect on competition and employment.

J. Ruth Kennedy	Evan Brasseaux
Medicaid Director	Staff Director
1502#070	Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Bureau of Health Services Financing

Nursing Facilities
Per Diem Rate Reduction
(LAC 50:II.20005)

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to amend LAC 50:II.20005 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.

For state fiscal year 2014-15, state general funds are required to continue nursing facility rates at the rebased level. Because of the fiscal constraints on the state's budget, the state general funds will not be available to sustain the increased rate. Consequently, the Department of Health and Hospitals, Bureau of Health Services Financing promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities in order to reduce the per diem rates paid to non-state nursing facilities (*Louisiana Register*, Volume 40, Number 5). This proposed Rule is being promulgated to continue the provisions of the July 1, 2014 Emergency Rule.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement
Chapter 200. Reimbursement Methodology
§20005. Rate Determination
[Formerly LAC 50:VII.1305]

A. - P. …

Q. Effective for dates of service on or after July 1, 2014, the per diem rate paid to non-state nursing facilities, shall be reduced by $90.26 of the rate in effect on June 30, 2014 until such time that the rate is rebased.

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 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:092 (March 2011), LR 37:1174 (April 2011), LR 37:2631 (September 2011), LR 38:1241 (May 2012), LR 39:1286 (May 2013), LR 39:3097 (November 2013), 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 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, but may increase the total direct and indirect cost of the provider to provide the same level of service due to the decrease in payments. The proposed Rule may also have a negative impact on the provider's ability to provide the same level of service as described in HCR 170 if the reduction in payments adversely impacts the provider's financial standing.

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, March 31, 2015 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: Nursing Facilities Per Diem Rate Reduction

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

It is anticipated that the implementation of this proposed rule will result in estimated programmatic savings to the state of $215,905,347 for FY 14-15, $221,737,972 for FY 15-16 and $228,390,111 for FY 16-17. It is anticipated that $432 ($216 SGF and $216 FED) will be expended in FY 14-15 for the state's administrative expense for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.06 percent in FY 14-15 and 62.17 percent in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 15 is the federal rate for disaster-recovery FMAP adjustment states.

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

It is anticipated that the implementation of this proposed rule will reduce federal revenue collections by approximately

$353,165,288 for FY 14-15, $364,405,227 for FY 15-16 and $375,337,384 for FY 16-17. It is anticipated that $216 will be expended in FY 14-15 for the federal administrative expenses for promulgation of this proposed rule and the final rule. The numbers reflected above are based on a blended Federal Medical Assistance Percentage (FMAP) rate of 62.06 percent in FY 14-15 and 62.17 in FY 15-16. The enhanced rate of 62.11 percent for the first three months of FY 15 is the federal rate for disaster-recovery FMAP adjustment states.

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 nursing facilities to further reduce the reimbursement rates for non-state nursing facilities. It is anticipated that implementation of this proposed rule will reduce program expenditures in the Medicaid Program for nursing facility services by approximately $569,071,067 for FY 14-15, $586,143,199 for FY 15-16 and $603,727,495 for 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. However, we anticipate that the implementation may have a negative effect on employment as it will reduce the payments made to nursing facilities. The reduction in payments may adversely impact the financial standing of nursing facilities and could possibly cause a reduction in employment opportunities.

J. Ruth Kennedy
Medicaid Director
1502#071

Evan Brasseaux
Staff Director
Legislative Fiscal Office

NOTICE OF INTENT

Department of Health and Hospitals
Emergency Response Network

LERN Destination Protocol: TRAUMA
(LAC 48:I.19119)

Notice is hereby given that the Louisiana Emergency Response Network Board has exercised the provisions of R.S. 49:950 et seq., the Administrative Procedure Act, and intends to codify into LAC 48:I.Chapter 191, a protocol heretofore adopted and promulgated by the Louisiana Emergency Response Network Board for the transport of trauma and time sensitive ill patients, adopted as authorized by R.S. 9:2798.5.

Title 48
PUBLIC HEALTH—GENERAL
Part I. General Administration
Subpart 15. Emergency Response Network Board
Chapter 191. Trauma Protocols
§19119. Destination Protocol: TRAUMA

A. On November 20, 2014, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "Destination Protocol: Trauma" to be effective January 1, 2015, and replacing the "LERN Destination Protocol: Trauma" adopted and promulgated November 21, 2013, as follows.

1. Call LERN communication center at (866) 320-8293 for patients meeting the following criteria.

• Unmanageable airway • Tension pneumothorax • Traumatic cardiac arrest • Burn patient without patent airway • Burn patient > 40 percent BSA without IV	Yes→	Closest ED/ Trauma Center
↓ No		
Measure vital signs and level of consciousness		
• GCS ≤13 • SBP <90mmHg • RR <10 or >29 breaths per minute, or need for ventilator Support (<20 in infant aged <1 year)	Yes→	Transport to Trauma Center/ Trauma Program These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program. ** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.*
↓ No		
Assess anatomy of injury		
• All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee • Chest wall instability or deformity (e.g. flail chest) • Two or more proximal long-bone fractures • Crushed, degloved, mangled, or pulseless extremity • Amputation proximal to wrist or ankle • Pelvic fractures • Open or depressed skull fracture • Paralysis • Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture)	Yes→	Transport to Trauma Center/ Trauma Program These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program. ** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.*
↓ No		
Assess mechanism of injury and evidence of high-energy impact		
• Falls - Adults: >20 feet (one story is equal to 10 feet) - Children: >10 feet or two or three times the height of the child • High-risk auto crash - Intrusion, including roof: > 12 inches occupant site; > 18 inches any site - Ejection (partial or complete) from automobile - Death in the same passenger compartment - Vehicle telemetry data consistent with a high risk of injury • Auto vs. pedestrian/bicyclist/ ATV thrown, run over, or with significant (>20 mph) impact	Yes→	Transport to Trauma Center/Trauma Program which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/Trauma Program in the region, LCC may route to the most appropriate resourced hospital.

• Motorcycle crash >20mph		
↓ No		
Assess special patient or system considerations		
• Older Adults - Risk of injury/death increases after age 55 years - SBP <110 may represent shock after age 65 - Low impact mechanisms (e.g. ground level falls) may result in severe injury • Children - Should be triaged preferentially to pediatric capable trauma centers • Anticoagulants and bleeding disorders - Patients with head injury are at high risk for rapid deterioration • Burns - With trauma mechanism: triage to trauma center • Pregnancy >20 weeks • Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls • Major joint dislocations (hip, knee, ankle, elbow) • Open Fractures • EMS provider judgment	Yes→	Transport to Trauma Center/Trauma Program which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/Trauma Program in the region, LCC may route to the most appropriate resourced hospital.
↓ No		
Multi/Mass Casualty Incident	No→	Transport according to protocol

2. When in doubt, transport to a trauma center.

B. This protocol was published at LR 40:2710 (December 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:

Family Impact Statement

1. What effect will this Rule have on the stability of the family? The proposed Rule will not affect the stability of the family.

