9. …

10. Any remaining balance of continuing education hours must be obtained by participation in live in-person or interactive live-streaming video CE classes taught by a board-certified education provider.

B.11. - F.4.c. …

5. All continuing education providers shall provide sign-in sheets, whether electronic or otherwise, for LHIs to complete upon entering a class, joining a streaming lecture, or participating online. Within five days of completion of a class, the instructor shall provide the LHI with a certificate of completion. Sign-in sheets and certificates of completion shall include the date and time of the course, the number of hours of credit assigned to each course by the board, and the name of the instructor teaching the course or courses. The continuing education provider shall forward all sign-in sheets to the board immediately upon request by the board.

6. - 9. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1477 and R.S. 37:1479-1480.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home Inspectors, LR 26:2742 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 36:2860 (December 2010), LR 37:2405 (August 2011), LR 38:2531 (October 2012), LR 40:1003 (May 2014), LR 43:314 (February 2017), LR 43:1911 (October 2017), RS 28:2288 (September 2022), LR 50:1466 (October 2024).

Chapter 3. Standards of Practice

§319. Electrical System

A. - C. …

D. The home inspector shall report on the presence or absence of smoke detectors and carbon monoxide alarms.

E. - E.5. …

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1475.

HISTORICAL NOTE: Promulgated by the Department of Economic Development, Board of Home inspectors, LR 26:2748 (December 2000), amended by the Office of the Governor, Board of Home Inspectors, LR 30:1691 (August 2004), LR 36:2863 (December 2010), LR 38:2533 (October 2012), LR 41:923 (May 2015), LR 43:1913 (October 2017), LR 50:1467 (October 2024).

Morgan Spinosa
Chief Operating Officer

2410#043

RULE

Office of the Governor
Division of Administration
Office of Group Benefits

Primary Plan of Benefits and
Additional Plans and Operations
(LAC 32:III.105, and V.203, 303, and 503)

In accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., as authorized pursuant to R.S. 42:801 and 42:802, the Office of the Governor, Division of Administration, Office of Group Benefits, amends Chapter 1 of LAC 32:III., Primary Plan of Benefits, and Chapters 2, 3, and 5 of LAC 32:V., Additional Plans and Operations. The revisions amend the Out-of-Pocket Maximums to comply with the federal Inflation Reduction Act (IRA) which limits plan participants with Medicare Part D coverage to a maximum out-of-pocket amount of $2,000 for prescription drugs. The revisions also amend these rules to create a division between medical and prescription maximum out-of-pocket amounts to comply with the IRA. This Rule is hereby adopted on the day of promulgation, and the effective date is January 1, 2025.

Title 32
EMPLOYEE BENEFITS
Part III. Primary Plan of Benefits

Chapter 1. Operation of Primary Plan

§105. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	**Non-Network**
Individual:		
Active Employee/Retirees on or after March 1, 2015	$3,500	No Coverage
Retirees prior to March 1, 2015	$2,000	No Coverage
Individual, Plus One Dependent:		
Active Employee/Retirees on or after March 1, 2015	$6,000	No Coverage
Retirees prior to March 1, 2015	$3,000	No Coverage
Individual, Plus Two or More Dependents:		
Active Employee/Retirees on or after March 1, 2015	$8,500	No Coverage
Retirees prior to March 1, 2015	$4,000	No Coverage

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximum[1] Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	**Non-Network**
Individual:		
Active Employee/Retirees on or after March 1, 2015	Medical: $1,500 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $500 Prescription: $1,500	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: $4,000 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $1,500 Prescription: $1,500	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: $2,000 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1,500 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for One):		

Out-of-Pocket Maximum[1] Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
Active Employee/Retirees on or after March 1, 2015	Medical: $6,500 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $2,500 Prescription: $1,500 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: $4,000 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $1,000 Prescription: $1,500 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for Three):		
Active Employee/Retirees on or after March 1, 2015	Medical: $2,500 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1,500	No Coverage

[1] Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

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, amended LR 43:2153 (November 2017), effective January 1, 2018, LR 49:1377 (August 2023), LR 50:1467 (October 2024), effective January 1, 2025.

