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.

Abeyance 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 Residential Care Provider (ARCP)—a facility, agency, institution, society, corporation, partnership, company, entity, residence, person or persons, or any other group, that provides adult residential care services for compensation to 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 services, and assistance with personal hygiene, assistance with transfers and ambulation, assistance with dressing, housekeeping and laundry. For the purposes of this Facility Need Review (FNR) Rule, ARCP refers to an entity that is or will be licensed as an ARCP level 4-adult residential care provider. All ARCPs that have received FNR approval prior to August 1, 2022 shall retain FNR approval unless such FNR approval has expired. Facility need review approval is not required for any ARCP that is initially licensed August 1, 2022 or thereafter.

Agonist—a drug that activates certain receptors in the brain.

Antagonist—a drug that blocks opioids by attaching to the opioid receptors without activating them. Antagonists cause no opioid effect and block full agonist opioids. Examples of antagonists include, but are not limited to naltrexone and naloxone.

Applicant—the person who is developing the proposal for purposes of receipt of FNR approval for the healthcare facility or provider beds to proceed to apply for licensure, and/or certification by the Louisiana Department of Health (LDH).

Applicant Representative(s)—the person(s) specified by the applicant on the FNR application form to whom written notifications are provided relative to the status of the application during the review process.

Application—the required and completed FNR form(s), documentation, fee, and any other required information.

Approval—a determination by the FNR committee that an application meets the requirements of the FNR program for purposes of proceeding with licensure and/or certification by the department.

Behavioral Health Services (*BHS*)—mental health services, addictive disorders and substance use disorders treatment services, or combination of such services, for adults, adolescents, and children.

Behavioral Health Services Provider (BHSP)—a facility, agency, institution, person, society, corporation, partnership, unincorporated association, group, or other legal entity that provides behavioral health services or, presents itself to the public as a provider of behavioral health services. For the purposes of this Rule, FNR shall be applied to providers or applicants who elect to provide psychosocial rehabilitation services, community psychiatric support and treatment services, and/or opioid treatment program services licensed under a BHSP license.

CMS—Centers for Medicare and Medicaid Services.

Community Home—a type of community residential facility that has a capacity in accordance with R.S. 28:451.2, or current law.

Community Psychiatric Support and Treatment (CPST) Services—behavioral health services as defined in Title 48, Chapter 56.

Department—the Louisiana Department of Health (LDH).

Denial—a determination by the department's FNR committee that a proposal does not meet the requirements of the Facility Need Review (FNR) program and that the proposed healthcare facility or provider beds may not be licensed and/or certified.

Facility Need Review (FNR)—a review conducted for specific provider types to determine whether there is a need for additional licensed and/or certified healthcare providers and/or beds.

FNR Committee—LDH secretary appointed committee to review and render a decision to approve or deny an FNR application in accordance with R.S. 40:2116, or current law.

FNR Program—the program within LDH, Health Standards Section that oversees the day-to-day operations of FNR application intake and submission to the FNR committee, and communicates with applicants regarding the status of the application, and tracks the status of the decisions of the FNR committee.

Full Agonist—a drug that activates the opioid receptors in the brain fully, resulting in the full opioid effect. Examples of full agonists include, but are not limited to, heroin, oxycodone, methadone, hydrocodone, morphine, and opium.

Geographic Service Area—the geographic area under which a healthcare provider operates and/or provides services pursuant to licensing requirements, and for the purposes of FNR application review, the geographic area in which additional need will be assessed.

Group Home—a type of community residential facility that has a capacity in accordance with R.S. 28:451.2, or current law.

Health Standards Section (HSS)—the section of LDH that is responsible for licensing healthcare facilities, certifying those facilities 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 (RC) services, personal care attendant (PCA) services, supervised independent living (SIL) services, monitored in-home caregiving (MIHC) services, or any combination of services thereof, including RC providers, SIL providers, MIHC providers, and PCA providers.

Hospice—an autonomous, centrally administered, medically directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his family. It employs an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out the physical, emotional, spiritual, social, and economic stresses that are experienced during the final stages of illness and during dying and bereavement.

Hospice Inpatient Facility—facility where specific hospice levels of care ranging from residential to acute, including respite, are provided in order to meet the needs of the patient/family.

Hospice Outpatient Provider—hospice services are provided to patients in their place of residence (e.g. their home, adult residential care provider, nursing home).

Hospice Providers—hospice inpatient facility or hospice outpatient provider that is licensed by LDH in accordance with the requirements of R.S. 40:2183, or current law.

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

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

LDH Administrative Regions—the administrative regions and the parishes that comprise these regions are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

Medication for Opioid Use Disorder—Food and Drug Administration (FDA) approved medication for opioid use disorder utilized to reduce opioid use and harmful opioid related behaviors when used as part of a comprehensive treatment program.

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

Monitored In-home Caregiving (MIHC) Services—home and community-based services module as defined in LAC 48:I, Chapter 50, pursuant to a HCBS provider license.

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.

Nursing Facility (*NF*)—a licensed institution that is primarily engaged in providing the following services to residents:

a. 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) that can be made available to them only through institutional facilities. Such institutional facilities

are those facilities that are not primarily for the care of mental diseases.

Opioid Agonist Treatment Medication—Food and Drug Administration approved medication to treat Opioid Use Disorder.

Opioid Treatment Program (OTP)—a program that engages in medication-assisted opioid treatment of clients with an opioid agonist treatment medication.

Office of Behavioral Health (OBH)—LDH office and single state agency that is statutorily responsible for the treatment and prevention of addictive disorders and substance use disorders.

Opioid Treatment Program Needs Assessment– the determination of a need for new a new opioid treatment program in a geographic service area(s) by the department's Office of Behavioral Health in accordance with the criteria identified in Section 12527.

Partial Agonist—a drug that activates the opioid receptors in the brain, but to a much lesser degree than a full agonist. Buprenorphine is an example of a partial agonist.

Pediatric Day Health Care (*PDHC*) *Providers*—a facility that serves medically fragile individuals under the age of 21, including technology dependent children who require close supervision, in accordance with the requirements of LAC 48:I, Chapter 52.

Person—a human being or juridical person.

Personal Care Attendant (PAC)–home and community-based services module as defined in LAC 48:1, Chapter 50, pursuant to a HCBS provider license.

Physical Location—the specific address, building, or other permanent structure wherein the provider operates its business.

Pre-Approved Beds—beds and/or facilities that are automatically granted FNR approval in accordance with the grandfather provisions of this program.

Program—the Facility Need Review Program.

Psychosocial Rehabilitation (PSR) Services–behavioral health services as defined in Title 48, Chapter 56.

Respite Care (RC) Services—an intermittent service designed to provide temporary relief to unpaid, informal caregivers of the elderly, and/or persons with disabilities, pursuant to a HCBS provider license.

Secretary—the secretary of Louisiana Department of Health (LDH).

Supervised Independent Living (SIL) Services—home and community-based services module as defined in LAC 48:I, Chapter 50, pursuant to an HCBS provider license.

State Opioid Treatment Authority—the OBH authority within LDH who is designated to exercise the responsibility and authority within the state for governing the treatment of opioid use disorders within OTPs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40: 2116 et seq

HISTORICAL NOTE: Promulgated Department of Health, Health Standards Section, LR 50:221 (February 2024), amended LR 50:984 (July 2024).

§12503. General Information

A. No healthcare provider designated in R.S. 40:2116 or R.S. 40.2116.1 shall be licensed by LDH and/or certified to participate in the Title XIX program without first obtaining FNR approval and complying with any and all licensing regulations promulgated by LDH. Any person establishing, managing, or operating a facility, provider, service, or bed without the approval required by this Chapter shall immediately cease providing services and shall be prohibited from obtaining a license from LDH and/or participating in the Title XIX program, until FNR approval has been granted by the department.

B. The FNR committee shall consist of the following members:

1. the secretary of LDH, or his designee;

2. the assistant secretary of the Office of Behavioral Health (OBH) of LDH, or his designee;

3. the assistant secretary of the Office for Citizens with Developmental Disabilities (OCDD) of LDH, or his designee;

4. the assistant secretary of the Office of Aging and Adult Services (OAAS) of LDH, or his designee;

5. the assistant secretary of the Office of Public Health (OPH) of LDH, or his designee;

6. the Medicaid director of LDH, or his designee;

7. the Medicaid medical director of LDH, or his designee; and

8. any additional FNR committee members appointed by LDH secretary when necessary in reviewing applications of OTPs, including but not limited to the following individuals:

a. the LDH OBH medical director or physician who has expertise in substance use disorder treatment and, in particular, opioid treatment;

b. an addiction counselor licensed in the state of Louisiana by Addictive Disorder Regulatory Authority; and

c. the Louisiana State Opioid Treatment Authority.

C. The FNR committee will conduct an FNR to determine if there is a need for additional providers, facilities, or beds to be licensed by LDH and/or enrolled to participate in the Title XIX program for the following healthcare facility types, as defined under this Chapter:

1. intermediate care facilities for persons with developmental disabilities (ICF-DD);

2. home and community-based service (HCBS) providers of respite care (RC) services, personal care attendant (PCA) services, supervised independent living

(SIL) services, and monitored in-home caregiving (MIHC) services;

3. hospice providers;

4. pediatric day health care (PDHC) facilities;

5. behavioral health services providers (BHSP)of psychosocial rehabilitation (PSR) services, and community psychiatric support and treatment (CPST) services; and

6. behavioral health services providers of opioid treatment program (OTP) services;

D. The responsibilities and duties of the FNR committee include, but are not limited to:

1. conducting initial and supplemental reviews of each FNR application, as applicable;

2. determining whether each application meets the established criteria for FNR approval; and

3. sending FNR application approval and/or denial notices.