2. What effect will this have on the authority and rights of persons regarding the education and supervision of their children? The proposed Rule will not affect 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 not affect the functioning of the family.

4. What effect will this have on family earnings and family budget? This Rule will not affect the family earnings or family budget.

5. What effect will this have on the behavior and personal responsibility of children? This Rule will not affect the behavior or personal responsibility of children.

6. Is the family or local government able to perform the function as contained in this proposed Rule? No, the proposed Rule will have no impact.

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S. 49:973.

Small Business Statement

The impact of the proposed amendment to Section 19119 of the Rule on small business has been considered and it is estimated that the proposed action is not expected to have a significant adverse impact on small business 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 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 no increase on direct or indirect cost. The proposed Rule 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 my submit written comments relative to the proposed Rule until 4:30 p.m., Tuesday, March 10, 2015 to Paige Hargrove, Louisiana Emergency Response Network, 14141 Airline Hwy., Suite B, Building 1, Baton Rouge, LA 70817, or via email to paige.hargrove@la.gov.

Paige Hargrove
Executive Director

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: LERN Destination Protocol: TRAUMA

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

This proposed rule adopts *Louisiana Administrative Code* (LAC) Title 48—Public Health General, Part I—General Administration, Subpart 15 - Louisiana Emergency Response Network Board, Chapter 191 - Trauma Protocols, Section 19119 – Destination Protocol: TRAUMA. The Louisiana Emergency Response Network (LERN) Board is authorized to adopt protocols for the transport of trauma and time sensitive ill patients.

Since 2009, the LERN Board has previously adopted protocols for trauma patients that were published in the Potpourri Section (announcements and various information that will never become part of the LAC) of the *State Register*. On November 20, 2014, the LERN Board revised and adopted "Destination Protocol: TRAUMA", to be effective January 1, 2015, that replaced the previous trauma destination protocol adopted and promulgated November 21, 2013. The revised destination protocol aligns closely with the federal CDC Guidelines for Field Triage of Injured Patients as well as recognizes Regional Trauma Programs as part of the destination for trauma patients. The revised trauma destination protocol was published in the Potpourri Section on December

20, 2014. This proposed rule codifies the revised trauma destination protocol in Section 19119; which is the latest trauma protocol adopted by the Louisiana Emergency Response Network Board.

Other than the cost to publish in the *Louisiana Register*, which is estimated to be $426 in FY 15, it is not anticipated that the proposed rule will result in any material costs or savings to LERN or any state or local governmental unit.

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

There is no anticipated effect on revenue collections of state or local governmental units as a result of this 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. The proposed rule is simply a codification of protocols as authorized by La. R.S. 9:2798.5A.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

This rule establishes a destination protocol for patients with specific injuries. The trauma system is a voluntary system. This rule does not prevent or restrict any hospital from pursuing a trauma center designation or restrict any hospital from developing a trauma program. There is no effect on employment.

Paige B. Hargrove Executive Director 1502#013	Evan Brasseaux Staff Director Legislative Fiscal Office

NOTICE OF INTENT

Department of Public Safety and Corrections
Office of State Fire Marshal

Fire Protection (LAC 55:V.3239)

The Department of Public Safety and Corrections, Public Safety Services, Office of State Fire Marshal, hereby gives notice that in accordance with the provisions of R.S. 49:953(B), the Administrative Procedure Act, the Office of the State Fire Marshal hereby proposes to repeal the following Rule regarding licensees of the State Fire Marshal engaging in door-to-door solicitation to "*...comply with all local permitting ordinances and requirements…"* This provision is being repealed as being facially defective and therefore unconstitutional based upon Attorney General Opinion No. 08-0098 0098 (2009), citing *Central Hudson Gas and ElectricCorp v. Public Service Commission*, 447 U.S. 557 (1980) and *Board of Trustees of the State University of New York v. Fox*, 492 U.S. 469 (1989) as authority. The repealed Rule requires licensees of the SFM engaging in door-to-door solicitation to "*...comply with all local permitting ordinances and requirements* ..." The above cited cases have held that door-to-door solicitation is speech within the meaning of the First Amendment of the U.S. Constitution, and local ordinances banning all door-to-door solicitation are constitutionally defective. Therefore, the repealed Section requiring that licensee's comply with all local ordinances is overly broad and therefore defective.

Title 55
PUBLIC SAFETY
Part V. Fire Protection
Chapter 32. Property Protection Licensing
§3239. Door-to-Door Solicitation

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1664.2 et seq.

HISTORICAL NOTE: Promulgated by the Department of Public Safety and Corrections, Office of State Fire Marshal, LR 37:2746 (September 2011), repealed LR 41:

Family Impact Statement

The proposed Rule will 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 the children;
6. local governmental entities have the ability to perform the enforcement of the action proposed in accordance with R.S. 40:1730.23.

Poverty Impact Statement

The proposed Rule amends LAC 55:V:3239. These Rule changes 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. the effect on household income, assets, and financial security;
2. the effect on early childhood development and preschool through postsecondary education development;
3. the effect on employment and workforce development;
4. the effect on taxes and tax credits;
5. the effect on 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 rules do not impact or affect a "Provider." "Provider" means an organization that provides services for

individuals with developmental disabilities as defined in HCR 170 of the 2014 Regular Session of the Legislature. In particular, the proposed rules have no effect or impact on a "provider" in regards to:

1. the staffing level requirements or qualifications required to provide the same level of service;
2. the cost to the provider to provide the same level of service;
3. the ability of the provider to provide the same level of service.

Public Comments

All interested persons are invited to submit written comments on the proposed regulation. Such comments should be submitted no later than March 12, 2015, at 4:30 p.m. to Felicia Cooper, 8181 Independence Blvd., Baton Rouge, LA 70806, (225) 925-4200.

Public Hearing

A public hearing will be scheduled pursuant to R.S. 49:953(A)(1)(a).

