

Chapter 125. Facility Need Review

Subchapter A. General Provisions

§12501. Definitions

A. Definitions. When used in this Chapter the following terms and phrases shall have the following meanings unless the context requires otherwise.

Abeysance of Nursing Facility Beds—a situation in which a nursing facility, if it meets certain requirements, may have all (but not only a portion) of its approved beds disenrolled from the Medicaid Program without causing the approval for the beds to be revoked after 120 days.

Adult Day Health Care (ADHC)—provides services five or more hours a day (not to exceed five days per week) for medical, nursing, social, care management, and personal care needs to adults who are functionally impaired.

Adult Day Health Care Provider—any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any other group, wherein two or more functionally impaired adults who are not related to the owner or operator of such agency are provided with adult day health care services.

Adult Residential Care Provider (ARCP)—a facility, agency, institution, society, corporation, partnership, company entity, residence, person or persons, or any other group which provides adult residential care services for compensation for two or more adults who are unrelated to the licensee or operator. Adult residential care includes, but is not limited to the following services: lodging, meals, medication administration, intermittent nursing service, and assistance with personal hygiene, assistance with transfers and ambulation, assistance with dressing, housekeeping and laundry.

Applicant—the person who is developing the proposal for purposes of enrolling the facility, units and/or beds in the Medicaid Program. See the definition of *Person*.

Applicant Representative—the person specified by the applicant on the application form to whom written notifications are sent relative to the status of the application during the review process.

Approval—a determination by the department that an application meets the criteria of the Facility Need Review (FNR) Program for purposes of participating in the Medicaid Program or a determination by the department that an application meets the criteria of the FNR Program for purposes of being licensed by the department.

Approved—beds and/or facilities which are grandfathered in accordance with the grandfather provisions of this program and/or beds approved in accordance with the Facility Need Review Program.

CMS—Centers for Medicare and Medicaid Services.

Community Home—a type of community residential facility which has a capacity of eight or fewer beds.

Department—the Department of Health and Hospitals in the state of Louisiana.

Department of Health and Hospitals (DHH)—the agency responsible for administering the Medicaid Program in Louisiana.

Disapproval—a determination by the department that a proposal does not meet the criteria of the Facility Need Review Program and that the proposed facility, beds or units may not participate in the Medicaid Program.

Emergency Community Home Bed Pool—a pool consisting of approved beds which have been transferred from state developmental centers and which are made available for transfer to non state-operated community homes in order to address emergency situations on a case-by-case basis.

Enrollment in Medicaid—execution of a provider agreement with respect to reimbursement for services provided to Title XIX eligibles.

Facility Need Review (FNR)—a review conducted for nursing facility beds (including skilled beds, IC-I and IC-II beds), intermediate care facility for the developmentally disabled beds, and adult residential care units to determine whether there is a need for additional beds to enroll and participate in the Medicaid Program.

Group Home—a type of community residential facility which has a capacity of nine to 15 beds.

Health Standards Section—the section in the Bureau of Health Services Financing which is responsible for licensing health care facilities and agencies, certifying those facilities and agencies that are applying for participation in the Medicaid (Title XIX) and Medicare (Title XVIII) Programs, and conducting surveys and inspections.

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, or supervised independent living (SIL) services, or any combination of services thereof, including respite providers, SIL providers, and PCA providers.

Hospital Service District—a political subdivision of the state of Louisiana created or authorized pursuant to R.S. 46:1051 et seq.

Intermediate Care-Level I (IC-I)—a level of care within a nursing facility which provides basic nursing services under the direction of a physician to persons who require a lesser degree of care than skilled services, but who need care and services beyond the level of room and board. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day.

Intermediate Care-Level II (IC-II)—a level of care within a nursing facility which provides supervised personal care and health related services, under the direction of a

physician, to persons who need nursing supervision in addition to help with personal care needs. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day.

Intermediate Care Facility for the Developmentally Disabled (ICF-DD)—a facility which provides developmentally disabled residents with professionally developed individual plans of care, supervision, and therapy in order to attain or maintain optimal functioning.

Legal Device—any legally binding instrument, such as a counter letter, made during the period a Notice of Abeyance is in effect, which would affect the transfer of disenrolled beds.

Notice of Abeyance—a written notice issued by the department to a nursing facility stating that the criteria for placing all of the facility's approved beds in abeyance have been met.

Medicaid Program—the medical assistance program administered in accordance with Title XIX of the Social Security Act.

Notification—is deemed to be given on the date on which a decision is mailed by the Facility Need Review Program or a hearing officer.

Nursing Facility—an institution which is primarily engaged in providing the following services to residents and has in effect a transfer agreement with one or more hospitals:

- a. skilled nursing care and related services for residents who require medical or nursing care;
- b. rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- c. on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities; said institutional facilities are those facilities which are not primarily for the care of mental diseases.

Person—an individual or other legal entity.

Program—the Facility Need Review Program.

Review Period—the period of time in which the review is conducted.

Secretary—the secretary of the Department of Health and Hospitals.

Skilled Nursing Care—a level of care within a nursing facility which provides intensive, frequent, and comprehensive nursing care and/or rehabilitation services ordered by and under the direction of a physician. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day. Skilled beds are located in nursing facilities and in "distinct parts" of acute care hospitals.

a. Facility Need Review policies governing skilled beds in nursing facilities also apply to Title XIX skilled beds in hospitals. In order to be enrolled to participate in Title XIX, skilled beds in hospitals must be approved through Facility Need Review. Skilled care is also referred to as "extended care".

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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).

§12503. General Information

A. The Department of Health and Hospitals will conduct a facility need review (FNR) to determine if there is a need for additional facilities, beds or units to enroll to participate in the Title XIX Program for the following facility types:

1. nursing facilities;
2. skilled nursing facilities; and
3. intermediate care facilities for persons with developmental disabilities.

B. 42 CFR Part 442.12(d) allows the Medicaid agency to refuse to execute a provider agreement if adequate documentation showing good cause for such refusal has been compiled (i.e., when sufficient beds are available to serve the Title XIX population). The Facility Need Review Program will review applications for additional beds, units and/or facilities to determine whether good cause exists to deny participation in the Title XIX Program to prospective providers of those services subject to the FNR process.

C. The department will also conduct a FNR for the following provider types to determine if there is a need to license additional units, providers or facilities:

1. adult residential care providers or facilities;
2. home and community-based service providers, as defined under this Chapter; and
3. adult day health care providers.

D. The department shall be responsible for reviewing proposals for facilities, beds, units and agencies submitted by health care providers seeking to be licensed or to participate in the Medicaid Program. The secretary or his designee shall issue a decision of approval or disapproval.

1. The duties of the department under this program include, but are not limited to:

- a. determining the applicability of these provisions to all requests for approval to enroll facilities, beds, or units in the Medicaid Program or to license facilities, units, providers or agencies;

b. reviewing, determining and issuing approvals or disapprovals for proposals determined to be subject to these provisions;

c. adopting and promulgating such rules and regulations as may be necessary to implement the provisions of this program pursuant to the Administrative Procedure Act; and

d. defining the appropriate methodology for the collection of data necessary for the administration of the program.

E. No nursing facility, skilled nursing facility, or ICF-DD bed, nor provider units/beds shall be enrolled in the Title XIX Program unless the bed has been approved through the FNR Program. No adult residential care provider, home and community-based services provider or adult day health care provider may be licensed by the department unless the facility, unit or agency has been approved through the FNR Program.

F. Grandfather Provision. An approval shall be deemed to have been granted under this program without review for NFs, ICFs-DD and/or beds that meet one of the following descriptions:

1. all valid Section 1122 approved health care facilities/beds;
2. all valid approvals for health care facilities/beds issued under the Medicaid Capital Expenditure Review Program prior to the effective date of this program;
3. all valid approvals for health care facilities issued under the Facility Need Review Program; or
4. all nursing facility beds which were enrolled in Medicaid as of January 20, 1991.