E. No FNR committee member shall have a proprietary or financial interest in any healthcare facility subject to FNR.

F. The department will determine if there is a need for additional providers, facilities, or beds to be licensed by LDH and/or enrolled to participate in the Title XIX program for nursing facilities.

G. Except as otherwise provided in the grandfather provisions of these regulations, each healthcare provider designated in R.S. 40:2116 or R.S. 40:2116.1 shall first receive FNR approval before applying to be licensed by LDH and before being certified to participate in the Title XIX program.

H. 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 healthcare facilities/beds;

2. all valid approvals for healthcare facilities/beds issued under the Medicaid Capital Expenditures Review Program prior to the effective date of this program;

3. all valid approvals for healthcare facilities issued under the FNR program; or

4. all NF beds that were enrolled in Medicaid as of January 20, 1991.

I. Additional Grandfather Provision. An approval shall be deemed to have been granted under FNR without review for HCBS providers of RC, PCA, SIL, or MIHC services, ICFs/DD, hospice providers, PDHC providers, or BHSPs that meet one of the following conditions:

1. Home and Community Based Service providers that 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 Residential Options Waiver;

3. licensed Adult Day Health Care (ADHC) providers who are enrolled or will enroll in the Louisiana Medicaid Program as a Program for All-inclusive Care for the Elderly (PACE) provider and apply for an HCBS license to provide PCA services as required by the program;

4. hospice providers that were licensed or had a completed initial licensing application submitted to the department by March 20, 2012;

5. pediatric day health care providers that were licensed by the department before March 1, 2014, or an entity that meets all of the following requirements:

a. has a building site or plan review approval for a PDHC facility from the Office of State Fire Marshal by March 1, 2014;

b. has begun construction on the PDHC facility by April 30, 2014, as verified by a notarized affidavit from a licensed architect submitted to the department, or the entity had a fully executed and recorded lease for a facility for the specific use as a PDHC facility by April 30, 2014, as verified by a copy of a lease agreement submitted to the department;

c. submits a letter of intent to the department's HSS by April 30, 2014, informing the department of its intent to operate a PDHC facility; and

d. became licensed as a PDHC by the department no later than December 31, 2014.

6. behavioral health services providers that are licensed to provide PSR and/or CPST, or that have submitted a completed application for licensure as a BHSP that includes PSR and/or CPST, prior to February 20, 2018;

7. behavioral health services providers that are licensed to provide OTP services, or that have submitted a complete application for licensure as a BHSP that includes OTP services prior to January 1, 2024; or

8. behavioral health services providers that fall within the provisions of Act 33 of the 2017 Regular Session of the Louisiana Legislature, commonly referred to as accredited mental health rehabilitation providers, that submit a completed BHSP licensing application by December 1, 2017 and become licensed by April 1, 2018.

J. Exemptions from the FNR process shall be made for:

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

2. a NF and/or facility building owned by a government entity that is replaced due to a potential health hazard.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:223 (February 2024), amended LR 50:985 (July 2024).

§12505. Initial Application and Review Process for ICF-DD, HCBS Providers of RC, PCA, SIL, or MIHC Services, Hospice Providers, PDHC Facilities, BHSP of PSR, CPST, and OTP Services

A. Facility need review (FNR) applications as defined in the Chapter except for FNR applications that are submitted pursuant to a Request for Proposal (RFP) or Request for Application (RFA) issued by the department will follow the initial application and review process, the supplemental application review process, and the appeal provisions set forth in this licensing Rule. Facility need review applications that are submitted pursuant to a RFP or RFA will follow the application process, the review process, the supplemental review process, the notice provisions, and the appeal provisions that are contained in the individual RFP or RFA.

B. Facility need review applications shall be submitted on 8.5 inch by 11 inch paper that shall not include Health Insurance Portability and Accountability Act (HIPAA) protected information, to the HSS, FNR program manager by one of the following means:

1. via postal service to the designated FNR program mailing address; or

2. electronically via the HSS designated system or software.

C. Application forms may be requested in writing or by telephone from the FNR program, or accessed via the department's designated website.

D. The applicant shall also submit with its application, any written documentation or evidence the applicant believes supports its FNR application, including but not limited to the following examples.

1. Any data/documents regarding waiting lists for the proposed services in the applicant's service area.

2. Any letters from healthcare facilities, medical professionals or others, who have clients/patients/recipients awaiting the proposed services in the applicant's service area.

3. Any data/documentation of complaints about clients/patients/recipients not being able to access the proposed services in the applicant's service area.

4. Any data/documentation about population groups that do not have access to the proposed services in the applicant's service area, to whom the applicant will provide such services.

5. Other data/documentation about the need in the applicant's service area for the proposed services.

6. Other data/documentation about the probability of serious adverse consequences to recipient's ability to access healthcare if the applicant was not allowed to be licensed.

E. 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's application information or representative changes at any time during the review process, the applicant is required to notify the FNR program in writing.

F. The required nonrefundable FNR application fee of $200 shall be submitted either by mail to the designated payment address or electronically via the HSS designated system or software.

G. The review period of the initial application will be no more than 90 days from receipt of the FNR application, or within the deadlines established in an RFP or RFA; thereafter, a decision will be rendered by the FNR committee. The review period begins on the first day after the date of receipt of the completed application, or, in the case of issuance of an RFP, on the first day after the period specified in the RFP.

1. Each FNR committee member shall receive a copy of the initial application and all documentation submitted for review.

2. The FNR committee shall meet as a committee to review the initial application within the specified time limits, as provided herein.

a. The FNR committee shall meet in-person or through virtual means, including telephone or virtual technology that facilitates synchronous interaction.

b. All members of the FNR committee shall attend the meeting, either in-person or by virtual means. The members shall review the initial application, and the members may request information from the department in considering an application.

c. The FNR committee shall render a decision on the initial application, and such decisions are to be by simple majority decision.

d. The FNR committee's decision may approve the initial application or may deny the initial application. Alternatively, the FNR committee may request that the applicant submit additional or clarifying information and documentation.

e. If the FNR committee decision is to approve or deny the initial application, the FNR committee shall forward written notice to the applicant of such decision. The notice shall include information on supplemental review, appeals, and any additional instructions.

f. If the FNR committee decision is to request additional or clarifying information and documentation from the applicant, the FNR committee shall send written notice to the applicant, requesting the information and documentation by a specific date. The initial application and any additional or clarifying information and documentation shall be considered at the next FNR committee meeting, wherein the FNR committee shall make a decision on the initial application and forward written notice to the applicant

of such decision. The notice shall include information on supplemental review, appeal rights, and any additional instructions.

3. Written notice of FNR decision along with required follow-up instructions shall be sent to the applicant by certified mail or by electronic mail with a request for an acknowledgement and a read and delivery receipt, to the applicant representative. Written notice of the FNR committee's request for additional or clarifying information and documentation shall be sent to the applicant by electronic mail with a request for an acknowledgement and a read and delivery receipt.

4. Unless otherwise stated in a specific RFP or RFA, the initial review and decision by the FNR committee shall consider all written materials and documentation submitted by the applicant and shall be conducted as a paper review.

5. If the FNR committee approves the FNR application, then the applicant may proceed with seeking licensure or certification to participate in the Title XIX program, as applicable.

6. If the FNR application is denied, the applicant may choose within 30 calendar days of receipt of notice of denial, to do one of the following:

a. Unless otherwise stated in a specific RFP or RFA, the applicant may file a request for a supplemental review by the FNR committee pursuant to the provisions of this Rule; or

b. In lieu of supplemental review, the applicant may file an administrative appeal, pursuant to the provisions of this Rule. Such request for administrative appeal shall be filed with the Division of Administrative Law (DAL) within 30 calendar days of receipt of the notice of the denial letter.

i. The applicant is not required to request a supplemental review and may elect to proceed directly to an administrative appeal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:224 (February 2024), amended LR 50:985 (July 2024).

§12507. Supplemental Application Review Process for ICF-DD, HCBS Providers of RC, PCA, SIL, or MIHC Services, Hospice Providers, PDHC Facilities, BHSP of PSR, CPST, and OTP Services

A. If the applicant decides to request a supplemental review of the denied initial application, a written request for supplemental application review must be received by the department within 30 days of receipt of notice of the denial letter.

B. Upon receipt of the applicant's timely written request to supplement its FNR application, a written confirmation notice will be sent to the applicant informing the applicant of the deadline to submit any additional documentation and evidence in support of the FNR application, pursuant to the provisions of this Rule.

1. If the applicant fails to timely submit the supplemental materials, the supplemental application is automatically denied. Written notice of the denial shall be forwarded to the applicant, with information regarding the applicant's right to file an administrative appeal with the DAL.

C. Upon timely receipt of the supplemental materials from the applicant, the FNR committee shall conduct a supplemental application review.

1. As part of the supplemental application review, the applicant is provided with an opportunity to meet with the FNR committee, or its designees. The meeting may be conducted in-person or, at the discretion of LDH, through virtual means, including by telephone or virtual technology that facilitates synchronous interaction, and includes an opportunity for questions from the applicant and/or committee member(s)/designee(s).

2. If the FNR applicant fails to attend the supplemental review meeting, then the FNR committee may proceed to complete the supplemental review by reviewing any supplemental material submitted by the applicant and issue a supplemental review decision. The FNR committee may, at its discretion, elect to re-schedule the supplemental review meeting upon good cause shown by the FNR applicant.

D. Following the meeting, the applicant will have an additional 30 days to submit any other evidence, data, and documentation to further supplement the FNR application. At the conclusion of this step, the FNR committee will meet to consider all the supplemental documentation, data, and evidence submitted by the applicant, as well as the issues discussed at the meeting with the applicant, if applicable.

1. All members of the FNR committee shall meet in-person or through virtual means, including telephone or virtual technology that facilitates synchronous interaction, to complete the supplemental application review process.