Jill P. Boudreaux
Undersecretary

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Fire Protection

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

There will be no implementation costs or savings to state or local governmental units as a result of the proposed rule change. The proposed rule repeals the current rule related to those licensed by the State Fire Marshal's (SFM) Office to comply with local permitting ordinances and requirements for door-to-door solicitation. The rule is being repealed as a result of an Attorney General's opinion and a U.S. Supreme Court decision that cites that door-to-door solicitation is speech within the 1st Amendment of the U.S. Constitution and ordinances banning door-to-door solicitation are unconstitutional.

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 be no anticipated costs and/or economic benefits to directly affected persons or non-governmental groups as a result of the proposed rule change. While the SFM will no longer have a door-to-door solicitation rule, SFM licensees will continue to follow local ordinances related to door-to-door solicitation that remain in effect.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change will have no effect on competition and employment.

Jill P. Boudreaux	Evan Brasseaux
Undersecretary	Staff Director
1502#038	Legislative Fiscal Office

NOTICE OF INTENT

Department of Wildlife and Fisheries
Wildlife and Fisheries Commission

Deer Management Assistance Program (DMAP)
(LAC 76:V.111)

The Department of Wildlife and Fisheries and the Wildlife and Fisheries Commission does hereby advertise their intent to amend the regulations for the Deer Management Assistance Program.

The secretary of the Department of Wildlife and Fisheries is authorized to take any and all necessary steps on behalf of the commission to promulgate and effectuate this Notice of Intent and the final Rule, including but not limited to, the filing of the fiscal and Economic Impact Statements, the filing of the Notice of Intent and final Rule and the preparation of reports and correspondence to other agencies of government.

Title 76
WILDLIFE AND FISHERIES
Part V. Wild Quadrupeds and Wild Birds
Chapter 1. Wild Quadrupeds
§111. Rules and Regulations for Participation in the Deer Management Assistance Program

A. - A.2.a. …

b. Each hunter must have a tag in his possession while hunting on DMAP land in order to harvest an antlerless deer (or antlered deer if antlered deer tags are issued). Antlerless deer may be harvested any day of the deer season on property enrolled in DMAP provided a DMAP tag is possessed by the hunter at time of harvest. The tag shall be attached through the hock in such a manner that it cannot be removed before the deer is transported. The DMAP tag will remain with the deer so long as the deer is kept in the camp or field, is enroute to the domicile of its possessor, or until it has been stored at the domicile of its possessor, or divided at a cold storage facility and has become identifiable as food rather than as wild game. The DMAP number shall be recorded on the possession tag of the deer or any part of the animal when divided and properly tagged.

A.2.c. - B.1.b. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 56:110.1 and R.S. 56:115.

HISTORICAL NOTE: Promulgated by the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission, LR 17:204 (February 1991), amended LR 25:1656 (September 1999), LR 26:2011 (September 2000), LR 30:2496 (November 2004), LR 34:1427 (July 2008), LR 35:1910 (September 2009), LR 37:2187 (July 2011), repromulgated LR 37:2753 (September 2011), amended LR 39:2292 (August 2013), LR 41:

Family Impact Statement

In accordance with Act 1183 of 1999 Regular Session of the Louisiana Legislature, the Department of Wildlife and Fisheries, Wildlife and Fisheries Commission hereby issues its Family Impact Statement in connection with the preceding Notice of Intent. This Notice of Intent will have no impact on the six criteria set out at R.S. 49:972(B).

Poverty Impact Statement

The proposed rulemaking will have no impact on poverty as described in R.S.49:973.

Provider Impact Statement

This Rule has no known impact on providers as described in HCR 170 of 2014.

Public Comments

Interested persons may submit written comments relative to the proposed Rule until 4:30 p.m., Thursday, March 29, 2015 to Mr. Jonathon Bordelon, Wildlife Division, Department of Wildlife and Fisheries, P.O. Box 98000, Baton Rouge, LA 70898-9000 or via email at jbordelon@wlf.la.gov.

Billy Broussard
Chairman

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Deer Management Assistance Program (DMAP)

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

The proposed rule change will have no impact on state or local governmental unit expenditures.

The proposed rule change clarifies language in existing regulations that permits the harvest of antlerless deer on any day of deer hunting season on land enrolled in the Deer Management Assistance Program (D.M.A.P.) by any licensed hunter who possesses a D.M.A.P. tag for antlerless deer.

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

The proposed rule change is anticipated to have no impact on revenue collections of the state or local governmental units.

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

The proposed rule change is a clarification of regulatory language. It is expected to have no effect on the costs or economic benefits of any affected persons or non-governmental groups.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

There is no estimated effect on competition and employment.

Bryan McClinton
Undersecretary
1502#041

Evan Brasseaux
Staff Director
Legislative Fiscal Office

Potpourri

POTPOURRI

Department of Agriculture and Forestry
Office of Forestry

Adopted Severance Tax Values for 2015

In accordance with LAC 7:XXXIX.105, the Louisiana Department of Agriculture and Forestry, Office of Forestry, hereby publishes the current average stumpage market value of trees, timber and pulpwood for 2015.

Product	Value Per Ton	Tax Rate	Tax Per Ton (2015)
Pine Sawtimber	$31.68	2.25%	$0.71
Hardwood Sawtimber	$35.00	2.25%	$0.79
Pine Chip-n-Saw	$16.50	2.25%	$0.37
Pine Pulpwood	$8.76	5.00%	$0.44
Hardwood Pulpwood	$10.50	5.00%	$0.53

Mike Strain, DVM
Commissioner

1502#088

POTPOURRI

Department of Agriculture and Forestry
Office of the Commissioner

Annual Listing of Agritourism Activities

In accordance with LAC 7:LXLV.101-105, and specifically LAC 7:LXLV.103.C, the Louisiana Department of Agriculture and Forestry hereby publishes the annual listing of agritourism activities.