G. Additional Grandfather Provision. An approval shall be deemed to have been granted under FNR without review for HCBS providers, ICFs-DD and ADHC providers that meet one of the following conditions:

1. HCBS providers which were licensed by January 31, 2009 or had a completed initial licensing application submitted to the department by June 30, 2008;
2. existing licensed ICFs-DD that are converting to the proposed Residential Options Waiver; or
3. ADHC providers who were licensed as of December 31, 2009 or who had a completed initial licensing application submitted to the department by December 31, 2009, or who are enrolled or will enroll in the Louisiana Medicaid Program solely as a Program for All-Inclusive Care for the Elderly provider.

H. Exemptions from the facility need review process shall be made for:

1. a nursing facility which needs to be replaced as a result of destruction by fire or a natural disaster, such as a hurricane; or

2. a nursing facility and/or facility building owned by a government agency which is replaced due to a potential health hazard.

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HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), amended LR 35:2437 (November 2009), LR 36:323 (February 2010).

§12505. Application and Review Process

A. FNR applications shall be submitted to the Bureau of Health Services Financing, Health Standards Section, Facility Need Review Program. Application shall be submitted on the forms (on 8.5 inch by 11 inch paper) provided for that purpose, contain such information as the department may require, and be accompanied by a nonrefundable fee of \$10 per bed or unit for nursing facilities, ICFs-DD and adult residential care providers. The nonrefundable application fee for an HCBS provider (other than an adult residential care provider) and an ADHC provider shall be a flat fee of \$150. An original and three copies of the application are required for submission.

1. Application forms may be requested in writing or by telephone from the FNR Program. The FNR Program will provide application forms, inventories, utilization data, and other materials relevant to the type of application.

2. The applicant representative specified on the application will be the only person to whom the FNR Program will send written notification in matters relative to the status of the application during the review process. If the applicant representative or his address changes at any time during the review process, the applicant shall notify the FNR Program in writing.

3. A prospective ARCP applicant shall submit the following documents as part of the application:

- a. certification of the number and ratio of Medicaid approved nursing facility beds that will be converted to ARC units;
- b. a letter of intent that includes the location of the proposed ARC site and the proposed date of opening;
- d. certification that the applicant will provide services as defined in the statute; and
- e. certification which includes the following:
 - i. that the applicant has reviewed the licensing regulations and will comply with the licensing regulation; and
 - ii. acknowledgement that failure to meet the time-frames established in this Chapter will result in automatic expiration of the FNR approval for the ARCP units.

B. The review period will be no more than 60 days, except as noted in the case of issuance of a request for proposals (RFP). The review period begins on the first day after the date of receipt of the application, or, in the case of issuance of an RFP, on the first day after the period specified in the RFP.

1. A longer review period will be permitted only when initiated by the Facility Need Review Program. A maximum of 30 days will be allowed for an extension, except as otherwise noted for the issuance of a RFP.

2. An applicant may not request an extension of the review period, but may withdraw an application (in writing) at any time prior to the notification of the decision by the FNR Program.

a. The application fee is non-refundable.

3. The FNR Program shall review the application within the specified time limits and provide written notification of the decision to the applicant representative.

a. Notification of disapproval shall be sent by certified mail to the applicant representative, with reasons for disapproval specified.

b. If notification is not sent by the sixtieth day, except as noted in the case of issuance of a RFP, the application is automatically denied.

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HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:812 (August 1995), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), , amended LR 35:2438 (November 2009), LR 36:323 (February 2010).

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

§12507. Intermediate Care Facilities for the Developmentally Disabled

A. The service area for a proposed or existing facility is designated as the department's administrative region in which the facility or proposed facility is or will be located. The administrative regions and the parishes which comprise these regions are as follows:

1. Region I: Jefferson, Orleans, Plaquemines, and St. Bernard;

2. Region II: Ascension, East Baton Rouge, East Feliciana, Iberville, Pointe Coupee, West Baton Rouge, and West Feliciana;

3. Region III: Assumption, Lafourche, St. Charles, St. James, St. John, St. Mary, and Terrebonne;

4. Region IV: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, and Vermilion;

5. Region V: Allen, Beauregard, Calcasieu, Cameron, and Jefferson Davis;

6. Region VI: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, and Winn;

7. Region VII: Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster;

8. Region VIII: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, and West Carroll; and

9. Region IX: Livingston, St. Helena, St. Tammany, Tangipahoa, and Washington.

B. The beds and population of the service area where the facility is located, or is proposed to be located, will be considered in determining the need for the facility or additional beds. The beds that are counted in determining the need for community and group homes are approved, licensed beds and approved, unlicensed beds as of the due date for a decision on an application.

C. Data sources utilized include information compiled by the FNR Program and the middle population projections recognized by the State Planning Office as official projections. The population projections utilized are those for the year in which the beds are to be enrolled in the Medicaid Program.

D. In accordance with the department's policy of least restrictive environment, there is currently no identified need for additional facilities with 16 or more beds. Therefore, applications for facilities of 16 or more beds shall not be accepted for review, and applications to increase existing facilities to 16 or more beds shall not be accepted for review.

E. At the present time, the recommended bed-to-population ratio for community and group homes has been achieved. However, special needs and circumstances may arise which the department may consider as indicators of need for additional beds such as occupancy rates, availability and accessibility of clients in need of placements, patient origin studies, and requests for special types of beds or services.

1. For service areas in which average annual occupancy for the four most recent quarters (as reported in the MR-2) is in excess of 93 percent, the department may review the census data, utilization trends, and other factors described in of this section to determine if additional beds are needed.

F. If the department determines that there is a need for beds in a parish with an average annual occupancy in excess of 93 percent, a Request for Proposals (RFP) will be issued. No applications will be accepted under these provisions unless the Department declares a need and issues a RFP. Applications will be accepted for expansion of existing facilities and/or for the development of new facilities.

1. The RFP will indicate the region in need of beds, the number of beds needed, the date by which the beds are to be available to the target population (enrolled in Medicaid),

and the factors which the department considers relevant in determining the need for the additional beds.

2. The RFP will specify the MR-2 on which the determination of need is based.

3. The RFP will be issued through newspaper publication and will specify the dates during which the department will accept applications.

4. Applications will be accepted for a period to be specified in the RFP. Once submitted, an application cannot be changed and additional information will not be accepted.

G. The department will review the proposals and independently evaluate and assign points to each of the following 10 items on the application for the quality and adequacy of the response to meet the need of the project:

1. work plan for Medicaid certification;
2. availability of the site for the proposal;
3. relationship or cooperative agreements with other health care providers;
4. accessibility to other health care providers;
5. availability of funds; financial viability;
6. experience and availability of key personnel;
7. range of services, organization of services and program design;
8. methods to achieve community integration;
9. methods to enhance and assure quality of life; and
10. plan to ensure client rights, maximize client choice and family involvement.

H. A score of 0-20 will be given to the applicant's response to each item using the following guideline:

1. 0 = inadequate response;
2. 5 = marginal response;
3. 10 = satisfactory response;
4. 15 = above average response; and
5. 20 = outstanding response.

I. In the case of a tie for the highest score for a specific facility or additional beds, the department will conduct a comparative review of the top scoring proposals which will include prior compliance history. The department will make a decision to approve one of the top scoring applications based on the comparative review of the proposals.

J. If no proposals are received which adequately respond to the need, the department may opt not to approve an application.

K. At the end of the 90-day review period, each applicant will be notified of the department's decision to approve or disapprove the application. However, the evaluation period may be extended for up to 60 days. Applicants will be given

30 days from the date of receipt of the notification by the department in which to file an appeal.