2. The FNR committee shall render a decision on the supplemental application within 60 days of the deadline for submission of any additional documentation and evidence by the applicant after the supplemental review meeting; such decisions are to be by simple majority decision.

3. The FNR committee will issue a final decision to either approve the FNR application or deny the FNR application, and shall forward written notice to the applicant of such decision.

a. The written notice of the supplemental application review decision from the FNR committee will be sent to the applicant by certified mail or by electronic mail with a request for acknowledgement and a read delivery receipt.

b. The written notice shall include information on the applicant's right to file an administrative appeal of the

denial with the DAL within 30 calendar days of receipt of the supplemental application denial notice.

c. Failure to file timely for an administrative appeal shall exhaust the applicant's remedies with the department, and the decision to deny FNR approval is final.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:225 (February 2024), amended LR 50:986 (July 2024).

§12509. Administrative Appeal Procedures for ICF-DD, HCBS Providers of RC, PCA, SIL, or MIHC Services, Hospice Providers, PDHC Facilities, BHSP of PSR, CPST, and OTP Services

A. An applicant who receives a denial of an initial FNR application or denial of a supplemental FNR application may request an administrative hearing within 30 calendar days after receipt of the department's notice of denial of FNR application.

1. The request for an administrative hearing shall be made in writing to the DAL with a copy of the request also sent to the department's FNR program.

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

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

B. The administrative appeal shall be conducted by the DAL in accordance with the Administrative Procedure Act.

C. Failure to file timely for an administrative appeal shall exhaust the applicant's remedies with the department and the decision to deny FNR approval is final.

D. Unless a timely and proper administrative appeal request is received by the DAL, the findings of the FNR committee shall be considered a final and binding administrative determination.

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

HISTORICAL NOTE: Promulgated amended by the Department of Health, Health Standards Section, LR 50:226 (February 2024), amended LR 50:986 (July 2024).

§12510. Initial Application and Review Process for Nursing Facilities

A. The department will conduct an FNR to determine if there is a need for additional nursing facilities or beds to be licensed by LDH and/or enrolled to participate in the Title XIX program.

B. Facility need review applications shall be submitted on 8.5 inch by 11 inch paper that shall not include Health Insurance Portability and Accountability Act (HIPAA) protected information, to the HSS, FNR program manager by one of the following means:

1. via postal service to the designated FNR program mailing address; or

2. electronically via the HSS designated system or software.

C. Application forms may be requested in writing or by telephone from the FNR program, or accessed via the department's designated website.

D. The applicant shall also submit with its application, any written documentation or evidence the applicant believes supports its FNR application, including but not limited to the following examples.

1. Any data/documents regarding waiting lists for the proposed services in the applicant's service area.

2. Any letters from healthcare facilities, medical professionals or others, who have clients/patients/recipients awaiting the proposed services in the applicant's service area.

3. Any data/documentation of complaints about clients/patients/recipients not being able to access the proposed services in the applicant's service area.

4. Any data/documentation about population groups that do not have access to the proposed services in the applicant's service area, to whom the applicant will provide such services.

5. Other data/documentation about the need in the applicant's service area for the proposed services.

6. Other data/documentation about the probability of serious adverse consequences to recipient's ability to access healthcare if the applicant was not allowed to be licensed.

E. 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's application information or representative changes at any time during the review process, the applicant is required to notify the FNR program in writing.

F. The required nonrefundable FNR application fee of $200 shall be submitted either by mail to the designated payment address or electronically via the HSS designated system or software.

G. The review period of the initial application will be no more than 90 days from receipt of the FNR application; thereafter, a decision will be rendered by the department. The review period begins on the first day after the date of receipt of the completed application.

H. Grandfather Provision. An FNR approval shall be deemed to have been granted under this program without review for NFs that meet one of the following descriptions:

1. all valid Section 1122 approved healthcare facilities/beds;

2. all valid approvals for healthcare facilities/beds issued under the Medicaid Capital Expenditure Review Program prior to the effective date of this program;

3. all valid approvals for healthcare facilities issued under the FNR program; or

4. all NF beds that were enrolled in Medicaid as of January 20, 1991.

I. Exemptions from the FNR process shall be made for:

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

2. a NF and/or facility building owned by a government entity that is replaced due to a potential health hazard.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:986 (July 2024).

§12511. Supplemental Application Review Process for Nursing Facilities

A. If the applicant decides to request a supplemental review of the denied initial application, a written request for supplemental application review must be received by the department within 30 days of receipt of notice of the denial letter.

B. Upon receipt of the applicant's timely written request to supplement its FNR application, a written confirmation notice will be sent to the applicant informing the applicant of the deadline to submit any additional documentation and evidence in support of the FNR application, pursuant to the provisions of this Rule.

1. If the applicant fails to timely submit the supplemental materials, the supplemental application is automatically denied. Written notice of the denial shall be forwarded to the applicant, with information regarding the applicant's right to file an administrative appeal with the DAL.

C. Upon timely receipt of the supplemental materials from the applicant, the department shall conduct a supplemental application review.

1. The department shall review all supplemental review material submitted by the applicant and issue a supplemental review decision to approve or deny the FNR application within 60 days of the deadline for submission of any additional documentation and evidence by the applicant, and shall forward written notice to the applicant of such decision.

a. The written notice of the supplemental application review decision shall be sent to the applicant by certified mail or by electronic mail with a request for acknowledgement and a read delivery receipt.

b. The written notice shall include information on the applicant's right to file an administrative appeal of the denial with the DAL within 30 calendar days of receipt of the supplemental application denial notice.

c. Failure to file timely for an administrative appeal shall exhaust the applicant's remedies with the department, and the decision to deny FNR approval is final.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:987 (July 2024).

§12512. Administrative Appeal Procedures for Nursing Facilities

A. An applicant who receives a denial of an initial FNR application or denial of a supplemental FNR application may request an administrative hearing within 30 calendar days after receipt of the department's notice of denial of FNR application.

1. The request for an administrative hearing shall be made in writing to the DAL with a copy of the request also sent to the department's FNR program.

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

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

B. The administrative appeal shall be conducted by the DAL in accordance with the Administrative Procedure Act.

C. Failure to file timely for an administrative appeal shall exhaust the applicant's remedies with the department and the decision to deny FNR approval is final.

D. Unless a timely and proper administrative appeal request is received by the DAL, the findings of the department shall be considered a final and binding administrative determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2116 et seq.
HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:987 (July 2024).

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

§12513. Intermediate Care Facilities for the Developmentally Disabled

A. Except as otherwise provided in this Chapter, no ICF-DD shall be certified or enrolled to participate in the Title XIX program unless the FNR program has granted an approval for an additional ICF-DD facility or additional ICF-DD beds to be enrolled in the Title XIX program.

B. The geographic service area for a proposed or existing ICF-DD facility is designated as the LDH administrative region in which the facility or proposed facility is or will be located. The administrative regions and the parishes that 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.

C. The beds and population of the geographic 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 licensed and approved Medicaid-enrolled beds as of the due date for a decision on application.

D. 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 that the beds are to be enrolled in the Medicaid program.

E. 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.

F. 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 that 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 this Section to determine if additional beds are needed.

G. 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) or Request for Applications (RFA) will be issued. No applications will be accepted under these provisions unless the department declares a need and issues a RFP or RFA. Applications will be accepted for expansion of existing facilities and/or for the development of new facilities. However, no applications will be considered for any facility with 16 or more beds.

1. The RFP or RFA will indicate the region in need of beds, the number of beds needed, the date that the beds are to be available to the target population (fully licensed and enrolled in Medicaid), and the factors that the department considers relevant in determining the need for the additional beds.

2. The RFP or RFA will specify the MR-2 that the determination of need is based.

3. The RFP or RFA will be issued and will specify the dates that the department will accept applications.

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

5. The RFP or RFA shall specify the following:

a. application submission requirements;

b. a due date for applications;

c. process of review by the FNR committee of any applications timely received, including any supplemental review process;

d. notice of selection;

e. information on appeals processes for applicants that are not granted FNR approval; and

f. other information or requirements for the RFP or its process, as determined by the department.

H. The FNR committee 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 healthcare providers;

4. accessibility to other healthcare providers;

5. availability of funds and financial viability;

6. experience and availability of key personnel, as well as compliance history if the applicant is or has been previously licensed as an ICF-DD;

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.

I. 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.

J. In the case of a tie for the highest score for a specific facility or additional beds, the FNR committee will conduct a comparative review of the top scoring proposals that will include prior compliance history. The FNR committee may request and review data from OCDD and HSS on prior compliance history. Subject to Subsection L of this Section, the FNR committee will make a decision to approve one of the top scoring applications based on the comparative review of the proposals.

K. If no proposals are received that adequately respond to the need, the FNR committee may opt not to approve an application. However, the evaluation period may be extended, if provided for in the RFP or RFA.

L. 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, if provided for in the RFP or RFA. 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.

M. 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 shall be used to meet the need identified.

N. Prior approval from the OCDD is required before admission of all Medicaid recipients to facilities in beds approved to meet a specific disability need identified in an RFP issued by the department.

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

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

a. Beds in group and community homes that 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 OCDD in the region where the proposed community or group home beds will be located. These proposals do not require FNR approval.

P. Exception for Additional Beds for Certain ICFs-DD

1. Any ICFs-DD that serve children or adults suffering from developmental disabilities, autism, or behavioral problems and that 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 §12513.Q.

Q. Group and community home beds shall be enrolled in the Title XIX program within 12 months of the date of approval by the FNR program.

1. 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.

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

R. Approval of a group or community home bed shall be revoked when the OCDD advises that the bed that 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.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:226 (February 2024).

§12515. Pediatric Day Health Care Providers

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

B. For purposes of FNR, the geographic service area for a proposed PDHC facility shall be within a 30 mile radius of the proposed physical location where the provider will be licensed.