Annual Listing of Agritourism Activities in Accordance with LAC 7:XLV.101-105	
Notice: The activities listed below are agritourism activities only when conducted in relation to an agricultural operation as defined in LAC 7:XLV.101.	
Agricultural Crafts Tours and Visits	Farm/Ranch Vacations
Agricultural Exhibits Tours and Visits	Farmers Markets/on Farm Sales/Roadside Stands Visits and Participation
Agricultural Fairs and Festivals Visits and Participation	
	Fishing
Agricultural Operations Planting, Harvesting and Working Activities	Game/Exotic Farm Animal Tours and Visits
Agricultural Operations Tours and Visits	Garden/Nursery Tours and Visits
	Guided Crop Tours and Visits
Bed and Breakfasts Tours, Visits, and Stays	Hiking/Packing Trips
	Historical Tours of or Visits to Former Agricultural Operations
Beekeeping	
Bird Watching	
Boating/Swamp Tours	Horseback/Pony Riding
Camping/Picnicking	Hunting
Christmas Tree Farms Visits and Tree Cutting	Hunting/Working Dog Trials/Training
Corn/Hay Bale/Other Mazes Visits and Participation	Petting Zoos Tours, Visits, and Interaction with Animals
Crop Harvesting at U-Pick	Pumpkin Patch Visits and

Annual Listing of Agritourism Activities in Accordance with LAC 7:XLV.101-105	
Notice: The activities listed below are agritourism activities only when conducted in relation to an agricultural operation as defined in LAC 7:XLV.101.	
Operations	Participation
Educational Tours and Visits	Skeet Shooting
Equine Activity [as defined in R.S. 9:2795.3(A)(3)] Attendance and Participation	Wagon Rides Attendance and Participation
	Winery Tours and Visits
Farm Animal Activity [as defined in R.S. 9:2795.1(A)(3)] Attendance and Participation	Youth Camp Stays and Participation

Mike Strain, DVM
Commissioner

1502#028

POTPOURRI

Office of the Governor
Division of Administration
Office of Technology Services

OTS IT Bulletin

Pursuant to Act 712 of the 2014 Regular Legislative Session, the Office of Technology Services (OTS) published the following IT bulletin in the period 02/01/2015 to 02/28/2015.

Bulletin Number	Topic	Date
ITB 15-01	IT STD 7-01 Geographic Information System (GIS) Product Standard	02/10/2015
	IT STD 1-17 Data Sanitization—Standards and Requirements	02/10/2015

OTS bulletins, standards, policies and guidelines are posted on the OTS website at: http://www.doa.louisiana.gov/ots/index.htm

To receive email notifications when an OTS bulletin is published, register at: http://louisiana.gov/Services/Email_Notifications_OTS_Bulletins.

Richard "Dickie" Howze
State Chief Information Officer

1502#043

POTPOURRI

Department of Health and Hospitals
Bureau of Health Services Financing

Substantive Changes and Public Hearing Notification
Managed Care for Physical and Basic Behavioral Health
(LAC 50:I.Chapters 31-40)

In accordance with the provisions of the Administrative Procedures Act, R.S. 49:950 et seq., the Department of Health and Hospitals, Bureau of Health Services Financing

published a Notice of Intent in the October 20, 2014 edition of the *Louisiana Register* (LR 40:2105-2122) to amend LAC 50:I.Chapters 31-40. This Notice of Intent proposed to amend the provisions governing the coordinated care network in order to change the name in this Subpart to "Managed Care for Physical and Basic Behavioral Health" and to incorporate other necessary programmatic changes. This Notice of Intent also incorporated provisions to permit Medicaid eligible children identified in the *Melanie Chisholm, et al vs. Kathy Kliebert* class action litigation (hereafter referred to as *Chisholm* class members) to have the option of voluntarily enrolling into a participating health plan under the Bayou Health program.

The department conducted a public hearing on this Notice of Intent on November 26, 2014 to solicit comments and testimony on the proposed Rule. As a result of the comments received, the department proposes to amend the provisions in the following Sections of the proposed Rule: 1) §3103. Recipient Participation, Paragraph C, which had no changes will now clarify that participants will be notified at enrollment of their rights to disenroll from a health plan; 2) §3105. Enrollment Process, Subparagraph E.5.b shall be amended to provide further clarification of the provisions for transferring out of a managed care organization (MCO) for cause; 3) §3501. Participation Requirements, Subparagraph B.9 shall be amended to remove the last sentence in the Subparagraph relative to the HIPPA and Fraud Assessments; 4) §3503. Managed Care Organization Responsibilities, Paragraph O shall be amended to add MCO committee participation requirements; Paragraph P (formerly Paragraph O) and Subparagraphs 1-1.a shall be amended only to ensure proper formatting; Subparagraph 1.b shall be amended to clarify the recipient notice provisions; Paragraphs and Subparagraphs Q-T.1 shall be amended only to ensure proper formatting; and the provisions, "2-T.1. Repealed" is being removed for proper formatting; 5) §3507. Benefits and Services, Subparagraph E.2 shall be amended to clarify the provisions for transferring between MCOs; and 6) §3705. General Provisions, Subparagraph B.1 shall be amended to clarify the filing requirements for member grievances; and Subparagraphs C.1.-1a shall be amended to clarify the grievance notice and appeal procedures.

Taken together, all of these proposed revisions will closely align the proposed Rule with the department's original intent and the concerns brought forth during the comment period for the Notice of Intent as originally published. No fiscal or economic impact will result from the amendments proposed in this notice.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Basic Behavioral Health

Chapter 31.General Provisions

§3103. Recipient Participation

A. - B.2. …

C. The enrollment broker will ensure that all participants are notified at the time of enrollment that they may request disenrollment from the CCN at any time for cause. All voluntary opt-in populations can disenroll from the CCN and return to legacy Medicaid at any time without cause.

D. - 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 41:

§3105. Enrollment Process

A. - E.5.a. …

b. Recipients may request to transfer out of the MCO for cause and the effective date of enrollment into the new plan shall be no later than the first day of the second month following the calendar month that the request for disenrollment is filed.

F. - I.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 37:1574 (June 2011), amended LR 40:310 (February 2014), LR 40:1097 (June 2014), LR 41:

Chapter 35. Managed Care Organization Participation Criteria

§3501. Participation Requirements

A. - B.8. …

9. Except for licensure and financial solvency requirements, no other provisions of title 22 of the *Revised Statutes* shall apply to an MCO participating in the Louisiana Medicaid Program;

C. - I.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 37:1583 (June 2011), amended LR 41:

§3503. Managed Care Organization Responsibilities

A. - N. …

O. A MCO shall participate on the department's established committees for administrative simplification and quality improvement, which will include physicians, hospitals, pharmacists, other healthcare providers as appropriate, and at least one member of the Senate and House Health and Welfare Committees or their designees.

P. The MCO shall provide both member and provider services in accordance with the terms of the contract and department issued guides.

1. The MCO shall submit member handbooks, provider handbooks, and templates for the provider directory to the department for approval prior to distribution and subsequent to any material revisions.

a. The MCO must submit all proposed changes to the member handbooks and/or provider manuals to the department for review and approval in accordance with the terms of the contract and the department issued guides.

b. After approval has been received from the department, the MCO must provide notice to the members and/or providers at least 30 days prior to the effective date of any proposed material changes to the plan through updates to the member handbooks and/or provider handbooks.

Q. The member handbook shall include, but not be limited to:

1. a table of contents;

a. - b. Repealed.