1. The issuance of the approval of the proposal with the highest number of points shall be suspended during the 30-day period for filing appeals and during the pendency of any administrative appeal. All administrative appeals shall be consolidated for purposes of the hearing.

L. Proposals approved under these provisions are bound to the description in the application with regard to type of beds and/or services proposed as well as to the location as defined in the RFP issued by the department.

1. Approval for Medicaid shall be revoked if these aspects of the proposal are altered.

2. Beds to meet a specific disability need approved through this exception must be used to meet the need identified.

M. Prior approval from the Office for Citizens with Developmental Disabilities is required before admission of all Medicaid recipients to facilities in beds approved to meet a specific disability need identified in a RFP issued by the department.

N. Exception for approved beds in downsizing large residential ICF-DD facilities (16 or more beds).

1. A facility with 16 or more beds which voluntarily downsizes its enrolled bed capacity in order to establish a group or community home will be exempt from the bed need criteria.

a. Beds in group and community homes which are approved under this exception are not included in the bed-to-population ratio or occupancy data for group and community homes approved under the FNR Program.

2. Any enrolled beds in the large facility will be disenrolled from the Title XIX Program upon enrollment of the same number of group or community home beds.

3. When the department intends to downsize the enrolled bed capacity of a state-owned facility with 16 or more beds in order to develop one or more group or community homes, and the approved beds will be owned by the state, a cooperative endeavor agreement (CEA) will be issued.

a. The CEA will be issued and beds shall be made available in accordance with the methods described in this Section;

4. For private facility beds downsized to privately owned group or community homes, these facilities should contact the regional Office for Citizens with Developmental Disabilities in the region where the proposed community or group home beds will be located. These proposals do not require facility need review approval.

O. Exception for Additional Beds for Certain ICFs-DD

1. Any ICF-DD which serves children or adults suffering from mental retardation, autism or behavioral problems and which had no less than 150 and no more than

180 approved beds as of August 15, 2003, shall, upon application to the department, be granted approval for up to 50 additional beds without being required to meet the standards set forth in this Section, §12505 or §12527.B.

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), amended LR 34:2613 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:2279 (October 2010).

§12509. Emergency Community Home Bed Pool Exception

A. The emergency community home bed pool consists of all Medicaid enrolled beds which have been authorized to be transferred from state developmental centers to non state-operated community homes on or before June 30, 2002 in order to address emergency situations on a case-by-case basis.

B. Effective July 1, 2002, the secretary of the department may not authorize the transfer of any beds from the emergency community home bed pool to a non-state operated community home unless the bed had been authorized to be transferred to a non state operated community home on or before June 30, 2002 and was subsequently transferred from that facility back to the pool pursuant to the provisions of this Section.

C. Emergency situations which may be addressed through the use of the emergency community home bed pool shall include, but not be limited to situations in which it is difficult or impossible to find a placement for an individual in an ICF-DD because of one of the following:

1. an inadequate number of available ICF-DD beds in the service area to serve the needs of the developmentally disabled population in general;
2. an inadequate number of available ICF-DD beds in the service area to serve the needs of the developmentally disabled population who also have physical or behavioral disabilities or difficulties; or
3. an inadequate number of available ICF-DD beds in the service area to provide for the transition of individuals from residing in large residential facilities to residing within the community.

D. Any agency or individual who becomes aware of an actual or potential emergency situation should contact the Office for Citizens with Developmental Disabilities (OCDD). OCDD shall submit its recommendations to the Facility Need Review Program for emergency placement. OCDD's recommendations shall include:

1. identification of the individual in need of emergency placement,
2. the individual's needs,

3. the service area in which transfer from the Emergency Community Home Bed Pool is requested, and

4. the names of one or more existing community homes that would be appropriate for the emergency placement.

E. To be eligible for transfer of one or more beds from the emergency community home bed pool, a community home must meet the following requirements, based on documentation provided by the Health Standards Section.

1. The facility must comply with the physical accessibility requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973; or if it does not comply with those requirements, it must have a written plan to be in compliance within 24 months.

2. The facility cannot have been on a termination track or have had any repeat deficiencies within the last 12 months.

3. The facility must meet all square footage requirements, *Life Safety Code* requirements and general construction requirements of 42 CFR Subpart I, Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded, as well as LAC 50:VII.Chapter 301 and LAC 48:I.Chapters 51, 63 and 79.

4. The facility must ensure the provision of sufficient staffing and behavior modification plans to meet the needs of current residents and prevent those residents from being adversely affected by the emergency admission.

F. The secretary shall authorize the transfer of the bed for use at the non state-operated community home. Upon the enrollment of the transferred bed at that community home, the bed shall be permanently transferred to that facility subject to the following conditions.

1. Once the bed is no longer needed to remedy the emergency situation, the facility shall continue to make it available for subsequent emergency placements. However, it may be used temporarily to serve other individuals until it is needed for a new emergency placement.

2. The facility shall make the bed available for a new emergency placement within 72 hours after receiving a request for such placement from the department as set forth herein. If the facility does not comply with such a request, the secretary may, at his discretion, transfer the bed from the facility back to the emergency community home bed pool.

G. Beds which have been placed in the emergency community home bed pool shall be exempt from the bed need criteria and the requirements for requests for proposals which are normally applicable to ICFs-DD.

H. For purposes of the emergency community home bed pool exception, the definition of a service area provided in §12507.A is applicable.

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

HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary,

Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), LR 34:2614 (December 2008).

§12511. Nursing Facilities

A. The service area for proposed or existing nursing facilities or beds is the parish in which the site is located. Exceptions are the parishes of Ascension, Iberville, Plaquemines and St. John, each of which is composed of two separate service areas as divided by the Mississippi River.

B. Nursing facility beds located in "distinct parts" of acute care general hospitals must be approved through FNR in order to be enrolled to participate in the Medicaid Program.

C. In reviewing the need for beds, all proposed beds shall be considered available as of the projected date of the project. The FNR Program does not recognize the concept of "phasing-in" beds, whereby an applicant provides two or more opening dates.

D. For reviews in which the bed to population ratio is a factor, the bed inventory which will be used is that which is current on the date on which the complete application is received.

1. The bed to population ratio will be recomputed during the review period when the report is incorrect due to an error by the department.

E. For reviews in which utilization is a factor, the occupancy report which will be used is that which is current on the date on which the complete application is received.

1. The occupancy rate will be recomputed during the review period when the report is incorrect due to an error by the department.

F. In determining occupancy rates of nursing facilities or beds:

1. beds for which occupancy shall be based shall include nursing facility beds (skilled, IC-I and IC- II) which are enrolled in Title XIX;

2. each licensed bed shall be considered as available for utilization for purposes of calculating occupancy; and

3. a bed shall be considered in use, regardless of physical occupancy, based on payment for nursing services available or provided to any individual or payer through formal or informal agreement.

G. The beds and population of the service area where the facility is located, or is proposed to be located, will be considered in determining need for the facility or beds.

1. The beds which are counted in determining need for nursing facilities or beds are approved, licensed beds and approved, unlicensed beds as of the due date for decision on an application.

H. Data sources to be used include information compiled by the FNR Program and the middle population projections recognized by the State Planning Office as official projections. Population projections to be used are those for

the year in which the beds are to be enrolled in the Medicaid Program.

I. In order for additional beds or facilities to be added in a service area, the bed-to-population ratio for nursing facility beds shall not exceed 65 Medicaid approved beds per 1,000 elderly population in a service area, and the average annual occupancy for the four most recent quarters (as reported in the LTC-2) shall exceed 95 percent in the service area.