C. Determination of Need/Approval

1. The FNR committee will review the application to determine if there is a need for an additional PDHC provider in the geographic service area for which the application is submitted.

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

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

a. the number of other PDHC providers in the same geographic service area servicing the same population; and

b. allegations involving issues of access to healthcare 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 healthcare if the provider is not allowed to be licensed. The FNR committee shall not approve an FNR application 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 physical location and/or geographic service area as defined in the application. Facility need review approval of licensed providers shall expire if these aspects of the application are altered or changed.

E. FNR approvals are non-transferable and are limited to the physical location and the name of the original licensee.

1. A PDHC provider undergoing a change of physical location in the same licensed geographic service area shall submit a written attestation of the change of physical location, including the license number, state identification (ID), current address and new address, and the department shall re-issue the FNR approval with the name and new physical location. A PDHC provider undergoing a change of physical location outside of the licensed geographic service area shall submit a new FNR application and appropriate fee and undergo the FNR approval process.

2. A PDHC provider undergoing a change of ownership shall submit a new application to the department's FNR program, requesting a transfer of the FNR approval to the new owner. Facility need review approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, provided that the legal change of ownership documents require the seller's or transferor's written relinquishment of 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.

F. The following timeframes shall apply for complying with the requirements for obtaining approval of architectural plans and licensure.

1. Pediatric Day Health Care facilities that are to be licensed in existing buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

2. PDHC facilities that are to be licensed in newly constructed buildings shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within 24 months from the date of the FNR approval.

3. 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.

4. Failure to meet any of the timeframes in this Section could result in an automatic expiration of the FNR approval of the PDHC facility.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:228 (February 2024).

§12517. Nursing Facilities

A. Except as otherwise provided in this Chapter, no nursing facility (NF) shall be licensed and certified or enrolled to participate in the Title XIX program unless the FNR program has granted an approval for an additional NF or additional nursing beds to be licensed and enrolled in the Title XIX program.

NOTE: The statutory moratorium in R.S. 40:2116.1(B), or any successor statute, prohibits the department from issuing new FNR approvals for NF or additional beds in NF until the statutory moratorium expires.

B. The geographic service area for proposed or existing NF or beds is the parish in which the physical location is located.

1. Exception. Any parish that has any portion of the parish below Interstate 10, and that is intersected by the Mississippi River, will be composed of two separate service areas as divided by the Mississippi River.

C. Nursing facility beds located in distinct parts of acute care general hospitals shall be approved through FNR in order to be enrolled to participate in the Medicaid program.

D. 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.

E. For FNRs in which the bed to population ratio is a factor, the bed inventory that will be used is that which is current on the date that 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.

F. For FNRs in which utilization is a factor, the occupancy report that will be used is that which is current on the date that 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.

G. The determination of occupancy rates of nursing facilities or beds shall be as follows:

1. Beds for which occupancy shall be based shall include NF beds that 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.

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

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

I. 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 that the beds are to be enrolled in the Medicaid program.

J. In order for additional beds or facilities to be added in a service area, the bed-to-population ratio for NF 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.

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

1. A Medicaid enrolled NF that 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 shall be enrolled in Title XIX.

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

c. The number of beds that 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 NF 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 NF 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 NF 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 shall 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) or Request for Applications (RFA) 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 that 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 healthcare providers and other knowledgeable sources in the area;

iii. waiting lists in existing nursing 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 nursing facilities;

xi. distribution of beds within a geographic service area; and

xii. such other factors as the department may deem relevant.

c. The number of beds that 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 NF 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 or RFA will be issued. No applications will be accepted under these provisions unless the department declares a need and issues a RFP or RFA. Applications will be accepted for expansions of existing facilities and/or for the development of new nursing facilities.

a. The RFP will be issued and will specify the dates that the department will accept applications. Also, NF in the geographic service area and adjoining parishes will be notified of the issuance of the RFP.

b. The RFP will indicate the parish and/or geographic service area in need of beds, the number of beds needed, the date that the beds are needed to be available to the target population enrolled in Medicaid, and the factors that the department considers relevant in determining need for the additional beds. The RFP will specify the LTC-2 that 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 RFP or RFA shall specify the following:

i. application submission requirements;

ii. a due date for applications;

iii. process of review by the department of any applications timely received, including any supplemental review process;

iv. notice of selection;

v. information on appeals processes for applicants that are not granted FNR approval; and

vi. other information or requirements for the RFP or its process, as determined by the department.

e. 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;

ii. 0-20 points: appropriateness of location or proposed location.

iii. 0-20 points: responsiveness to groups with special needs (e.g., Acquired Immunodeficiency Syndrome 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 geographic service area. Geographic distribution of existing beds and population density will be taken into account.

f. 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.

g. If there is a tie for the highest score for a specific facility or beds, the department will conduct a comparative review of the top scoring proposals that will include prior compliance history, if applicable. The department may request and review data from OAAS and HSS on prior compliance history. Subject to K.3.h of this Section, the department will make a decision to approve one of the top scoring applications based on comparative review of the proposals.

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

i. At the end of the 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, if provided for in the RFP or RFA. Applicants will be given 30 days from the date of receipt of the department’s notification in which to file an appeal.

j. 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 licensing and Medicaid certification shall be revoked if these aspects of the proposal are altered.

L. The following timelines are established for additional NF or beds in NF approved through FNR.

1. Beds that are approved to be added to an existing licensed facility, shall be licensed and enrolled in the Title XIX program within one year of the date of approval by the FNR program.

2. New NF that are approved to be constructed, shall be licensed and enrolled in the Title XIX program within 24 months of the date of the approval by the FNR program.

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.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:229 (February 2024), amended LR 50:987 (July 2024).

§12519. 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 shall 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. Unless excepted in accordance with R.S. 40:2116.1, a NF 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 NF 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 NF beds converted to alternate use shall be used solely for the purpose of providing healthcare services at a licensed and/or certified facility.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:231 (February 2024).

§12521. Additional Beds for Replacement Facility

A. A NF 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 shall 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 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:231 (February 2024).

§12523. Home and Community-Based Service Providers (PCA, RC, SIL, and MIHC Modules Only)

A. Except as otherwise provided in this Chapter, no HCBS provider shall be licensed to operate unless the FNR committee has granted an FNR approval for the issuance of an HCBS provider license. Once the FNR 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 geographic service area for proposed or existing HCBS providers is the LDH administrative region that the provider is or will be licensed.

C. Determination of Need/Approval

1. The FNR committee will review the application to determine if there is a need for an additional HCBS provider in the geographic service area for which the application is submitted.

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

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

a. the number of other HCBS providers in the same geographic service area servicing the same population; and

b. allegations involving issues of access to healthcare 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 healthcare if the provider is not allowed to be licensed. The FNR committee shall not approve an FNR application if it 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 physical location and/or geographic service area as defined in the application. Facility need review approval of licensed providers shall expire if these aspects of the application are altered or changed.

E. Except as provided in the Subparagraphs below, FNR approvals for licensed providers are non-transferrable and are limited to the physical location and the name of the original licensee.

1. An HCBS provider undergoing a change of physical location in the same licensed geographic service area shall submit a written attestation of the change of physical location, including the license number, state ID, current address and new address, and the department shall re-issue the FNR approval with the name and new physical location. An HCBS provider undergoing a change of physical location outside of the licensed geographic service area 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, requesting a transfer of the FNR approval to the new owner. Facility need review approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, provided that the legal change of ownership documents require the seller's or transferor's written relinquishment of the FNR approval.

3. Facility need review approval of a licensed provider shall automatically expire if the provider is moved or transferred to another party, entity, or geographic service area/physical location without application to and approval by the FNR program.

F. FNR-approved HCBS applicants shall become licensed no later than six months from the date of the FNR approval.

1. 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.

2. Failure to meet any of the timeframes in this Section shall result in an automatic expiration of the FNR approval of the HCBS agency.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:231 (February 2024).

§12525. Behavioral Health Services Providers (PSR and CPST Only)

A. Except as otherwise provided in this Chapter, no BHSP or applicants seeking to provide psychosocial rehabilitation (PSR) and/or community psychiatric support and treatment (CPST) services shall be eligible to apply for licensure to provide PSR and/or CPST services unless the FNR committee has granted FNR approval for the issuance of a BHSP license for such services. Once the FNR approval is granted, a BHSP is eligible to apply for a BHSP license to provide PSR and/or CPST services.

B. The geographic service area for proposed or existing BHSP shall be defined to include:

1. the parish that the provider's business office is located;

2. any parish contiguous to the parish that the provider's business office is located;

3. any location within a 50 mile radius of the provider's business office; and

4. within a 50-mile radius of one designated offsite location of the licensed BHSP.

NOTE: The geographic service area described in this Part is also applicable to opioid treatment programs licensed as BHSPs.

C. Determination of Need/Approval

1. The FNR committee shall review the FNR application to determine if there is a need for additional BHSPs to provide PSR and/or CPST services in the geographic service area.

2. The FNR committee shall approve the FNR application only if the data contained in the application and other evidence effectively establishes the probability of serious, adverse consequences to recipients' ability to access behavioral health PSR and/or CPST services if the provider is not allowed to be licensed.

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

a. the number of other BHSPs providing PSR and/or CPST services in the same geographic service area and servicing the same population;

b. the number of members that the BHSP is able to provide PSR and/or PST services to; and

c. allegations involving issues of access to behavioral health PSR and/or CPST 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 behavioral health PSR and/or CPST services if the provider is not granted approval to be licensed. The FNR committee shall not approve an FNR application if it fails to provide such data and evidence.

D. Applications for approvals of BHSPs of PSR and/or CPST services 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 physical location and/or geographic service area as defined in the application. Facility need review approval of such providers shall expire if these aspects of the application are altered or changed.