2. a general description regarding:

a. how the MCO operates;

b. member rights and responsibilities;

c. appropriate utilization of services including emergency room visits for non-emergent conditions;

d. the PCP selection process; and

e. the PCP's role as coordinator of services;

3. member rights and protections as specified in 42 CFR §438.100 and the MCO's contract with the department including, but not limited to:

a. a member's right to disenroll from the MCO;

b. a member's right to change providers within the MCO;

c. any restrictions on the member's freedom of choice among MCO providers; and

d. a member's right to refuse to undergo any medical service, diagnoses, or treatment, or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;

4. member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or the department, including but not limited to:

a. immediately notifying the MCO if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;

b. reporting to the department if the member has or obtains another health insurance policy, including employer sponsored insurance; and

c. a statement that the member is responsible for protecting his/her identification card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;

5. the amount, duration, and scope of benefits available under the MCO's contract with the department in sufficient detail to ensure that members have information needed to aid in understanding the benefits to which they are entitled including, but not limited to:

a. information about health education and promotion programs, including chronic care management;

b. the procedures for obtaining benefits, including prior authorization requirements and benefit limits;

c. how members may obtain benefits, including family planning services and specialized behavioral health services, from out-of-network providers;

d. how and where to access any benefits that are available under the Louisiana Medicaid state plan, but are not covered under the MCO's contract with the department;

e. information about early and periodic screening, diagnosis and treatment (EPSDT) services;

f. how transportation is provided, including how to obtain emergency and non-emergency medical transportation;

g. the post-stabilization care services rules set forth in 42 CFR 422.113(c);

h. the policy on referrals for specialty care, including behavioral health services and other benefits not furnished by the member's primary care provider;

i. for counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO is required to furnish information on how or where to obtain the service;

j. how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";

k. the extent to which and how after-hour services are provided; and

l. information about the MCO's formulary and/or preferred drug list (PDL), including where the member can access the most current information regarding pharmacy benefits;

6. instructions to the member to call the Medicaid customer service unit toll free telephone number or access the Medicaid member website to report changes in parish of residence, mailing address or family size changes;

7. a description of the MCO's member services and the toll-free telephone number, fax number, e-mail address and mailing address to contact the MCO's member services unit;

8. instructions on how to request multi-lingual interpretation and translation services when needed at no cost to the member. This information shall be included in all versions of the handbook in English and Spanish; and

9. grievance, appeal, and state fair hearing procedures and time frames as described in 42 CFR §438.400 through §438.424 and the MCO's contract with the department.

R. The provider manual shall include, but not be limited to:

1. billing guidelines;

2. medical management/utilization review guidelines;

a. - e. Repealed.

3. case management guidelines;

a. - d. Repealed.

4. claims processing guidelines and edits;

a. - c. Repealed.

5. grievance and appeals procedures and process; and

a. - l. Repealed.

6. other policies, procedures, guidelines, or manuals containing pertinent information related to operations and pre-processing claims.

7. - 9. Repealed.

S. The provider directory for members shall be developed in three formats:

1. a hard copy directory to be made available to members and potential members upon request;

2. an accurate electronic file refreshed weekly of the directory in a format to be specified by the department and used to populate a web-based online directory for members and the public; and

3. an accurate electronic file refreshed weekly of the directory for use by the enrollment broker.

4. - 6. Repealed.

T. The department shall require all MCOs to utilize the standard form designated by the department for the prior authorization of prescription drugs, in addition to any other currently accepted facsimile and electronic prior authorization forms.

1. An MCO may submit the prior authorization form electronically if it has the capabilities to submit the form in this manner.

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 37:1583 (June 2011), amended LR 39:92 (January 2013), LR 40:66 (January 2014), LR 41:

§3507. Benefits and Services

A. - E.1. …

2. In the event a member is transitioning from one MCO to another and is hospitalized at 12:01 a.m. on the effective date of the transfer, the relinquishing MCO shall be responsible for both the inpatient hospital charges and the charges for professional services provided through the date of discharge. Services other than inpatient hospital will be the financial responsibility of the receiving MCO.

F. - H.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 37:185 (June 2011), amended LR 39:92 (January 2013), LR 39:318 (February 2013), LR 41:

Chapter 37. Grievance and Appeal Process

Subchapter A. Member Grievances and Appeals

§3705. General Provisions

A. …

B. Filing Requirements

1. Authority to file. A member, or a representative of his/her choice, including a network provider acting on behalf of the member and with the member's consent, may file a grievance and an MCO level appeal. Once the MCO's appeals process has been exhausted, a member or his/her representative may request a state fair hearing.

1.a. - 3.b. …

C. Grievance Notice and Appeal Procedures

1. The MCO shall ensure that all members are informed of the state fair hearing process and of the MCO's grievance and appeal procedures.

a. The MCO shall provide a member handbook to each member that shall include descriptions of the MCO's grievance and appeal procedures.

C.1.b. - 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 37:1590 (June 2011), amended LR 41:

Implementation of these amendments to the proposed 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 these substantive amendments to the proposed Rule. A public hearing on these substantive changes to the proposed Rule is scheduled for Tuesday, March 31, 2015 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. 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

1502#091

POTPOURRI

Department of Natural Resources
Office of Conservation
Environmental Division

Ecoserv Environmental Services—Hearing Notice

Notice is hereby given that the commissioner of conservation will conduct a hearing at 6 p.m., Wednesday, March 25, 2015, at the Lafourche Parish Government, Mathews Complex, Council Chambers Room, 4876 Hwy 1, Mathews, LA.

At such hearing, the commissioner, or his designated representative, will hear testimony relative to the application of Ecoserv Environmental Services, LLC, 207 Town Center Parkway, second floor, Lafayette, LA 70506. The applicant requests approval from the Office of Conservation to construct and operate a commercial transfer station for temporary storage of exploration and production waste (E and P waste) located in Port Fourchon at latitude 29º 8' 6.3" north, longitude 90º 11' 34.2" west in Lafourche Parish.

The application is available for inspection by contacting Mr. Stephen Olivier, Office of Conservation, Environmental Division, eighth floor of the LaSalle Office Building, 617 North Third Street, Baton Rouge, LA. Copies of the application will be available for review at the Lafourche Parish Council in Mathews, LA or the Lafourche Parish Public Library in Golden Meadow, LA no later than 30 days prior to the hearing date. Verbal information may be received by calling Mr. Olivier at (225) 342-7394.