J. Exceptions for areas with high occupancy rates may be considered in the following situations.

1. A Medicaid enrolled nursing facility which maintains 98 percent average annual occupancy of its enrolled beds for the four most recent quarters (as reported in the LTC-2) may apply for approval of additional beds to be enrolled in the Medicaid Program.

a. In order for an application to be considered, all approved beds in the facility must be enrolled in Title XIX.

b. In order for a facility to reapply for additional beds, all approved beds must be enrolled in Title XIX for the four most recent quarters, as reported in the LTC-2.

c. The number of beds for which application may be made shall not exceed 10 beds.

d. In determining occupancy rates for purposes of this exception, only an adjustment of one additional day after the date of death, for the removal of personal belongings, shall be allowed if used for that purpose.

i. This adjustment shall not be allowed if nursing services available or provided to another individual are paid for through formal or informal agreement in the same bed for that time period.

e. In determining occupancy rates, more than one nursing facility bed enrolled in Title XIX shall not be considered occupied by the same resident, regardless of payment for nursing services available or provided.

f. For a Medicaid enrolled nursing facility with high occupancy to apply for additional bed approval, documentation of availability of health manpower for the proposed expansion shall be required.

g. For a Medicaid enrolled nursing facility with high occupancy to apply for additional bed approval, for the most recent 36 months preceding the date of application, compliance history and quality of care performance of the applicant facility must be void of any of the following sanctions:

i. appointment of a temporary manager;

ii. termination, non-renewal or cancellation, or initiation of termination or non-renewal of provider agreement; or

iii. license revocation or non-renewal.

2. When average annual occupancy for the four most recent quarters (as reported in the LTC-2) exceeds 95 percent in a parish, the department will determine whether additional

beds are needed, and if indicated, may issue a Request for Proposals (RFP) to develop the needed beds.

a. Upon issuance of the utilization report, the department will identify the parishes with average annual occupancy in excess of 95 percent. The LTC-2 is issued by the department in the fourth month following the end of each calendar quarter.

b. In order to determine if additional beds are needed for each parish in which average annual occupancy is in excess of 95 percent, the department may review the census data, utilization trends, and other factors such as:

- i. special needs in an area;
- ii. information received from other health care providers and other knowledgeable sources in the area;
- iii. waiting lists in existing facilities;
- iv. requests from the community;
- v. patient origin studies;
- vi. appropriateness of placements in an area;
- vii. remoteness of an area;
- viii. occupancy rates in adjoining and/or adjacent parishes;
- ix. availability of alternatives;
- x. reasonableness of distance to facilities;
- xi. distribution of beds within a service area or geographical area; and
- xii. such other factors as the department may deem relevant.

c. The number of beds which can be added shall not exceed 15 percent of the existing approved beds in the parish, or 120 beds, whichever is less. The department will strive to assure that occupancy in existing facilities in the area will not decline below 85 percent as a result of the additional beds;

3. If the department determines that there is, in fact, a need for beds in a parish with average annual occupancy in excess of 95 percent, a RFP will be issued. No applications will be accepted under these provisions unless the department declares a need and issues a RFP. Applications will be accepted for expansions of existing facilities and/or for the development of new facilities.

a. The RFP will be issued through newspaper publication, and will specify the dates during which the department will accept applications. Also, nursing facilities in the service area and adjoining parishes will be notified of the issuance of the RFP.

b. The RFP will indicate the parish and/or area in need of beds, the number of beds needed, the date by which the beds are needed to be available to the target population (enrolled in Medicaid), and the factors which the department considers relevant in determining need for the additional

beds. The RFP will specify the LTC-2 on which the determination of need is based.

c. Applications will be accepted for a 30-day period, to be specified in the RFP. Once submitted, an application cannot be changed and additional information will not be accepted.

d. The department will review the proposals and independently evaluate and assign points (out of a possible 120) to the applications as follows:

i. 0-20 points: Availability of beds to the Title XIX population.

NOTE: Work plan for Medicaid certification and availability of site for the proposal.

ii. 0-20 points: Appropriateness of location, or proposed location.

NOTE: Accessibility to target population, relationship or cooperative agreements with other health care providers, and distance to other health care providers.

iii. 0-20 points: Responsiveness to groups with special needs (e.g. AIDS patients, ventilator assisted patients; technology dependent patients);

iv. 0-20 points: Experience and availability of key personnel (e. g., director of nursing, administrator, medical director);

v. 0-20 points: Distribution of beds/facilities within the service area. Geographic distribution of existing beds and population density will be taken into account.

e. A score of 0-20 will be given to the applicant's response to each item using the following guideline:

- i. 0 = inadequate response;
- ii. 5 = marginal response;
- iii. 10 = satisfactory response;
- iv. 15 = above average response; and
- v. 20 = outstanding response.

f. If there is a tie for highest score for a specific facility or beds, a comparative review of the top scoring proposals will be conducted. In the case of a tie, the department will make a decision to approve one of the top scoring applications based on comparative review of the proposals.

g. If no proposals are received which adequately respond to the need, the department may opt not to approve an application.

h. At the end of the 60-day review period, each applicant will be notified of the department's decision to approve or disapprove the application. However, the department may extend the evaluation period for up to 30 days. Applicants will be given 30 days from the date of receipt of the department's notification by in which to file an appeal.

i. The issuance of the approval of the application with the highest number of points shall be suspended during the 30-day period for filing appeals and during the pendency of any administrative appeal. All administrative appeals shall be consolidated for purposes of the hearing.

4. Proposals submitted under these provisions are bound to the description in the application with regard to the type of beds and/or services proposed as well as to the site/location as defined in the request issued by the department.

a. Approval for Medicaid certification shall be revoked if these aspects of the proposal are altered.

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

HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), LR 34:2615 (December 2008).

§12513. Alternate Use of Licensed Approved Title XIX Beds

A. In a service area in which average annual occupancy is lower than 93 percent, a nursing home may elect to temporarily convert a number of Title XIX beds to an alternate use (e.g., adult day care).

1. The beds may be converted for alternate use until such time as the average annual occupancy in the service area exceeds 93 percent (based on the LTC-2 report) and the facility is notified of the same.

2. The facility shall then either re-enroll the beds as nursing home beds within one year of receipt of notice from the department that the average annual occupancy in the service area exceeds 93 percent.

3. The approval for beds not re-enrolled by that time will be expired.

B. A facility is prohibited from adding beds when alternately using beds.

C. All approved beds must be enrolled as nursing home beds in Title XIX for the four most recent quarters, as reported in the department's occupancy report, in order for additional beds to be approved.

D. A total conversion of all beds is prohibited.

E. A nursing facility that has converted beds to alternate use may elect to remove the beds from alternate use and re-license and re-enroll the beds as nursing facility beds. The facility has 120 days from removal from alternate use to re-license and re-enroll the beds. Failure to re-license and re-enroll the beds within 120 days will result in the automatic expiration of FNR approval.

F. The nursing facility beds converted to alternate use shall be used solely for the purpose of providing health care services at a licensed and/or certified facility.

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

HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2617 (December 2008), amended LR 35:2438 (November 2009).

§12515. Additional Beds for Replacement Facility

A. A nursing facility that has had all approved beds enrolled for the four most recent quarters (as reported in the LTC-2) and is structurally older than 25 years, may apply for approval for additional beds to be enrolled in the Medicaid Program in a replacement facility.

B. The number of beds for which an application may be made shall not exceed 20 beds, with the following exception:

1. a facility may be approved for sufficient beds to bring the total approved beds in the replacement facility to 80.

C. A facility shall not be approved for beds that would exceed 130 total approved beds in the replacement facility.

D. Sufficient documentation must be submitted to demonstrate to the department's satisfaction that the facility is structurally older than 25 years.

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

HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), LR 34:2617 (December 2008).