E. Except as provided in the Subparagraphs below, FNR approvals for behavioral health PSR and/or CPST applicants are non-transferrable and are limited to the location and the name on the original license.

1. A BHSP of PSR and/or CPST services undergoing a change of physical location in the same licensed geographic service area shall submit a written attestation of the change of physical location, including the license number, state ID, current address and new address, and the department shall re-issue the FNR approval with the name and new physical location. A BHSP undergoing a change of physical location outside of the licensed geographic service area shall submit a new completed FNR application and required fee and undergo the FNR approval process.

2. A BHSP of PSR and/or CPST services undergoing a change of ownership shall submit a new completed application and required fee to the department's FNR program, requesting a transfer of the FNR approval to the new owner. Facility need review approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, provided that the legal change of ownership documents require the seller's or transferor's written relinquishment of the FNR approval.

3. Facility need review approval of a licensed BHSP of PSR and/or CPST services shall automatically expire if the provider is moved or transferred to another party, entity, or physical location without application to and approval by the FNR program.

4. Facility need review approved BHSPs of PSR and/or CPST shall become licensed no later than one year from the date of the FNR approval. Failure to meet this timeframe shall result in an automatic expiration of the FNR approval of the BHSP.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2116 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:232 (February 2024).

§12527. Opioid Treatment Program Needs Assessment

A. The department shall conduct an OTP needs assessment to determine if there is a need for new or additional OTPs in a geographic service area. The OTP needs assessment includes criteria and processes that the department utilizes to determine the need for new or additional OTPs in an identified geographic service area. For purposes of this Section, geographic service area follows the criteria established in §12503.H. The OTP needs assessment may include all or some of the following review criteria:

1. estimated prevalence of opioid use disorder in the population of the geographic service area to be served;

2. estimated number of persons in need of medication for opioid use disorder (MOUD) in the geographic service area;

3. estimated demand for MOUD treatment in the geographic service area to be served;

4. existing access, utilization, and availability of MOUD treatment in the geographic service area to be served; and

5. data sources that include information compiled and recognized by the department and/or any of the following: Substance Abuse and Mental Health Services Administration (SAMHSA), the United States Census Bureau, the Drug Enforcement Administration (DEA), the National Institute on Drug Abuse (NIDA), and any other state or federally recognized data surveillance system.

B. The department may conduct additional OTP needs assessments only when special needs and circumstances arise that indicate the need for additional MOUD treatment services, such as increased utilization rates, reduced availability, and/or reduced accessibility of services.

C. Exemptions from OTP needs assessment and OTP FNR application review shall be made for OTP clinics that meet the following criteria:

1. an existing, licensed OTP clinic that is destroyed by fire or a natural disaster, such as hurricane, and that obtains a license for a replacement location within eight months of closure from the fire or natural disaster; or

2. an existing, licensed OTP clinic that is replaced due to potential health hazard in the clinic, and that obtains a license for a replacement location within 150 days of closing due to the potential health hazard.

NOTE: As it relates to the circumstances of C.1 and 2 of this Section, one extension of no more than three months may be granted by the department, at its discretion, upon receipt of documentation from the OTP provider demonstrating good cause, provided the extension is requested no later than one month from the original deadline.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:233 (February 2024).

§12529. Opioid Treatment Program - Request for Applications

A. If the department has assessed a need for OTP services in a geographic service area(s) in accordance with §12527, the department will issue an RFA for the specified geographic service area via a statewide public announcement. The RFA will specify the dates that the department will accept applications.

1. The RFA shall specify the following:

a. geographic service area(s) in need of OTP provider(s);

b. number of OTP providers needed;

c. date that the OTP providers need to be available to the target population;

d. application submission requirements;

e. a due date for applications;

f. process of review by the FNR committee of any applications timely received, including any supplemental review process;

g. notice of selection;

h. information on appeals processes for applicants that are not granted FNR approval; and

i. other information or requirements for the RFP or its process, as determined by the department.

2. The RFA shall require the applicant to submit a letter of intent as part of its OTP FNR application. The letter of intent shall include the following:

a. the name, address, and telephone number of the FNR applicant;

b. the name of the FNR applicant representative, an individual authorized to respond to the department's questions regarding the application, and who also signs the letter of intent;

c. the proposed location of the OTP;

d. a brief statement of the OTP FNR applicant's financial viability and availability of funds;

e. a brief statement regarding licensure history as a BHSP, and a written work plan demonstrating a timeline to achieve accreditation and licensure as an OTP;

f. history of compliance with accreditation, licensure and/or certification bodies related to the provision of healthcare services;

g. range of services and program design;

h. community integration;

i. availability, accessibility and appropriateness of the location of the proposed OTP site (e.g., accessibility to public transportation and healthcare providers, location in relation to children's schools and playgrounds, local letters of support from political parties, itemized timeline of action items/dates leading to service start date); and

j. methods to achieve community integration through a community relations/targeted outreach plan.

3. Any OTP FNR application that fails to provide the required information will not be considered for FNR approval by the FNR committee.

4. Any proposed owner, director, or manager of an OTP applying for OTP FNR approval shall be free of any conviction, guilty plea, or plea of nolo contendere to a felony. If the OTP FNR applicant is an agency, the owners of that agency shall be free of such felony convictions, felony guilty pleas, or plea of nolo contendere to a felony.

5. The RFA shall specify that the FNR applicant designate a representative on the FNR application. This identified representative shall be the only person to whom the department or FNR committee will send notification regarding the decision of the OTP FNR application. If the FNR applicant representative or address changes at any time during the review process, the FNR applicant shall notify the LDH FNR program in writing.

B. All timely and complete OTP FNR applications, received by the department after the department has issued an RFA for new OTP FNR applicants, will be reviewed by the FNR committee to determine FNR approval. Only approved OTP FNR applicants may apply for an OTP license from the department.

C. The FNR committee will review the applications and independently evaluate and assign points to each of the following items, considering the quality and adequacy of the response to meet the need of the project:

1. applicant's financial viability and availability of funds to support the proposed OTP;

2. history of BHSP licensure and a written work plan demonstrating timeline to achieve accreditation and licensure as an OTP;

3. range of services/program design; and

4. community integration plan.

D. Subject to Subsection F below, the highest scoring OTP FNR applicant shall receive FNR approval.

E. In the case of a tie for the highest score, the FNR committee will conduct a comparative review of the top scoring proposals that will include prior compliance history. The FNR committee may request and review data from HSS on prior compliance history. Subject to Subsection F of this Section, the FNR committee will make a decision to approve one of the top scoring applications based on the comparative review of the proposals.

F. If no proposals are received that adequately respond to the need, the FNR committee may opt not to approve an application. In that case, a new RFA will be issued.

G. The OTP FNR applicants will receive written notifications of approvals and denials of FNR applications via certified mail or by electronic mail with a request for an acknowledgement and a read and delivery receipt, or as otherwise specified in the RFA.

H. The OTP FNR applications approved under these provisions are bound to the description in the application with regard to:

1. opioid treatment model;

2. services including but not limited to screening, assessment, counseling, and methadone dosing;

3. communication integration plan;

4. evidence of community supports/partnerships;

5. outreach plan;

6. location; and

7. identified opening date to begin services.

I. The OTP FNR approval shall expire if the aspects of the application listed in Subsection H of this Section are altered. However, the OTP FNR approved provider may submit a request to the FNR committee to request approval to change the proposed location within the approved geographic service area within 30 days of receipt of FNR approval.

J. No FNR committee member shall have a proprietary, financial, professional, or other personal interest of any nature or kind in any OTP.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:233 (February 2024).

§12531. Behavioral Health Services Providers (OTP Only)

A. No OTP may be licensed in the state of Louisiana unless the department has assessed, in its discretion, a need for a new or additional OTP in the geographic service area in accordance with §12527. For purposes of this Section, the geographic service area follows the criteria established in §12503.H. All licensed OTPs shall be in compliance with all applicable OTP federal, state, and local laws and regulations.

B. Except as otherwise provided in this Chapter or in the Subparagraphs below, FNR approvals are non-transferable and are limited to the physical location and the name of the original licensee identified in the OTP FNR application.

1. Change of Physical Location

a. A licensed OTP provider, including those OTPs who qualify under the grandfather provision, undergoing a change of physical location in the same licensed geographic service area shall submit a written attestation of the change of physical location, including the license number, state ID, current address and new address, and the department shall re-issue the FNR approval with the name and new physical location.

b. A licensed OTP provider, including those OTPs who qualify under the grandfather provision, undergoing a change of physical location outside of the licensed geographic service area shall submit a new FNR application and appropriate fee and undergo the FNR approval process.

2. A licensed OTP provider undergoing a change of ownership shall submit a new application to the department's FNR program, requesting a transfer of the FNR approval to the new owner. Facility need review approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, provided that the legal change of ownership documents require the seller's or transferor's written relinquishment of the FNR approval.

3. Facility need review 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.

C. The following timeframes shall apply for complying with the requirements for obtaining LDH licensure as an opioid treatment program after receipt of OTP FNR approval and for complying with all applicable federal, state, and local laws and regulations.

1. An approved OTP that shall operate in existing buildings, shall achieve LDH licensure no later than one year from the date of the OTP FNR approval.

2. For an approved OTP that shall operate in a newly constructed building, licensure shall be achieved no later than 18 months from the date of OTP FNR approval. For approved OTPs that will operate in a newly constructed building, architectural plan approvals shall be obtained no later than six months from the date of the OTP FNR approval.

a. 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.

b. Inappropriate zoning is not a basis for extension.

3. If the OTP FNR approved location(s) fails for any reason, LDH reserves the right to reissue the RFA. If the approved OTP does not become licensed within these timeframes the OTP FNR approval shall automatically expire.