All interested persons will be afforded an opportunity to present data, views or arguments, orally or in writing, at said public hearing. Written comments which will not be presented at the hearing must be received no later than 4:30 p.m., Wednesday, April 1, 2015, at the Baton Rouge office. Comments should be directed to:

Office of Conservation
Environmental Division
P.O. Box 94275
Baton Rouge, LA 70804
Re: Docket No. ENV 2015-02
Commercial Transfer Station Application
Lafourche Parish

James H. Welsh
Commissioner

1502#002

POTPOURRI

Department of Natural Resources
Office of Conservation

Public Hearing—Substantive Changes to Proposed Rule
Plug and Abandonment of Oil and Gas Wells, Financial
Security, Utility Review Status (LAC 43:XIX.Chapter 1)

The Department of Natural Resources, Office of Conservation published a Notice of Intent to amend its rules in the October 20, 2014 edition of the *Louisiana Register* (LR 40:2156-2159). The notice solicited comments. As a result of Conservation's consideration of the comments received, it agreed to revise the original proposed amendments in the following respects: (i). in §101, in the definition of *inactive well*, after the word "months," to add the words "and is not part of an approved production program."; (ii). in §104.C.1.a, to delete the number 4 and replace it with 5 and to delete the following number 5 and replace it with 4; (iii). in §104.C.6, to add the words "Financial security amounts will be periodically reviewed and adjusted to ensure they are reflective of the costs to plug and clear orphan well sites."; (iv). in §137.A.1.b, to delete the word "penalty" and replace it with the word "assessment." As substantively amended, these provisions will read as set forth below.

Title 43
NATURAL RESOURCES
Part XIX. Office of Conservation—General Operations
Subpart 1. Statewide Order No. 29-B
Chapter 1. General Provisions
Subchapter A. General Provisions
§101. Definitions

A. ...

* * *

Inactive Well—an unplugged well that has been spud or has been equipped with cemented casing and that has had no reported production, disposal, injection, or other permitted activity for a period of greater than six months and is not part of an approved production program.

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:4 et seq.

HISTORICAL NOTE: Adopted by the Department of Conservation (August 1943), amended by the Department of Natural Resources, Office of Conservation, LR 41:

§104. Financial Security

A. - B.4. …

C. Financial Security Amount

1. Land Location

a. Individual well financial security shall be provided in accordance with the following.

Measured Depth	Amount
< 3000'	$ 7 per foot
3001-10000'	$5 per foot
> 10001'	$4 per foot

1.b - 5. …

6. Financial security amounts will be periodically reviewed and adjusted to ensure they are reflective of the costs to plug and clear orphan well sites.

D. - H. ...

AUTHORITY NOTE: Promulgated in accordance with R. S. 30:4 et seq.

HISTORICAL NOTE: Promulgated by the Department of Natural Resources, Office of Conservation LR 26:1306 (June 2000), amended LR 27:1917 (November 2001), LR 41:

§137. Plugging and Abandonment

A. - A.2.a. ...

b. If an operator chooses not to plug an inactive well in accordance with this Section for reasons of future utility, an annual assessment of $250.00 per well per year shall be assessed until the well is plugged.

A.2.c - H. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 30:4 et seq.

HISTORICAL NOTE: Adopted by the Department of Conservation (August 1943), amended (March 1974), amended by the Department of Natural Resources, Office of Conservation, LR 41:

Public Hearing

In accordance with R.S. 49:968(H)(2), Conservation gives notice that a public hearing to receive comments and testimony on these substantive amendments to the rule amendments original1y proposed will be held March 26, 2015, at 9 a.m., in the LaBelle Room located on the first floor of the LaSalle Building, 617 North Third Street, Baton Rouge, LA. Interested persons may submit written comments on these proposed substantive changes to John Adams at P.O. Box 94275, Baton Rouge, LA, 70804-9275; or by hand delivery at Office of Conservation, 617 North Third Street, Room 931, Baton Rouge, LA 70802. Reference Docket No. CON ENG 2014-11 on all correspondence. Emailed or faxed comments will not be accepted. Written comments will be accepted until 4 p.m., March 26, 2015.

James H. Welsh
Commissioner

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES
RULE TITLE: Public Hearing—Substantive Changes to Proposed Rule—Plug and Abandonment of Oil and Gas Wells, Financial Security, Utility Review Status

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

The proposed rule change will have no implementation costs to the state or local governmental units. The proposed rule change implements recommendations of the Legislative Auditor in the Performance Audit issued May 28, 2014 and has been updated to reflect certain comments received at the November 24, 2014 hearing and subsequent comment period. The intent of the rule change is to update the financial security requirements so that the financial security provided will cover the costs of plugging and abandoning these same wells if the operator fails to do so pursuant to State law. The proposed rule will also remove an exception that permitted 48-month compliant operators to not have to provide financial security. There are no costs to the Office of Conservation since the financial security will be able to be documented using existing procedures and staff.

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

The proposed rule change may effect revenue collections of state governmental units. In the event an unplugged well is abandoned and will require site restoration, the department will

access the financial security provided by the company to pay for the costs associated with the abandoned well. The proposed rule change will have no impact on local governmental units.

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

The group directly affected by the rule change will be Exploration and Production (E&P) companies. These companies will be required to provide larger amounts of financial security if a new well is permitted or if an existing well is transferred, since the compliant operator exemption will be removed.

Currently E&P companies can choose between individual well financial security and blanket well security. The proposed rule change increases the financial security required based on the factors of well depth, well location, and number of wells operated. Amounts for individual well security depend on well location (land, inland water and offshore water) and well depth. Blanket financial security amounts depend on well location and the number of wells operated by the company. The exact financial security of each E&P company that applies for a permit cannot be determined.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

The proposed rule change will have no effect on competition and employment.

James H. Welsh	Evan Brasseaux
Commissioner	Staff Director
1502#045	Legislative Fiscal Office

POTPOURRI

Department of Wildlife and Fisheries
Wildlife and Fisheries Commission

Public Hearing—Substantive changes to
Louisiana Fisheries Forward Program (LAC 76:VII.347)

The Department of Wildlife and Fisheries published a Notice of Intent to establish the Louisiana Fisheries Forward Program in the July 20, 2014 edition of the *Louisiana Register* (LR Vol. 40, No. 07). After a thorough review of the proposed rules, the Department of Wildlife and Fisheries proposed substantive changes in LAC 76:VII.347.G.2. A public hearing pursuant to R.S. 49:968(H)(2) was conducted October 22, 2014, at 10 a.m., and the changes were accepted. After further review, the Department of Wildlife and Fisheries proposes the following substantive changes found in LAC 76:VII.347.B, C.2, E.1, F.1, F.2, F.3, G.1, G.3, H.1.a, H.1.b, and H.2. A public hearing pursuant to R.S. 49:968(H)(2) will be conducted March 25, 2015, at 10 a.m. at the Louisiana Department of Wildlife and Fisheries, 2000 Quail Dr., Baton Rouge, LA 70808.