§12517. Adult Residential Care Provider

A. The FNR Program will determine the number of adult residential care provider (ARCP) units to be licensed by the department. No ARCP unit shall be licensed to operate unless the FNR Program has granted an approval for the licensed ARCP unit. Once the FNR Program approval is granted, the unit is then eligible to be licensed by the department, subject to meeting all the requirements for licensure.

1. An existing licensed nursing facility that converts Medicaid approved nursing facility beds to ARCP units shall be automatically granted FNR approval for the converted units. The nursing home must submit an application to the department requesting the approval. The application must detail the Medicaid approved nursing home beds being converted.

B. The service area for proposed or existing adult residential care units is the parish in which the units are to be located. Exceptions are the parishes of Ascension, Iberville, Plaquemines and St. John, each of which is composed of two separate service areas divided by the Mississippi River.

C. Determination of Need Methodology

1. Population Based Methodology. The FNR Program methodology projects the need for ARCP units to be 15 units per 1,000 persons who are 65 years old and older for each

service area. The approved unit to population ratio for ARCP shall not exceed 15 units per 1000 persons who are 65 years old and older except as provided for in paragraph three.

2. The need for facilities will be projected five years forward using the most recent census data available from the Louisiana State Division of Administration.

3. Approval for additional units or facilities may be granted by the department if the service area's average annual occupancy for the four most recent quarters exceeds 98 percent. Approval for additional units in new or existing ARCP facilities shall be granted in increments not to exceed 20 units.

D. ARCP facilities that have approval for licensed units shall submit quarterly reports to the DHH Office of Aging and Adult Services (OAAS). The report shall contain the facility's patient/resident days and such other information as determined by OAAS.

E. Applications for approvals of licensed units submitted under these provisions are bound to the description in the application with regard to the type of units and/or services proposed as well as to the site/location as defined in the application. FNR approval of licensed units shall expire if these aspects of the application are altered.

F. FNR approvals for licensed units are non-transferable. Approvals for licensed units are limited to location and name of original licensee.

1. No portion of the units may be transferred to another party or moved to another location without the submission of a new application to and approval by the department's FNR Program. Approval of licensed units shall automatically expire if moved or transferred without application to and approval by the FNR Program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:2617 (December 2008).

§12519. Conversion of Medicaid Approved Nursing Facility Beds to Adult Residential Care Provider Units

A. Existing licensed nursing facilities that convert Medicaid approved beds to ARCP units will be automatically granted FNR approval of licensed ARCP units, upon submission of a completed application to the FNR Program.

B. Existing licensed nursing homes shall convert Medicaid approved beds to ARC units on a ratio of four Medicaid approved nursing facility beds for each approved ARCP unit if the existing nursing home facility structure is utilized.

1. Nursing facilities that build new ARC buildings shall surrender two Medicaid approved beds for each approved ARCP unit. The license for any such converted nursing facility bed is surrendered at the date of conversion.

C. Conversion of nursing facility beds to ARCP units is irrevocable and units so converted may not be returned to nursing facility service, except in the case of a gubernatorial or presidential declaration of emergency or natural disaster.

1. In the case of an emergency or natural disaster, the nursing home use shall be temporary, not to exceed six months.

D. Conversion Requirements

1. A nursing facility that utilizes the existing facility structure to convert Medicaid approved beds to ARCP units will have the square footage associated with those converted beds removed from its nursing facility fair rental value calculation.

2. If a nursing facility which constructs a new ARC building certifies that it will utilize the space associated with the converted beds for other nursing facility use, then nursing facility will not have the square footage associated with those converted beds removed from its nursing facility fair rental value calculation.

a. If a nursing home which constructs a new ARC building utilizes the converted space for any purposes other than nursing facility services associated with the remaining licensed beds in the facility, then the nursing facility will have the square footage associated with those converted beds removed from its nursing facility fair rental value calculation.

3. Beds forfeited for purposes of ARC units cannot simultaneously be utilized to convert semi-private rooms to private rooms or be used for any other separate benefits in the rate methodology.

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 34:2618 (December 2008).

§12521. Architectural and Licensing Compliance

A. The following time frames shall apply for complying with the requirements for obtaining approval of architectural plans and licensure.

1. ARCP units which are converted from Medicaid approved beds in existing nursing facilities shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within one year from the date of the FNR approval.

2. ARCP units which are converted from Medicaid approved nursing facility beds in new facilities shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

3. ARCP units which are to be licensed in existing adult residential facilities shall have final architectural plans approved no later than six months from the date of the FNR

approval. Such units shall be licensed within one year from the date of the FNR approval.

4. ARCP units which are to be licensed in new adult residential facilities shall have final architectural plans approved no later than six months from the date of the FNR approval. Such units shall be licensed within 24 months from the date of the FNR approval.

B. A one-time 90 day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant. Inappropriate zoning is not a basis for extension.

C. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the ARCP units.

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 34:2618 (December 2008).

§12523. Home and Community-Based Service Providers

A. No HCBS provider shall be licensed to operate unless the FNR Program has granted an approval for the issuance of an HCBS provider license. Once the FNR Program approval is granted, an HCBS provider is eligible to be licensed by the department, subject to meeting all of the requirements for licensure.

B. The service area for proposed or existing HCBS providers is the DHH region in which the provider is or will be licensed.

C. Determination of Need/Approval

1. The department will review the application to determine if there is a need for an additional HCBS provider in the geographic location for which the application is submitted.

2. The department shall grant FNR approval only if the FNR application, the data contained in the application, and other evidence effectively establishes the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed.

3. In reviewing the application, the department may consider, but is not limited to, evidence showing:

a. the number of other HCBS providers in the same geographic location and region servicing the same population; and

b. allegations involving issues of access to health care and services.

4. The burden is on the applicant to provide data and evidence to effectively establish the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed. The department shall not grant any FNR approvals if the application fails to provide such data and evidence.

D. Applications for approvals of licensed providers submitted under these provisions are bound to the description in the application with regard to the type of services proposed as well as to the site and location as defined in the application. FNR approval of licensed providers shall expire if these aspects of the application are altered or changed.

E. FNR approvals for licensed providers are non-transferrable and are limited to the location and the name of the original licensee.

1. An HCBS provider undergoing a change of location in the same licensed region shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. An HCBS provider undergoing a change of location outside of the licensed region shall submit a new FNR application and fee and undergo the FNR approval process.

2. An HCBS provider undergoing a change of ownership shall submit a new application to the department's FNR Program. FNR approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, which must show the seller's or transferor's intent to relinquish the FNR approval.

3. FNR Approval of a licensed provider shall automatically expire if the provider is moved or transferred to another party, entity or location without application to and approval by the FNR program.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2438 (November 2009).

§12525. Adult Day Health Care Providers

A. No ADHC provider shall be licensed to operate unless the FNR Program has granted an approval for the issuance of an ADHC provider license. Once the FNR Program approval is granted, an ADHC provider is eligible to be licensed by the department, subject to meeting all of the requirements for licensure.

B. The service area for proposed or existing ADHC providers is the parish in which the ADHC provider is or will be licensed.

C. Determination of Need/Approval

1. The department will review the application to determine if there is a need for an additional ADHC provider in the geographic location for which the application is submitted.

2. The department shall grant FNR approval only if the FNR application, the data contained in the application, and other evidence effectively establishes the probability of serious, adverse consequences to recipients' ability to access adult day health care if the ADHC provider is not allowed to be licensed.

3. In reviewing the application, the department may consider, but is not limited to, evidence showing:

a. the number of other AHDC providers in the same geographic location and parish servicing the same population; and

b. allegations involving issues of access to health care and services.