Part V. Additional Plans and Operations

Chapter 2. PPO Plan Structure—Magnolia Open Access Plan

§203. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

	Active Employee/Retirees on or after March 1, 2015		Retirees prior to March 1, 2015 Without Medicare	
	Network	Non-Network	Network	Non-Network
Individual Only	$3,500	$4,700	$2,300	$4,300
Individual Plus One Dependent	$6,000	$8,500	$3,600	$7,600
Individual Plus Two or More Dependents	$8,500	$12,250	$4,900	$10,900

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximums[1] (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	Medical: $1,500 Prescription: $2,000	$4,700	See Subsection A	See Subsection A	Medical: $1,300 Prescription: $2,000
Individual Plus One Dependent (Medicare Paying Primary for One)	Medical: $4,000 Prescription: $2,000	$8,500	Medical: $1,600 Prescription: $2,000	$7,600	Medical: $3,600 Prescription: $2,000
Individual Plus One Dependent (Medicare Paying Primary for Two)	Medical: $2,000 Prescription: $2,000 per participant	$8,500	Not Applicable	Not Applicable	Medical: $1,600 Prescription: $2,000 per participant
Individual Plus Two or More Dependents (Medicare Paying Primary for One)	Medical: $6,500 Prescription: $2,000	$12,250	Medical: $2,900 Prescription: $2,000	$10,900	Medical: $5,900 Prescription: $2,000
Individual Plus Two or More Dependents (Medicare Paying Primary for Two)	Medical: $4,500 Prescription: $2,000 per participant	$12,250	Medical: $900 Prescription: $2,000 per participant	$10,900	Medical: $3,900 Prescription: $2,000 per participant
Individual Plus Two or More Dependents (Medicare Paying Primary for Three)	Medical: $2,500 Prescription: $2,000 per participant	$12,250	Medical: $0 Prescription: $2,000 per participant	$10,900	Medical: $1,900 Prescription: $2,000 per participant

[1]Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

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, amended LR 43:2155 (November 2017), effective January 1, 2018, amended LR 50:1468 (October 2024), effective January 1, 2025.

Chapter 3. Narrow Network HMO Plan Structure—Magnolia Local Plan (in certain geographical areas)

§303. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

Out-of-Pocket Maximum Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	**Non-Network**
Individual:		
Active Employee/Retirees on or after March 1, 2015	$2,500	No Coverage
Retirees prior to March 1, 2015	$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	$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	$3,000	No Coverage

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximum[1] Per Benefit Period (Includes All Eligible Copayments, Coinsurance Amounts and Deductibles)		
	Network	**Non-Network**
Individual:		
Active Employee/Retirees on or after March 1, 2015	Medical: $500 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1000	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: $3,000 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $1,000 Prescription: $1,000	No Coverage
Individual, Plus One Dependent (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: $1,000 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1,000 per participant	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for One):		
Active Employee/Retirees on or after March 1, 2015	Medical: $5,500 Prescription: $2,000	No Coverage
Retirees prior to March 1, 2015	Medical: $2,000 Prescription: $1,000	No Coverage
Individual, Plus Two or More Dependents (Medicare Paying Primary for Two):		
Active Employee/Retirees on or after March 1, 2015	Medical: $3,500 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $1,000 Prescription: $1,000 per participant	No Coverage
Individual, Plus Two or More Dependents (Three with Medicare Paying Primary):		
Active Employee/Retirees on or after March 1, 2015	Medical: $1,500 Prescription: $2,000 per participant	No Coverage
Retirees prior to March 1, 2015	Medical: $0 Prescription: $1,000 per participant	No Coverage

[1] Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

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, amended LR 50:1469 (October 2024), effective January 1, 2025.