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. …

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 person holding a valid commercial crab trap gear license who mentors an apprentice in completing the apprenticeship path;

sponsor—a person holding a valid commercial crab trap gear license who sponsors an apprentice in completing sponsorship path.

C. - C.1. …

2. Before beginning a training path, an applicant must possess a valid Louisiana commercial fisherman's license and submit an application including copies of the applicant and mentor/sponsor's state issue identification to the department for approval. The license number will be used to track participation in the program.

C.3. - D.1. …

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 sales of crabs caught in Louisiana 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 sales of crabs caught in Louisiana waters in any two of the previous four years.

E. …

1. Each applicant must successfully complete an NASBLA-approved boating safety class as required by R.S. 34:851.36.

E.2. - F. …

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 last four digits of the Social Security number, name and address, commercial fishing license number 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 of approval of the apprenticeship by the department 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 along with copies of the trip tickets evidencing harvesting hours. The affidavit shall be provided by the department and indicate the completion of the apprenticeship, affirm the accuracy of the associated log forms and corresponding trip tickets, and include the name, address, and commercial fishing license of both the applicant and the mentor.

G. …

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 last four digits of the Social Security number, name and address, commercial fishing license number 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. …

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 of both the applicant and the sponsor.

H. - H.1. …

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 5 fishing trips may be substituted for the sponsorship requirements. Attendance at meetings or educational events shall be documented by a designated department employee or agent. The applicant shall sign in upon arrival, present a valid photo ID and provide their commercial license number. Upon departure, the applicant shall sign out.

2. - 2.b. ...

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:

Public Hearing

A public hearing will be held on March 25, 2015, at 10 a.m. at the Louisiana Department of Wildlife and Fisheries, 2000 Quail Dr., Baton Rouge, LA 70808.

Jason Froeba
Director

1502#039

CUMULATIVE INDEX
(Volume 41, Number 2)

2015	
Pages	**Issue**
1-298	January
299-505	February

EO—Executive Order
PPM—Policy and Procedure Memoranda
ER—Emergency Rule
R—Rule
N—Notice of Intent
CR—Committee Report
GR—Governor's Report
L—Legislation
P—Potpourri
QU—Administrative Code Quarterly Update

ADMINISTRATIVE CODE UPDATE
Cumulative
January 2014-December 2014, 289QU

AGRICULTURE AND FORESTRY
Agricultural and Environmental Sciences, Office of
Structural Pest Control Commission
Hydraulic injection, 333R
Beef Industry Council
Beef promotion and research program, 3ER, 332R
Commissioner, Office of the
Annual listing of agritourism activities, 495P
Forestry, Office of
Adopted severance tax values for 2015, 495P

CHILDREN AND FAMILY SERVICES
Division of Programs
Temporary assistance for needy families (TANF)
Caseload reduction, 292P
Economic Stability Section
TANF initiatives, 403N

CULTURE, RECREATION AND TOURISM
Seafood Promotion and Marketing Board
Seafood promotion and marketing, 38R

ECONOMIC DEVELOPMENT
Office of Business Development
Quality jobs program, 404N

EDUCATION
Elementary and Secondary Education, Board of
Bulletin 111—The Louisiana School, District, and State Accountability System, 156N
Bulletin 118—Statewide Assessment Standards and Practices, 157N
Bulletin 131—Alternative Education Schools/Programs Standards, 370R
Bulletin 134—Tuition Donation Rebate Program, 40R
Bulletin 135—Health and Safety, 4ER, 371R
Bulletin 137—Louisiana Early Learning Center Licensing Regulations, 158N
Bulletin 138—Jump Start Program, 371R
Bulletin 741—Louisiana Handbook for School Administrators, 7ER, 41R, 186N, 406N
Emergency Planning and Attendance, 372R
Bulletin 746—Louisiana Standards for State Certification of School Personnel, 188N, 408N
Bulletin 996—Standards for Approval of Teacher and/or Educational Leader Preparation Programs, 412N
Nonpublic Bulletin 741—Louisiana Handbook for Nonpublic School Administrators, 407N
Student Financial Assistance Commission
Office of Student Financial Assistance
Scholarship/grant programs
TOPS core curriculum
Equivalents, 373R
Art media I-IV, 301ER, 414N
TOPS tech early start award, 374R

ENVIRONMENTAL QUALITY
Secretary, Office of the
Legal Division
Air quality, standards, 198N
Permit, minor source, 376R

EXECUTIVE ORDERS
BJ 14-18 Executive Branch—Expenditure Reduction, 1EO
BJ 15-01 BESE's Duty to Uphold the Accountability System and Offer Alternatives to the PARCC Test, 299EO
BJ 15-02 Carry-Forward Bond Allocation 2014, 300EO

GOVERNOR
Administration, Division of
Office of Group Benefits
Benefit limits, 302ER
Employee benefits, 338R
General provisions, 302ER
Pharmacy benefits formulary, 302ER
Prior authorization requirements, 302ER
Property Assistance Agency
Electronic media sanitization, 197N
State Procurement, Office of
Procurement, 194N

GOVERNOR (continued)

Tax Commission
Public hearing
Ad valorem taxation, oil and gas properties, 293P
Technology Services, Office of
Office of technology services consolidation, 46R
OTS IT Bulletin, 495P
Certified Shorthand Reporters, Board of Examiners of
Ethics, Code of, 336R
Transcript, certification, 334
Coastal Protection and Restoration Authority
Public hearings
State fiscal year 2016 draft annual plan, 292P
Crime Victims Reparations Board
Compensation to victims, 414N
Eligibility and application process, 301ER
Eligibility for sexual assault victims, 416N
Financial Institutions, Office of
Judicial interest rate, 2015293P
Home Inspectors, Board of
Mold growth, visually observable evidence of suspected, 193N
Pardons, Board of
Parole, Committee on
Parole
Administration, 42R
Eligibility, 42R
Hearings, 42R
Meetings, 42R
Types of parole, 42R
Public Defender Board
Performance standards, criminal defense representation in indigent capital cases, 48R
Real Estate Appraisers Board
Real estate, 368R