4. The burden is on the applicant to provide data and evidence to effectively establish the probability of serious, adverse consequences to recipients' ability to access health care if the provider is not allowed to be licensed. The department shall not grant any FNR approvals if the application fails to provide such data and evidence.

D. Applications for approvals of licensed providers submitted under these provisions are bound to the description in the application with regard to the type of services proposed as well as to the site and location as defined in the application. FNR approval of licensed ADHC providers shall expire if these aspects of the application are altered or changed.

E. FNR approvals for licensed ADHC providers are non-transferrable and are limited to the location and the name of the original licensee.

1. An ADHC provider undergoing a change of location in the same parish in which it is licensed shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. An ADHC provider undergoing a change of location outside of the parish in which it is licensed shall submit a new FNR application and fee and undergo the FNR approval process.

2. An ADHC provider undergoing a change of ownership shall submit a new application to the department's FNR Program. FNR approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, which shall show the seller's or transferor's intent to relinquish the FNR approval.

3. FNR approval of a licensed ADHC provider shall automatically expire if the ADHC provider moves or relocates, if the ADHC provider sells, transfers, or conveys ownership of the ADHC provider to another party or entity, or if the ADHC provider sells, transfers or conveys the FNR approval to another party, entity, or location, unless the ADHC provider has submitted application to and received approval from the FNR Program.

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

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

Subchapter C. Revocation of Facility Need Review Approvals

§12527. General Provisions

A. Nursing Facilities

1. Beds which are added to an existing, licensed facility must be enrolled in the Title XIX Program within one year of the date of approval by the FNR Program.

2. New nursing facilities which are approved to be constructed must be enrolled in the Title XIX Program within 24 months of the date of the approval.

3. An extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant (e.g., acts of God). Inappropriate zoning is not a basis for extension.

B. Intermediate Care Facilities for the Developmentally Disabled

1. Group and community home beds must be enrolled in the Title XIX Program within nine months of the date of approval by the Facility Need Review Program.

2. A one-time 90-day extension may be granted, at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant (e.g., acts of God). Inappropriate zoning is not a basis for an extension.

3. If the beds are not enrolled in the Title XIX program within the time limits specified in this Section, the approval will automatically expire.

C. Approval of a group or community home bed shall be revoked when the Office for Citizens with Developmental Disabilities advises that the bed, which was approved for Title XIX reimbursement to meet a specific disability need identified in a RFP issued by the department, is not being used to meet that identified need based on the facility serving a Medicaid recipient in the bed without prior approval from the OCDD.

D. Except as provided in Subchapter E and Subchapter F of this Chapter, approval shall be revoked under the following circumstances:

1. a facility's license is revoked, not renewed, or denied, unless the facility obtains a license within 120 days from the date of such revocation, nonrenewal or denial.

2. a facility's provider agreement is terminated unless, within 120 days thereof, the facility enters into a new provider agreement.

E. Except as provided in Subchapter E and Subchapter F of this Chapter, beds may not be disenrolled except as provided under the alternate use policy and during the 120-day period to have beds relicensed or recertified. The approval for beds disenrolled will automatically expire except as otherwise indicated.

F. The facility need review approval for licensed nursing facilities or ICF/DDs located in an area(s) which have been

affected by an executive order or proclamation of emergency or disaster due to Hurricanes Katrina and/or Rita, and which were operating at the time the executive order or proclamation was issued under R.S. 29:794, shall be revoked or terminated unless the nursing facility or ICF/DD re-licenses and re-enrolls its beds in the Medicaid Program within 120 days from January 1, 2010.

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), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2619 (December 2008), amended LR 35:2439 (November 2009).

Subchapter D. Relocation of Nursing Facility Beds

§12529. General Provisions

A. A nursing facility's approved beds cannot be relocated to a different service area.

B. Approved beds may be relocated in the same service area only under the following conditions.

1. Subject to the exceptions provided in Paragraphs 2 and 6, all of a nursing facility's approved beds must be relocated to a single new location.

a. The approval of any beds not relocated to that new location shall be revoked.

2. Notwithstanding the requirements of Subparagraph 1, a partial relocation of approved beds may be effected if the following conditions are met:

a. the approved beds are in a nursing facility owned by a hospital service district as of the date of adoption of this Rule and at the time of the partial relocation;

b. the partial relocation does not place the approved beds in a different service area;

c. the approved beds are relocated to the site of a currently operational hospital owned by the same or a different hospital service district.

i. If the new location is owned by a different hospital service district, the ownership of the approval of the relocated beds must be transferred to the hospital service district to which the beds are relocated; and

d. no more than 25 percent of the nursing facility's approved beds are relocated.

3. If, within five years after a partial relocation to a hospital site pursuant to Subparagraph 2, the hospital located at that site ceases operations, the relocated beds shall revert to the original facility from which they were relocated. This provision shall not apply to relocations which require a transfer of ownership of the approval of the relocated beds.

4. A hospital service district may relocate or transfer the ownership of the approval of approved beds pursuant to Subparagraph c only once.

5. Subparagraphs B.2, B.3 and B.4 are not intended to prohibit or restrict the relocation of all of the approved beds in a nursing facility by a hospital service district in accordance with Paragraph A and Subparagraph B.1.

6. The department may approve a one-time partial relocation/transfer of a nursing facility's approved beds (Medicaid bed approvals) to another operational nursing facility, provided that the following provisions are met.

a. The transferring nursing facility may relocate/transfer approved beds to another nursing facility pursuant to this subparagraph only once.

b. The transferring nursing facility may not relocate/transfer less than 10 approved beds to another nursing facility.

c. A transferring nursing facility may not relocate/transfer more than 25 percent of its approved beds to another nursing facility.

i. If the transferring nursing facility relocates/transfers more than 25 percent of its approved beds to another nursing facility, the approval of any beds not relocated to the receiving nursing facility shall be immediately revoked.

d. The approved beds relocated/transferred become approved beds of the receiving nursing facility, and the transferring nursing facility relinquishes all rights in those approved beds, but may retain licensure.

e. The relocation of approved beds is subject to the receiving facility having licensed-only capacity in order to accommodate the relocation/transfer. Under no circumstances shall a receiving nursing facility license additional beds in order to accommodate the relocated, approved beds.

f. All relocated, approved beds are subject to state and federal bed change guidelines and procedures.

g. The provisions of this rule pertaining to the splitting of facility need review approvals shall sunset in 24 months from the date of the promulgation of the final Rule and shall have no effect henceforth.

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 34:2619 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1009 (May 2010).

Subchapter E. Nursing Facility Bed Abeyance

§12531. General Provisions

A. A nursing facility may have all of its approved beds disenrolled from the Medicaid Program and placed in abeyance if the department determines that the average annual occupancy in the service area where the facility is located is less than 85 percent. The department shall base this determination on the occupancy figures contained in the most recent LTC-2 report issued by the department prior to its receipt of a written request that the facility's beds be placed in abeyance in accordance with Paragraph B of this Section.

B. In order to request that a facility's beds be placed in abeyance, all persons or entities who are the holders of the approval, the nursing facility license, and the Medicaid provider agreement must submit to the department a written request signed by each such person or entity. The written request shall:

1. specify the date (which must be no later than 120 days after the receipt of the request by the department) on which the intended closure of the facility will occur; and

2. designate an individual (referred to hereinafter as the "designated contact person") who shall serve as the contact between the party(ies) submitting the request and the department with respect to all matters involving the placing of the facility's beds in abeyance and their removal from abeyance.

- a. The written request must include the mailing address and telephone number of that person.

- b. If the designated contact person is changed, a written notice thereof, signed by each person or entity who submitted the original request, shall be given to the department.