4. If an approved OTP fails to become licensed within these timeframes, the department may issue a new RFA.

D. An OTP that intends to relinquish its FNR approval prior to the expiration of the timeframes in this Section, shall submit a letter of such intent to the LDH FNR program.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:234 (February 2024).

§12533. Hospice Providers

A. Except as otherwise provided in this Chapter, no hospice provider shall be licensed to operate unless the FNR

program has granted an approval for the issuance of a hospice provider license. Once the FNR approval is granted, a hospice provider is eligible to be licensed by the department, subject to meeting all of the requirements for licensure.

B. The geographic service area for proposed or existing hospice providers is any parish within a 50 mile radius of the proposed physical location where the provider is or will be licensed.

C. Determination of Need/Approval.

1. The FNR committee will review the FNR application to determine if there is a need for an additional hospice provider within a 50 mile radius of the proposed physical location that the application is submitted.

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

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

a. the number of other hospice providers within a 50 mile radius of the proposed physical location servicing the same population; and

b. allegations involving issues of access to hospice provider 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 the recipients' ability to access hospice care if the hospice provider is not allowed to be licensed. The FNR committee shall not approve any FNR application if the application fails to provide such data and evidence.

D. Applications for approvals of licensed hospice 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 physical location as defined in the application. Facility need review approval of licensed hospice providers shall expire if these aspects of the application are altered or changed.

E. Except as otherwise provided below, FNR approvals for licensed hospice providers are non-transferrable and are limited to the physical location and the name of the original licensee.

1. A hospice provider undergoing a change of physical location within a 50 mile radius of the licensed physical location shall submit a written attestation of the change of physical location, including the license number, state ID, current address and new address, and the department shall re-issue the FNR approval with the name and new physical location. A hospice provider undergoing a change of physical location outside of the 50 mile radius of the licensed physical location shall submit a new FNR application and fee, and undergo the FNR approval process.

2. A hospice provider undergoing a change of ownership shall submit a new FNR application to the department's FNR program, requesting a transfer of the FNR approval to the new owner. Facility need review approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, provided that the legal change of ownership documents require the seller's or transferor's written relinquishment of the FNR approval.

3. Facility need review approval of a licensed provider shall automatically expire if the hospice provider is moved or transferred to another party, entity or physical location without an application being made to, and approval from the FNR program.

F. The following timeframes shall apply for complying with the requirements for obtaining approval of architectural plans and/or licensure.

1. Hospice outpatient providers shall be licensed within six months from the date of the FNR approval.

2. Hospice inpatient facilities that are to be licensed in existing buildings, shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within one year from the date of the FNR approval.

3. Hospice inpatient facilities that are to be licensed in newly constructed buildings, shall have final architectural plans approved no later than six months from the date of the FNR approval. Such facilities shall be licensed within 24 months from the date of the FNR approval.

4. 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 an extension.

5. Failure to meet any of the timeframes in this Section shall result in an automatic expiration of the FNR approval of the hospice agency or facility.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and 40:2116 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:235 (February 2024).

Subchapter C. Revocation of Facility Need Review Approvals

§12537. General Provisions

A. 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.

B. 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.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:235 (February 2024).

Subchapter D. Relocation of Nursing Facility Beds

§12541. General Provisions

A. A NF's approved beds (e.g. Medicaid FNR approvals) cannot be relocated to a different service area, subject to the exceptions in §12541.C.and §12541.D. below.

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

1. Subject to the exceptions in B.2 and C of this Section all of a NF's approved beds shall 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 B.1 of this Section, a partial relocation of approved beds may be affected if the following conditions are met:

a. the approved beds are in a NF 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 shall be transferred to the hospital service district to which the beds are relocated; and

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

3. If, within five years after a partial relocation to a hospital site pursuant to B.2 of this Section, 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 that 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 B.2.c of this Section only once.

5. Subsection B.2-4 of this Section are not intended to prohibit or restrict the relocation of all of the approved beds in a NF by a hospital service district in accordance with Subsections A and B.1 of this Section.

C. In addition to §12541.B approved beds may be relocated in the same service district or same parish under the following conditions.

1. The department may approve a one-time partial relocation/transfer of a NF's Medicaid FNR approvals to another licensed, certified, operational NF in the same parish, provided that all of the following provisions are met.

a. The transferring NF shall send a written request to the department's licensing section at least 30 days before the proposed transfer, for the department's review and approval.

b. The transferring NF may relocate/transfer Medicaid FNR approvals to another NF pursuant to §12541.C only once.

c. The transferring NF and the receiving NF shall be related companies that are under common ownership.

i. For purposes of §12541.C, common ownership is defined as the same persons or entities owning at least 80 percent of both companies.

ii. For purposes of §12541.C, ownership includes, but is not limited to, shares in a corporation, membership in a limited liability company, or partnership interest in a partnership or limited liability partnership.

d. The transferring NF may not relocate/transfer less than 10 Medicaid FNR approvals to another NF.

e. A transferring NF may not relocate/transfer more than 25 percent of its Medicaid FNR approvals to another facility.

f. The Medicaid FNR approvals relocated/transferred become Medicaid FNR approvals of the receiving NF, and the transferring NF relinquishes all rights in those Medicaid FNR approvals, but may retain licensure of the licensed NF beds.

g. At the time of the relocation/transfer of the Medicaid FNR approvals, the receiving facility shall have more licensed NF beds than it has Medicaid FNR approvals. The number of Medicaid FNR approvals transferred shall not exceed the number of licensed-only beds (e.g., licensed NF beds not having Medicaid FNR approval) at the receiving NF. The receiving NF is prohibited from receiving more Medicaid FNR approvals than can be utilized for the receiving NF's current licensed bed capacity. Under no circumstances shall a receiving facility license additional beds in order to accommodate the relocated Medicaid FNR approvals. After the relocation, the receiving NF shall have the same number of licensed beds as prior to the relocation.

h. All relocated Medicaid FNR approvals are subject to state and federal bed change guidelines and procedures.

i. The provisions of §12541.C pertaining to the transfer of Medicaid FNR approvals shall sunset in 24 months from the date of the promulgation of the final Rule implementing §12541.C and shall have no effect henceforth.

D. In addition to Subsections B and C of this Section, Medicaid FNR approvals of an existing licensed and certified NF that is awaiting the completion of a replacement NF building, may be temporarily relocated to a licensed building that may be outside of the service area or parish of the existing FNR approved service area or parish under the following conditions.

1. The department may approve a one-time temporary relocation of a NF's Medicaid FNR approvals to another licensed building that may be outside the existing FNR approved service area or parish provided that all of the following provisions are met.

a. The relocating NF shall send a written request to the department's HSS at least 30 days before the proposed temporary relocation outside the existing FNR approved service area or parish, for the department's review and approval. This request shall include all good cause grounds for the temporary relocation of the Medicaid FNR approvals. The department will determine if approval of the temporary relocation will be granted.

b. The NF shall not temporarily relocate to a licensed building located in a service area or parish that is greater than 100 miles from the existing licensed service area or parish of the NF.

c. The temporarily relocating NF shall maintain the same number of licensed and Medicaid FNR approved beds as prior to the relocation.

d. All temporarily relocated Medicaid FNR approvals of the licensed and certified NF are subject to compliance with all state and federal licensure/certification guidelines and procedures.

e. The temporary location shall be in compliance with all licensing and certification standards for nursing facilities, and receive a temporary NF license issued by the department.

f. The temporary license shall expire six months from the date of issuance and the facility shall relocate to its new replacement NF building during that period. One extension of the temporary license, not to exceed 90 days, may be granted by the department for good cause shown.

g. During the period of temporary licensure, the NF shall not accept any new admissions to the facility.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:236 (February 2024) amended LR 50:988 (July 2024).

Subchapter E. Nursing Facility Bed Abeyance

§12545. General Provisions

A. A NF 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 §12545.B.

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 NF license, and the Medicaid provider agreement shall submit to the department a written request signed by each such person or entity. The written request shall:

1. specify the date, that shall be no later than 120 days after the receipt of the request by the department that the intended closure of the facility will occur; and

2. designate an individual, referred to hereafter 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 shall 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 in §12545.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 §12545.,L. If the department determines that these requirements have not been met or that the issuance of a Notice of Abeyance would conflict with §12545.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 shall 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 that are not designated to be re-enrolled as Medicaid NF 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 that must be taken out of abeyance and re-enrolled as Medicaid NF beds.

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

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

b. A NF 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 NF 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 NF 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 §12545.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 shall be taken out of abeyance and re-enrolled as Medicaid NF 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 that are designated to be re-enrolled as Medicaid NF 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 §12545.I to the designated contact person, the department determines that the requirement set forth in §12545.H is no longer met, the obligation to place the facility's beds back in service in accordance with §12545.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 §12545.L, 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 instrument purporting to transfer a bed.

N. All of a facility's beds that are taken out of abeyance and re-enrolled in the Medicaid program, shall remain located together in one facility that 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 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:237 (February 2024).

Subchapter F. Exception Criteria for Facility Need Review Bed Approvals

§12549. Declared Disasters and Emergency Events

A. The FNR approvals for a licensed and Medicaid certified NF, ICF/DD, ARCP, hospice, PDHC, BHSP of CPST, PSR or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services, located in an area or areas that 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 NF or ARCP, and one year for an ICF/DD, a hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services, following the original date of such executive order or proclamation, provided that the following conditions are met:

1. The NF, ICF/DD, ARCP, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or and HCBS provider of RC, PCA, SIL, or MIHC services, 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 NF, ICF/DD, ARCP, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services, has experienced an interruption in the provision 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 NF, ICF/DD, ARCP, hospice, PDHC, BHSP of CPST, PSR, or OTP services or, an HCBS provider of RC, PCA, SIL, or MIHC services, intends to resume operation as a NF, ICF/DD, ARCP, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services, in the same geographic service area;

i. if the ICF/DD was approved through a request for proposal (RFP), the ICF/DD shall conform to the requirements of the RFP as defined by the department;

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

d. pursuant to these provisions, an extension of the 60-day deadline may be granted at the discretion of the department.