HEALTH AND HOSPITALS

Aging and Adult Services, Office of
Home and community-based services waivers
Adult day health care, 379R
Community choices waiver, 311ER
Nursing Facilities
Standards for payment
Level of care determinations, 318ER
State personal assistance services program, 385R
Behavior Analyst Board
Continuing education, 417N
Behavioral Health, Office of
Adult behavioral health services, 377R
School based behavioral health services, 384R
Citizens with Developmental Disabilities, Office for
Certification of medication attendants, 328ER
Home and community-based services waivers
Children's choice waiver, 125R
Infant intervention services, 146R
Embalmers and Funeral Directors, Board of
Internship, 199N
Inspection, 199N
License, 199N
Emergency Response Network
Protocols
LERN destination,
Trauma, 490N
STEMI, 137R
Stroke, 137R
Trauma, 137R
Health Services Financing, Bureau of
Adult behavioral health services, 377R
Applied behavior analysis-based therapy services, 9ER, 436N
Behavioral health service providers
Licensing standards, 439N
Coordinated care network
Physician services
Reimbursement methodology, 304ER
Recipient participation, 305ER
Crisis receiving centers
Licensing standards, 101R
Facility need review, 306ER
Family planning services, 378R
Home and community-based services providers
Licensing standards, 306ER
Home and community-based services waivers
Adult day health care, 379R
Children's choice waiver, 125R
Community choices waiver, 311ER
Home health program
Rehabilitation services, reimbursement rate increase, 12ER
Hospice services, 129R
Hospital licensing standards
Therapeutic recreational therapists, 481N
Inpatient hospital services
Children's specialty hospitals
Supplemental payments for New Orleans area hospitals, 312ER
Non-rural, non-state hospitals
Children's specialty hospitals reimbursements, 13ER
Supplemental payments, 133R
Supplemental payments for Baton Rouge area hospitals, 313ER
Supplemental payments for Monroe area hospitals, 314ER
Public-private partnerships
Reimbursement methodology, 315ER
South Louisiana area, 14ER
Supplemental payments, 315ER
Intermediate care facilities for persons with intellectual disabilities
Complex care reimbursements, 15ER
Public facilities, reimbursement rate increase, 16ER
Medicaid eligibility
Children supplemental security income (SSI), 482N
Modified adjusted gross income, 483N
Provisional Medicaid program, 17ER
Medical transportation program
Non-emergency medical transportation, 18ER

HEALTH AND HOSPITALS (continued)
Nursing facilities
Leave of absence days, reimbursement reduction, 133R
Per diem rate reduction, 201N, 316ER, 317ER, 489N
Standards for payment
Level of care determinations, 318ER
Outpatient hospital services
Children's specialty hospitals
Supplemental payments for New Orleans area hospitals, 320ER
Non-rural, non-state hospitals
Supplemental Payments for Baton Rouge area hospitals, 320ER
Supplemental payments for Monroe area hospitals, 319ER
Public-private partnerships
South Louisiana area, 21ER
Supplemental payments, 321ER
Pediatric day health care program, 133R
Pharmacy benefits management program
Methods of payment, 22ER
State supplemental rebate agreement program, 22ER
Professional services program
Immunizations, reimbursement methodology, 23ER
Recovery audit contractor program, 322ER
Rehabilitation clinics
Physical and occupational therapies, reimbursement rate increase, 24ER, 203N
School based behavioral health services, 384R
School based health centers
Rehabilitation services, reimbursement rate increase, 25ER, 204N
State children's health insurance program
Prenatal care services, coverage of, 205N
Substantive changes and public hearing notification managed care for physical and basic behavioral health, 495P
Targeted case management
Reimbursement methodology, 325ER
Therapeutic group homes
Licensing standards, 325ER
Licensed Professional Counselors Board of Examiners
PLPC and PLMFT, 207N
Fee structure adjustments/changes, 207N
Medical Examiners, Board of
Physician assistants, licensure and certification; practice, 431N
Public hearing—substantive changes to proposed rule amendments, physician practice
Telemedicine, 293P
Unprofessional conduct 294P
Nursing Facility Administrators, Board of Examiners
Continuing education, 96R
Fee schedule, 96R
License, refusal, suspension, and revocation, 96R
Preceptor update, 96R
Pharmacy, Board of
Compounding, 97R
Permit, special event, 100R
Prescriptions, 98R
Psychologists, Board of Examiners of
Continuing education, 419N
Licensure, provisional, 420N, 427N
Public Health, Office of
Added controlled dangerous substances, 329ER
Plumbing Fixtures and Water Supply and Distribution, 389R
Reclassification of failure to obtain a food safety certification as a class A violation, 148R
Veterinary Medicine, Board of
License procedures, 434N

NATURAL RESOURCES
Coastal Management, Office of
Fisherman's gear compensation fund, administration, 150R
Conservation, Office of
Carbon dioxide enhanced oil recovery, 258N
Ecoserv environmental services, hearing notice, 498P
Orphaned oilfield sites, 295P
Public hearing, substantive changes to proposed rule, plug and abandonment of oil and gas wells, financial security, utility review status, 499P
Statewide orders
29-B, 26ER
Commercial facilities and transfer stations setbacks, 260N
29-B-a, 26ER
Environmental Division
Legal notice
Docket no. ENV 2015-01, 295P

PUBLIC SAFETY AND CORRECTIONS
Liquefied Petroleum Gas Commission
Classes of permits, 394R
Liquefied petroleum gas, 395R
Motor Vehicles, Office of
Driving schools, 150R
State Fire Marshal, Office of
Door-to-door solicitations, 330ER
Fire protection, 492N

REVENUE

Policy Services Division

Secretary, Office of the

Louisiana tax delinquency amnesty act of 2014, 151R

TRANSPORTATION

Operations, Office of

Advertising on DOTD-owned assets, 261N

Sponsorships and acknowledgment signs on public rights of way, 261N

TREASURY

Louisiana Housing Corporation

Workforce housing initiative program, 401R

Teachers' Retirement System of Louisiana, Board of Trustees of the

Defined benefit plan, 397R

WILDLIFE AND FISHERIES

Wildlife and Fisheries Commission

Crab traps

Abandoned, removal, 154R

Deer management assistance program (DMAP), 4933N

King mackerel season

Commercial, 2015-16 season, 38ER

Louisiana fisheries forward program

Public hearing, substantive changes, 500P

Resident game hunting season

Areas, seasons, and bag limits, 264N

Game birds and animals, 264N

General and wildlife management area, 264N

Turkey hunting, 264N

Shrimp season closures, 330ER

Wild quadrupeds, possession of potentially dangerous big exotic cats and non-human primates, 152R

WORKFORCE COMMISSION

Plumbing Board

Water supply protection specialist, recertification, 287N