C. If the department determines that the requirements set forth (Paragraphs A and B) have been met, it shall issue a written Notice of Abeyance and forward it to the designated contact person within 30 calendar days after its receipt of the request for abeyance, subject to the provisions of Paragraph L. If the department determines that these requirements have not been met or that the issuance of a Notice of Abeyance would conflict with Paragraph L, it shall issue a written denial and forward it to the designated contact person within 30 calendar days after its receipt of the request.

D. All of a facility's approved beds must be disenrolled from the Medicaid Program within 120 days after the designated contact person's receipt of a notice of abeyance. An extension not to exceed 90 days may be granted if extenuating circumstances warrant said extension, such as safe transfer of patients. Otherwise, the notice of abeyance will automatically expire at the end of the 120-day period.

E. All of a facility's approved beds may be disenrolled before the designated contact person's receipt of a notice of abeyance. However if he or she does not receive a notice of

abeyance within 120 days after the beds are disenrolled, the provisions of §12527. D and E will be applicable.

F. With respect to the facility's beds which are not designated to be re-enrolled as Medicaid nursing facility beds, the approval shall automatically expire after 120 days from receipt of the notice of abeyance by the designated contact person; unless the beds are re-enrolled by that date, thus rescinding the notice of abeyance.

G. A notice of abeyance shall remain in effect until the facility's beds are taken out of abeyance and are re-enrolled in Medicaid.

H. A facility's beds shall remain in abeyance until the average annual occupancy in the facility's service area, as shown in the most recent LTC-2 report, has exceeded 93 percent.

I. If the department determines that the average annual occupancy in the facility's service area, as shown in the most recent LTC-2 report, has exceeded 93 percent, it shall give written notice thereof to the designated contact person.

1. The written notice shall specify the number of the facility's approved beds which must be taken out of abeyance and re-enrolled as Medicaid nursing facility beds.

2. That number shall be determined by the department based upon the following criteria.

- a. A nursing facility with 120 or fewer enrolled beds at the time of the request may return all of its enrolled beds from abeyance.

- b. A nursing facility with 121 to 160 enrolled beds at the time of the request may return up to 80 percent of its beds from abeyance, but in no case shall it be required to return fewer than 120 beds.

- c. A nursing facility with 161 or more enrolled beds at the time of the request may return up to 75 percent of its beds from abeyance, but in no case shall it be required to return fewer than 128 beds, nor shall it be allowed to return more than 175 beds.

- d. A nursing facility may choose to return fewer beds from abeyance than are allowed by this Subparagraph and if it does so, the balance of the beds shall be disenrolled.

J. Within one year after the receipt of the written notice described in Paragraph I (or, in the case of new construction for a replacement facility, within 24 months after the receipt of such notice), the beds specified by the department must be taken out of abeyance and re-enrolled as Medicaid nursing facility beds.

1. An extension of that time may be granted at the discretion of the department, when delays are caused by circumstances beyond the control of the applicant (e.g., acts of God).

2. Inappropriate zoning is not a basis for extension.

3. If the facility's beds which are designated to be re-enrolled as Medicaid nursing facility beds are not re-enrolled

within the specified time period, the approval for those beds will automatically expire at the end of that period.

K. If, after issuing the written notice provided in Paragraph I to the designated contact person, the department determines that the requirement set forth in Paragraph H is no longer met, the obligation to place the facility's beds back in service in accordance with Paragraph J shall not be affected or negated.

L. If two or more requests to place beds in abeyance are pending at the same time, and the issuance of notices of abeyance for all of the pending requests would conflict with this Paragraph, priority shall be assigned to the requests as follows.

1. If two or more facilities are located in the same service area, a request with respect to a facility having a lower average annual occupancy rate shall have priority over a request with respect to a facility having a higher average annual occupancy rate, based on the most recent LTC-2 report issued by the department.

M. While a facility's beds are in abeyance, the ownership of the approval for those beds may not be transferred and shall not be subject to any legal device.

N. All of a facility's beds which are taken out of abeyance and re-enrolled in the Medicaid Program must remain located together in one facility, which shall be either the original facility in which they were located before being placed in abeyance or another facility located in the same service area as the original facility.

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 30:1023 (May 2004), amended LR 34:2620 (December 2008).

Subchapter F. Exception Criteria for Bed Approvals

§12533. General Provisions

A. The facility need review bed approvals for a licensed and Medicaid certified nursing facility or ICF/DD located in an area or areas which have been affected by an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 shall remain in effect and shall not be terminated, revoked or considered to have expired for a period not to exceed two years for a nursing facility and one year for an ICF/DD, following the date of such executive order or proclamation, provided that the following conditions are met:

1. the nursing facility or ICF/DD shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the nursing facility or ICF/DD has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or

proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the nursing facility or ICF/DD intends to resume operation as a nursing facility or ICF/DD in the same service area;

i. if the ICF/DD was approved through an RFP, the ICF/DD must conform to the requirements of the RFP as defined by the department; and

c. includes an attestation that the emergency or disaster is the sole causal factor in the interruption of the provision of services;

NOTE: Pursuant to these provisions, an extension of the 60-day deadline may be granted at the discretion of the department.

2. A the nursing facility or ICF/DD resumes operating as a nursing facility or ICF/DD in the same service area, within two years for a nursing facility and within one year for an ICF/DD, of the executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766; and

3. the nursing facility or ICF/DD continues to submit the required documentation and information to the department.

B. The provisions of this Section shall not apply to:

1. a nursing facility or ICF/DD which has voluntarily surrendered its facility need review bed approval; or

2. a nursing facility or ICF/DD which fails to resume operations as a nursing facility or ICF/DD in the same service area, within two years for a nursing facility and within one year for an ICF/DD, of the executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 or R.S. 29:766.

C. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the facility need review bed approvals.

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

HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary, LR 21:812 (August 1995), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2621 (December 2008), amended LR 35:2439 (November 2009).

Subchapter G. Administrative Appeals

§12541. Appeal Procedures

A. Administrative appeal hearings shall be conducted pursuant to the Administrative Procedures Act.

B. An applicant may request an administrative hearing within 30 calendar days after receipt of the department's notice of denial of facility need review.

1. The request for an administrative hearing must be made in writing to the department's Bureau of Appeals.

2. The request must contain a statement setting forth the specific reason with which the applicant disagrees and the reasons for the disagreement.

3. Unless a timely and proper request is received by the Bureau of Appeals, the findings of the department shall be considered a final and binding administrative determination.

4. The request shall be considered timely if it is postmarked by the 30th calendar day after receipt of the department's notice of denial.

5. A fee of \$500 must accompany a request for an appeal.

C. When an administrative hearing is scheduled, the Bureau of Appeals shall notify the applicant in writing.

1. The notice shall be mailed no later than 15 calendar days before the scheduled date of the administrative hearing and shall contain the:

- a. date of the hearing;
- b. time of the hearing; and
- c. place of the hearing.

D. The administrative hearing shall be conducted by an administrative law judge from the Bureau of Appeals according to the following procedures.

1. An audio recording of the hearing shall be made.

2. A copy of the recording may be prepared and reproduced at the request of a party to the hearing, provided he bears the cost of the copy of the recording.

3. Testimony at the hearing shall be taken only under oath, affirmation or penalty of perjury.

4. Each party shall have the right to:

- a. call and examine parties and witnesses;
- b. introduce exhibits;
- c. question opposing witnesses and parties on any matter relevant to the issue, even though the matter was not covered in the direct examination;
- d. impeach any witness, regardless of which party first called him to testify; and
- e. rebut the evidence against him/her.

5. Any relevant evidence shall be admitted if it is the sort of evidence upon which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make the admission of such evidence improper over objection in civil or criminal actions.

a. Documentary evidence may be received in the form of copies or excerpts.

b. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded.

c. The rules of privilege recognized by law shall be given effect.