2. A NF, ICF/DD, ARCP, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services resumes operating as a NF, ICF/DD, ARCP, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services in the same geographic service area, within two years for a NF or ARCP and within one year for an ICF/DD, a hospice, PDHC, BHSP

provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services of the original executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

3. The NF, ICF/DD, ARCP, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services, continues to submit licensure required documentation and information to the department, as requested;

4. All necessary repairs shall be completed, and all construction plans by all required agencies shall be approved during the period described in Paragraph 2 of §12549.A; and

5. if a provider temporarily relocates to another licensed location as a result of an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766, such relocation shall not extend beyond the period described in Paragraph 2 of §12549.A.

B. For good cause shown, the department may, in its sole discretion, grant two extensions of six months each, for a total of twelve additional months, to a facility described in Subsection A of this Section, during which time the FNR approvals shall remain in effect and not be terminated, revoked, or considered to have expired, provided that the following conditions are met:

1. A NF, ICF/DD, ARCP, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services submits a written extension request to the department 30 days prior to the expiration of the original time period established in Subsection A of this Section or the expiration of the first extension granted under these provisions.

a. The written extension request shall include evidence of progress in re-opening, including construction and expenditures on the repairs to or replacement of the facility.

b. The written extension request shall include an estimated re-opening date for the facility.

2. The facility resumes operating as a NF, ICF/DD, ARCP, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services in the same geographic service area, within the time period of the extension(s).

3. The facility continues to submit the required documentation and information to the department, as requested.

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

1. a NF, ICF/DD,ARCP, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services that has voluntarily surrendered its FNR bed approval; or

2. a NF, ICF/DD,ARCP, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services that fails to resume operations as a NF, ICF/DD,ARCP, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services in the same service area, within two years for a NF or ARCP and within one year for an ICF/DD, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services or within the deadlines of any extensions granted thereto, of the original executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766.

D. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the FNR bed approvals.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:238 (February 2024).

§12551. Non-Declared or Other Emergency Events

A. This section applies to emergency situations that an executive order or proclamation of emergency or disaster pursuant to R.S. 29:724 or R.S. 29:766 has not been issued.

B. The FNR approvals for a licensed and Medicaid certified NF, ARCP,ICF/DD, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services that is rendered unable to provide services to the public because of an emergency situation or disaster, including, but not limited to, fire, flood, tornado, or other condition that the provider is not primarily responsible, 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 NF and ARCP, and one year for an ICF/DD, hospice, PDHC, BHSP of CPST, PSR, and OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services, following the date of such emergency situation or disaster, provided that the following conditions are met:

1. the NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, and OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services shall submit written notification to the HSS within 30 calendar days of the date of the emergency situation or disaster that:

a. the NF, ARCP, ICF/DD, hospice, PDHC, BHSP provider of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services has experienced an interruption in the provisions of services as a result of conditions that are described in §12551.B;

b. the NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services intends to resume operation as a NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services in the same service area;

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

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

2. the NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services resumes operating in the same geographic service area, within two years for a NF or ARCP, and within one year for an ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services of the non-declared emergency or disaster; and

3. the NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services continues to submit the required documentation and information to the department, as requested.

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

1. a NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services that has voluntarily surrendered its FNR bed approval; or

2. a NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services that fails to resume operations in the same geographic service area, within two years for a NF or ARCP, and within one year for an ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services of the non-declared emergency or disaster.

F. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the FNR bed approvals.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:239 (February 2024).

§12553. Temporary Inactivation Due to Major Alterations

A. A NF, ARCP, ICF/DD, hospice, PDHC, or BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services that is undergoing major alterations to its physical plant may request a temporary inactivation of a certain number of the facility's FNR bed approvals provided that:

1. the NF, ARCP, ICF/DD, hospice, PDHC, or BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services submits a written request to the licensing agency of the department seeking temporary inactivation of a certain number of its FNR bed approvals. Such written request shall include the following:

a. a statement that the NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services is undergoing major alterations to ensure or enhance the health, safety, and welfare of the residents;

b. a statement that the major alterations to the NF, ARCP, ICF/DD, hospice, PDHC, or BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services will cause a certain number of beds to be de-licensed and dis-enrolled;

c. an attestation that the major alterations are the sole causal factor in the request for temporary inactivation of a certain number of the facility's FNR bed approvals;

d. the anticipated start date of the temporary inactivation of a certain number of the facility's FNR bed approvals;

e. the anticipated end date of the temporary inactivation of a certain number of the facility's FNR bed approvals; and

f. the number of the facility's FNR bed approvals requested to be inactivated temporarily;

2. upon receipt of a completed written request by a facility for temporary inactivation of FNR approvals for a NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services, the department shall issue a notice of temporary inactivation of a certain number of the facility's FNR bed approvals;

3. upon completion of the major alterations and meeting the requirements for licensure, the facility shall submit to the department a completed written request to reinstate the FNR bed approvals that were inactivated due to the major alterations to the facility;

4. the FNR bed approvals capacity, after major alterations are completed, shall not exceed the FNR bed approvals capacity of the NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services at the time of the request to temporarily inactivate a certain number of its FNR bed approvals prior to the major alterations.

5. the provisions of this Subsection shall not apply to:

a. a NF, ARCP, ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services, that has voluntarily surrendered its license or has voluntarily dis-enrolled the facility's beds from Medicaid; or

b. a NF, ARCP, ICF/DD, hospice, PDHC, or BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services that fails to resume operations in the same geographic service area, within two years for a NF or ARCP, and within one year for an ICF/DD, hospice, PDHC, BHSP of CPST, PSR, or OTP services, or an HCBS provider of RC, PCA, SIL, or MIHC services.

6. there shall be no effect upon the Medicaid reimbursement rate of a nursing facility or an ICF/DD that is undergoing major alterations pursuant to this Rule during the period of the inactivation of the FNR approval.

7. failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the FNR bed approvals.

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

HISTORICAL NOTE: Promulgated by the Department of Health, Health Standards Section, LR 50:240 (February 2024), amended LR 50:988 (July 2024).

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.

Committee—The Opioid Treatment Program (OTP) application review committee.

Department—the Department of Health and Hospitals (DHH) in the state of Louisiana. The following is a list of pertinent sections.

DHH Administrative Regions—The administrative regions and the parishes which comprise these regions are as follows:

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

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

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

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

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

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

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

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

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

Health Standards Section (HSS)—Section of Bureau of Health Services Financing, DHH that surveys, licenses and serves as the regulatory body for health care facilities in the state, including opioid treatment programs.

Methadone Maintenance Program—see *Opioid Treatment Program.*

Notification—is deemed to be given on the date on which a decision is mailed by DHH by certified mail to the last known address of the applicant.

Office for Addictive Disorders (OAD) or its successor organization—DHH office and single state agency that is statutorily responsible for the treatment and prevention of addictive disorders.

Opioid Treatment Program (OTP)—a program engaged in medication-assisted opioid treatment of individuals with an opioid agonist treatment medication.

Opioid Treatment Program Application Review—a review of applications to select an OTP to be licensed once a need has been determined.

Opioid Treatment Program Need Review—a review to determine whether there is a need for new or additional OTPs in a certain geographic location.

Secretary—the Secretary of the DHH.

State Opioid Treatment Authority—the OAD authority within DHH designated to exercise the responsibility and authority within the state for governing the treatment of opiate addiction with an opioid drug.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:521 (March 2010).

§12903. General Information

A. No opioid treatment program may be licensed in the state of Louisiana after July 1, 2001 unless the department has determined, in its discretion, that there is a need for new or additional opioid treatment programs in a certain geographic location. The department will provide criteria and processes for determining whether such a need exists and procedures for selecting an opioid treatment program to

be licensed once a need has been determined. An offsite location and/or a mobile site of an existing OTP clinic is considered a new OTP and, as such, must receive approval of the department OTP need and applications reviews.

1. The department shall conduct an OTP need review to determine if there is a need for new or additional opioid treatment programs in a certain geographic location.

2. Once the need has been determined, the department will issue a request for applications for new or additional OTPs.

3. The department shall conduct an OTP application review.

4. Once the application review approval is granted, the OTP is then eligible to apply for a license from the department.

B. The duties of the department under this opioid treatment program (OTP) need review and application review include, but are not limited to:

1. defining the appropriate methodology for the collection of data necessary for the administration of the OTP need review; and

2. developing the application review process.

C. Grandfather Provision. An approval shall be deemed to have been granted without OTP need or application review for OTPs that were licensed and approved in Section 7403 prior to July 1, 2001.

D. OTP application review approvals are non-transferable. Approvals for licensed OTPs are limited to the name of the original licensee and to the location unless exempted from the need and application reviews.

1. For all OTPs undergoing a change of ownership after July 1, 2010, including those OTPs who qualify for the Grandfather Provision, the buyer must submit a new application and obtain approval from the OTP application review committee prior to the change of ownership.

2. For all OTPs undergoing a change in location after July 1, 2010, including those OTPs who qualify for the Grandfather Provision, the owner must submit a new application and obtain approval from the OTP application review committee prior to the change of location.

E. Exemptions from OTP Need Review and Application Review

1. Exemptions from OTP need review and application review shall be made for OTP clinics that meet the following criteria:

a. an OTP clinic is replaced due to destruction by fire or a natural disaster, such as a hurricane, and is closed no longer than eight months; or

b. an OTP clinic is replaced due to potential

health hazard in the clinic and is closed for no longer than 150 days.

2. One extension of no more than three months may be granted upon the documentation of good cause, provided the extension is requested no later than one month from the original deadline.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:522 (March 2010).