Chapter 5. PPO/Consumer-Driven Health Plan Structure—Pelican HRA 1000 Plan

§503. Out of Pocket Maximums

A. Plan Participants When OGB Is the Primary Payer for All Plan Participants

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

B. Plan Participants When Medicare Is the Primary Payer for at Least One Plan Participant

Out-of-Pocket Maximum[1] Per Benefit Period (Includes All Eligible Deductibles, Coinsurance Amounts and Copayments)		
	Network	Non-Network
Individual	Medical: $3,000 Prescription: $2,000	$10,000
Family (Medicare Paying Primary for One)	Medical: $8,000 Prescription: $2,000	$20,000
Family (Medicare Paying Primary for Two)	Medical: $6,000 Prescription: $2,000 per participant	$20,000
Family (Medicare Paying Primary for Three)	Medical: $4,000 Prescription: $2,000 per participant	$20,000

[1] Medical Out-of-Pocket Maximum applies to medical expenditures for all Plan Participants and to Prescription expenditures for Plan Participants when OGB is the primary payer. Prescription Out-of-Pocket Maximum applies to each Plan Participant when Medicare is the primary payer.

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, amended LR 50:1470 (October 2024), effective January 1, 2025.

Heath Williams
Chief Executive Officer

2410#038

RULE

Department of Health
Bureau of Health Services Financing

Pharmacy Benefits Management Program
Drug Shortages
(LAC 50:XXIX.105)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.105 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. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXIX. Pharmacy

Chapter 1. General Provisions

§105. Medicaid Pharmacy Benefits Management System Point of Sale—Prospective Drug Utilization Program

A. - C. ...

D. Drug Shortages. Drugs that are not on the list of covered drugs, including drugs authorized for import by the Food and Drug Administration (FDA), may be covered when deemed medically necessary during drug shortages identified by the FDA.

E. Reimbursement Management. The cost of pharmaceutical care is managed through NADAC of the ingredient or through wholesale acquisition cost (WAC) when no NADAC is assigned, and compliance with FUL regulations, the establishment of the professional dispensing fee, drug rebates and copayments. Usual and customary charges are compared to other reimbursement methodologies and the "lesser of" is reimbursed.

F. Claims Management. The claims management component is performed through the processing of pharmacy claims against established edits. Claim edit patterns and operational reports are analyzed to review the effectiveness of established edits and to identify those areas where the development of additional edits are needed.

1. - 3. Repealed.

G. Pharmacy Program Integrity. Program integrity is maintained through the following mechanisms:

1. retrospective drug utilization review;
2. Lock-In Program for patient education; and
3. Surveillance and Utilization Review Systems (SURS) Program processes which provide for on-going review for mis-utilization, abuse and fraud and audits of the pharmacy providers.

H. Pharmacy Provider Network. Enrolled Medicaid pharmacy providers are required to comply with all applicable federal and state laws and regulations.

I. Point-of-Sale Prospective Drug Utilization Review System. This on-line point-of-sale system provides electronic claims management to evaluate and improve drug utilization quality. Information about the patient and the drug will be analyzed through the use of therapeutic modules in accordance with the standards of the National Council of Prescription Drug Programs. The purpose of prospective drug utilization review is to reduce duplication of drug therapy, prevent drug-to-drug interactions, and assure appropriate drug use, dosage and duration. The prospective modules may screen for drug interactions, therapeutic duplication, improper duration of therapy, incorrect dosages, clinical abuse/misuse and age restrictions. Electronic claims submission inform pharmacists of potential drug-related problems and pharmacists document their responses by using interventions codes. By using these codes, pharmacists will document prescription reporting and outcomes of therapy for Medicaid recipients.

1. - 5. Repealed.

J. POS/PRO-DUR Requirements Provider Participation.

1. Point-of-sale (POS) enrollment amendment and certification is required prior to billing POS/PRO-DUR system. Annual recertification is required.