6. The administrative law judge may question any party or witness and may admit any relevant and material evidence.

7. A party has the burden of proving whatever facts he/she must establish to sustain his/her position.

8. An applicant who has been denied through the facility need review process shall present his case first and has the burden to show by a preponderance of the evidence that facility need review approval should have been granted by the department pursuant to the provisions of this rules.

9. After an applicant denied facility need review has presented his evidence, the department will then have the opportunity to present its case and to refute and rebut the testimony and evidence presented by the applicant.

E. Any party may appear, and be heard, at any appeals proceeding through an attorney or a designated representative. The representative shall have a written authorization to appear on behalf of the applicant.

1. A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider identifying:

- a. his/her name;
- b. address;
- c. telephone number; and
- d. the party being represented.

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 35:2440 (November 2009).

§12543. Preliminary Conferences

A. Although not specifically required, the Bureau of Appeals may schedule a preliminary conference. The purposes of the preliminary conference include, but are not limited to:

1. clarification, formulations and simplifications of issues;
2. resolution of controversial matters;
3. exchange of documents and information;
4. stipulations of fact to avoid unnecessary introduction of witnesses;
5. other matters which may aid disposition of the issues; and
6. scheduling a hearing date that is convenient to all parties.

B. When the Bureau of Appeals schedules a preliminary conference, all parties shall be notified in writing. The notice

shall direct any parties and their attorneys to appear on a specific date and at a specific time and place.

C. When the preliminary conference resolves all or some of the matters in controversy, a summary of the findings agreed to at the conference shall be provided by the administrative law judge. When the preliminary conference does not resolve all of the matters in controversy, an administrative hearing shall be scheduled on those matters still in controversy.

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 35:2441 (November 2009).

§12545. Responsibilities of the Administrative Law Judge

A. The administrative law judge shall have the power to:

1. administer oaths and affirmations;
2. regulate the course of the hearings;
3. set the time and place for continued hearings;
4. fix the time for filing briefs and other documents;

and

5. direct the parties to appear and confer to consider simplification of the issues.

B. At the conclusion of the administrative hearing, the administrative law judge shall:

1. take the matter under advisement; and
2. prepare a written proposed decision which will contain:
 - a. findings of fact;
 - b. a determination of the issues presented;
 - c. a citation of applicable policy and regulations;

and

- d. an order.

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 35:2441 (November 2009).

§12547. Witnesses and Subpoenas

A. Each party shall arrange for the presence of their witnesses at the administrative hearing.

B. A subpoena to compel the attendance of a witness shall be issued by the administrative law judge upon written request by a party or on his own motion.

C. The party is required to notify the administrative law judge in writing at least 10 days in advance of the hearing of those witnesses whom he wishes to be subpoenaed.

D. No subpoena shall be issued until the party (other than the department) who wishes to subpoena a witness first

deposits with the hearing officer a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled pursuant to R.S. 13:3661 and R.S. 13:3671.

E. The department may request issuance of subpoenas without depositing said sum of money. The witness fee may be waived if the person is an employee of the department.

F. An application for subpoena duces tecum for the production by a witness of books, papers, correspondence, memoranda or other records, or to permit inspection of such, shall be made in writing to the administrative law judge. The written application shall:

1. give the name and address of the person or entity upon whom the subpoena is to be served.
2. precisely describe the material that is desired to be produced;
3. state the materiality thereof to the issues involved in the proceedings; and
4. include a statement that, to the best of applicant's knowledge, the witness has such items in his possession or under his control.

G. Any party or witness may file a motion to quash, which shall be scheduled by the administrative law judge for a contradictory hearing.

H. When any person summoned under this Section neglects or refuses to obey such summons, or to produce books, papers, correspondence, memoranda or other records, or to give testimony as required, any party may apply to the judge of the district court for the district within which the person so summoned resides or is found, for an attachment against him as for a contempt pursuant to the Administrative Procedures Act.

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 35:2441 (November 2009).

§12549. Continuances or Further Hearings

A. The Bureau of Appeals shall conduct the hearing within 90 days of the docketing of the administrative appeal. One extension, not to exceed 90 days, may be granted by the Bureau of Appeals upon good cause shown.

1. If the hearing is not commenced within 180 days from the docketing of the appeal, the decision of the department will be considered upheld.

B. Where the administrative law judge, at his/her discretion, determines that additional evidence is necessary for the proper determination of the case, he/she may:

1. continue the hearing to a later date and order the party(s) to produce additional evidence; or
2. close the hearing and hold the record open in order to permit the introduction of additional documentary evidence.

3. any evidence submitted shall be made available to both parties and each party shall have the opportunity for rebuttal.

C. Written notice of the time and place of a continued or further hearing shall be given. When a continuance of further hearing is ordered during an administrative hearing, oral notice of the time and place of the continued hearing may be given to each party present.

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 35:2441 (November 2009).

§12551. Proposed and Final Decisions

A. The written proposed decision shall be provided to the secretary of the department or his designee. The secretary or his designee may:

1. adopt the proposed decision;
2. reject it based upon the record; or
3. remand the proposed decision to the administrative law judge to take additional evidence.

a. If the proposed decision is remanded, the administrative law judge shall submit a new proposed decision to the secretary or his designee.

B. The decision of the secretary shall be final and binding upon adoption, subject only to judicial review by the courts. A copy of the decision shall be mailed to the applicant at his last known address or to his authorized representative.

C. Judicial review of the decision of the hearing officer shall be in accordance with the provisions of R.S. 49:964.

D. Motions for Rehearing, Reopening or Reconsideration.

1. A decision or order shall be subject to a motion for rehearing, reopening, or reconsideration by the agency, within 10 days from the date of its entry. Such motion may be made to either the administrative law judge, the director of the Bureau of Appeals, the secretary or the undersecretary, and a copy shall be filed into the administrative record.

2. The grounds for such motion shall be either that:

- a. The decision or order is clearly contrary to the law and the evidence;
- b. The party has discovered since the hearing evidence important to the issues which he could not have with due diligence obtained before or during the hearing;
- c. There is a showing that issues not previously considered ought to be examined in order to properly dispose of the matter; or

d. There is other good ground for further consideration of the issues and the evidence in the public interest

3. Such motion shall be ruled upon within 15 days from the date of filing such motion. If the motion for rehearing, reopening or reconsideration is granted, the ALJ shall take further action to rehear, reopen or reconsider the matter.

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 35:2442 (November 2009).

§12553. Failure to Appear at Administrative Hearings

A. If an applicant fails to appear at an administrative hearing, a decision shall be issued by the Bureau of Appeals dismissing the appeal. A copy of the decision shall be mailed to each party or his representative at his last known address.

B. Any dismissal may be rescinded upon order of the Bureau of Appeals if the applicant:

1. makes written application within 10 calendar days after the mailing of the dismissal notice; and
2. provides evidence of good cause for his/her failure to appear at the hearing.

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 35:2442 (November 2009).

Chapter 129. Opioid Treatment Program (OTP) Need and Application Reviews

Subchapter A. General Provisions

§12901. Definitions

A. Definitions. When used in this Chapter the following terms and phrases shall have the following meanings unless the context requires otherwise.

Applicant—the individual or legal entity who is applying to open an OTP.

Applicant Representative—the person specified by the applicant on the application form who is authorized to respond to Department of Health and Hospital questions regarding the OTP application review process and to whom written notifications are sent relative to the status of the application during the review process.

Applicant Review Period—the period of time in which the review is conducted.

Approval—a determination by the Department of Health and Hospitals (DHH) that an application meets the criteria of the OTP application review.

Approved—opioid treatment programs which are grandfathered in accordance with the grandfather provisions of this program and/or opioid treatment programs approved in accordance with the OTP application review.