Subchapter B. Determination of Need

§12905. Opioid Treatment Program Need Review

A. The OTP need review includes criteria and processes to determine the need for new or additional OTPs in a certain geographic location within an identified DHH administrative region.

B. Determination of Need

1. The department will determine need through a review and evaluation of the following criteria:

a. estimated prevalence of opioid addiction in the population of the geographic area to be served; and

b. estimated number of persons in need of medication-assisted treatment for opioid addiction in the geographic area; and

c. estimated treatment demand for medication-assisted opioid addiction treatment in the geographic area to be served; and

d. existing access, utilization and availability of medication-assisted opioid addiction treatment in the geographic area to be served.

2. A determination of need will utilize data sources that include information compiled and recognized by the department and/or any of the following: Substance Abuse and Mental Health Services Administration (SAMHSA), the United States Census Bureau, the Drug Enforcement Administration (DEA) and the National Institute on Drug Abuse (NIDA).

C. The department may conduct additional need reviews only when special needs and circumstances arise which indicate the need for additional medication-assisted opioid addiction treatment services, such as increased utilization rates, reduced availability, and/or reduced accessibility of services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:523 (March 2010).

Subchapter C. Procedure for Selection of Opioid Treatment Program

§12907. Opioid Treatment Program Application Review

A. If the department determines that there is a need for services in a DHH region, the department will issue a request for applications (RFA) announcement statewide through the Louisiana Press Association. The RFA will specify the dates during which the department will accept applications.

B. No applications will be accepted under these provisions unless the department declares a need and issues an RFA.

C. Any applicant to open an OTP must adhere to all policies, rules and regulations set forth by the State of Louisiana and the Department of Health and Hospitals. Services shall be provided in accordance with standards set forth by SAMHSA, DHH Health Standards, the US Department of Justice/Drug Enforcement Administration (DEA), the Louisiana Board of Pharmacy and all applicable, SAMHSA-approved accrediting bodies.

D. Any applicant to open an OTP shall be free of any conviction for, or guilty plea, or plea of nolle contendere to a felony. If the applicant is an agency, the owners of that agency must be free of such felony convictions.

E. The OTP request for applications will indicate which department administrative region is in need of openings, or slots, for clients; the number of slots needed, the date by which the slots need to be available to the target population and the factors which the department considered relevant in determining the need for the treatment slots. The OTP request for applications will specify the type of information on which the determination of need was based.

F. OTP applications shall be submitted to the DHH Office for Addictive Disorders, State Opioid Treatment Authority.

1. Application forms shall be requested in writing or by telephone from the Office for Addictive Disorders, State Opioid Treatment Authority, who will provide application forms, criteria utilized to determine need and other materials relevant to the application process.

2. The applicant representative specified on the application will be the only person to whom the DHH Office for Addictive Disorders 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 DHH Office for Addictive Disorders, State Opioid Treatment Authority, in writing.

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

a. a letter of intent to inform the department that the applicant requests an OTP application review and to include the following:

i. the name, address and telephone number of the applicant;

ii. the name of the applicant representative, an individual authorized to respond to department questions regarding the application and who also signs the letter of intent;

iii. the proposed location of the OTP; and

iv. a brief description of the proposed service, and the proposed date of implementation;

b. an original and three copies of the application. An application shall be submitted on forms provided for that purpose, contain such information as the department may require, and be accompanied by a nonrefundable fee of $600.

4. Applications will be accepted for a period to be specified in the request for application.

5. Once submitted, an application cannot be changed and additional information will not be accepted.

6. Submitted applications failing to meet these guidelines or without the required fee will not be processed and will be returned to the applicant.

G. The OTP committee shall be appointed by the Secretary of the Department of Health and Hospitals. DHH appointments to the OTP committee shall include the following members:

1. DHH OAD Medical Director or physician who has expertise in substance abuse treatment and, in particular, opioid treatment;

2. Executive Director of the DHH Office for Addictive Disorders program service region or district in which the proposed OTP would be located;

3. licensed addiction counselor approved by the Louisiana Addictive Disorder Regulatory Authority and DHH Office for Addictive Disorders;

4. member of the Louisiana Board of Pharmacy;

5. Louisiana State Opioid Treatment Authority;

6. current President of the State Opioid Treatment Authority Alliance or a State Opioid Treatment Authority from another state; and

7. DHH OAD Fiscal Director.

H. No committee member shall have a proprietary, financial, professional or other personal interest of any nature or kind in any OTP.

I. The applicant shall make a brief presentation of the proposed program before the committee and respond to questions raised by the committee.

J. The department sets the review period, which will be no more than 60 days, except as noted below. The review period begins on the first day after the date of receipt of the application.

1. A longer review period will be permitted only when initiated by the committee. A maximum of 30 days will be allowed for an extension.

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 DHH Office for Addictive Disorders.

K. The committee will review the applications and independently evaluate and assign points in each of the following subject areas for the quality and adequacy of the applicant's responses:

1. financial viability and availability of funds;

2. licensure and/or accreditation:

a. work plan for accreditation and state licensure;

b. history of compliance with accreditation, licensure and/or certification bodies related to the provision of healthcare services;

3. range of services and program design;

4. community integration:

a. availability, accessibility and appropriateness of the location of the proposed OTP site; (for example: accessibility to public transportation and healthcare providers; location in relation to children's schools and playgrounds);

b. methods to achieve community integration through a community relations plan.

L. A score will be given to the applicants' responses on the application.

M. The approved highest scoring application will then be forwarded to the DHH Secretary for final approval.

N. Upon the secretary's final approval, the Office for Addictive Disorders State Opioid Treatment Authority will forward a notice of approval letter to the applicant representative.

O. Each applicant will be notified of the department's decision. Notification shall be sent by certified mail to the applicant representative.

P. Notification shall be sent to the applicant at his last known address. An applicant is responsible for notifying the department of any change of address.

Q. Applications approved under these provisions are bound to the description in the application with regard to opioid treatment as well as to the location. The OTP application review approval shall expire if these aspects of the application are altered, except as noted below.

1. If, due to no fault of the approved OTP applicant, the location fails, the applicant has 30 days from the application approval date to secure an alternate location and submit the location to the committee.

2. The committee will approve or deny the alternate location within 15 days of submittal.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:523 (March 2010).

Subchapter D. Administrative Appeals

§12909. Appeal Procedures

A. Upon denial of the department to grant an OTP proposal review approval, only the applicant shall have the right to request an administrative appeal.

1. A written request for such an appeal must be submitted to the secretary within 30 days after the notification of the denial is received by the applicant.

2. The request shall contain a statement setting forth the specific reasons the applicant disagrees with the denial.

3. All administrative appeals shall be consolidated for purposes of the hearing.

B. Administrative Hearings

1. The hearings shall be conducted at the DHH Bureau of Appeals in accordance with the Administrative Procedures Act.

2. Any party may appear and be heard at any appeal proceeding through an attorney or designated representative. A person appearing in a representative capacity shall file a written notice of appearance on behalf of the provider identifying his/her name, address, telephone number and the party being represented.

3. The hearing shall be conducted within 60 days after receipt of the written request for the hearing. Either party may request an extension of the hearing date upon a showing of good cause provided that the hearing is rescheduled to a date no later than 120 days from receipt of notice of the department's decision.

4. The Bureau of Appeals may schedule a preliminary conference. If one is scheduled, the parties shall be notified in writing of the date, time and place of the conference.

5. The applicant and department will be notified in writing of the date, time and place of the administrative hearing no later than 15 calendar days prior to the hearing.

6. An applicant who has requested an administrative appeal shall present his case first and has the burden to show by a preponderance of the evidence that his application should have been approved by the department pursuant to the provisions of this rule. After the applicant 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.

7. If an applicant fails to appear at the administrative hearing, a decision shall be issued by the Bureau of Appeals dismissing the appeal. The dismissal may be rescinded upon order of the Bureau of Appeals if the applicant makes written application within 10 calendar days following the mailing of the dismissal order and provides evidence of good cause for the failure to attend the hearing.

C. The issuance of the approval shall be suspended if an applicant files an appeal. The suspension is effective only during the administrative appeal process.

D. Within 20 days of the completion of the hearing, The Bureau of Appeals shall make a written decision. The written decision shall be final, binding and enforceable. A copy of the decision shall be mailed to the applicant at his last known address or to his authorized representative.

E. An applicant has the right to file for judicial review in accordance with the Administrative Procedures Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:524 (March 2010).

§12911. Licensing and Certification Compliance

A. The following time frames shall apply for complying with the requirements for obtaining DHH licensure as an opioid treatment program and for complying with all applicable federal, state, and local laws and regulations.

1. Opioid treatment programs shall achieve DHH licensure no later than one year from the date of the OTP application review approval.

2. OTPs shall be in compliance with all applicable OTP federal, state, and local laws and regulations no later than one year from the date of the OTP application review approval.

B. Failure to meet the timeframes in this section could result in an automatic expiration of the OTP application review approval of the OTP.

C. An OTP that intends to relinquish application review approval prior to the expiration of the timeframes in this Section, shall submit a letter of such intent to the DHH Office for Addictive Disorders State Opioid Treatment Authority.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:525 (March 2010).

Subchapter E. Rescission of OTP Need Review Application Approvals

§12913. General Provisions

A. Opioid treatment program application review approval shall be automatically rescinded upon rendering of a final decision under the following circumstances:

1. a clinic's license is revoked;
2. a clinic's license is not renewed;
3. a clinic's license is denied;
4. a clinic's license is voluntarily surrendered;
5. a cessation of the clinic's business;
6. a clinic's accreditation is revoked;
7. a clinic's accreditation is not renewed;
8. a clinic's accreditation is denied.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:1058.1 et seq.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office for Addictive Disorders, LR 36:525 (March 2010).