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

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

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

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

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

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

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

*CMS*—Centers for Medicare and Medicaid Services.

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

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

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

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

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

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

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

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

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

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

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

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

*Intermediate Care-Level II (IC-II)*—a level of care within a nursing facility which provides supervised personal care and health related services, under the direction of a physician, to persons who need nursing supervision in addition to help with personal care needs. Services are provided under the supervision of a registered nurse seven days a week during the day tour of duty with licensed nurses 24 hours a day.

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

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

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

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

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

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

a. skilled nursing care and related services for residents who require medical or nursing care;

b. rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

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

*Outpatient Abortion Facility*—any outpatient facility licensed by the Department of Health and Hospitals pursuant to R.S. 40:2175.1 et seq., or its successor licensing statute.

*Pediatric Day Health Care (PDHC) Providers*—a facility that may operate seven days a week, not to exceed 12 hours a day, to provide care for medically fragile children under the age of 21, including technology dependent children who require close supervision. Care and services to be provided by the pediatric day health care facility shall include, but not be limited to:

a. nursing care, including, but not limited to:

i. tracheotomy and suctioning care;

ii. medication management; and

iii. intravenous (IV) therapy;

b. respiratory care;

c. physical, speech, and occupational therapies;

d. assistance with activities of daily living;

e. transportation services; and

f. education and training.

*Person*—an individual or other legal entity.

*Program*—the Facility Need Review Program.

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

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), LR 28:2190 (October 2002), LR 30:1023 (May 2004) , LR 32:845 (May 2006), , LR 34:2611 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2437 (November 2009), amended LR 36:323 (February 2010), LR 38:1961 (August 2012), LR 41:135 (January 2015).

**§12505. Application and Review Process**

A. FNR applications shall be submitted to the Bureau of Health Services Financing, Health Standards Section, Facility Need Review Program. The application shall be submitted on the forms (on 8.5 inch by 11 inch paper) provided for that purpose, contain such information as the department may require and be accompanied by a nonrefundable fee of $200. An original and three copies of the application are required for submission.

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

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

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

a. certification of the number and ratio of Medicaid approved nursing facility beds that will be converted to ARC units;

b. a letter of intent that includes the location of the proposed ARC site and the proposed date of opening;

d. certification that the applicant will provide services as defined in the statute; and

e. certification which includes the following:

i. that the applicant has reviewed the licensing regulations and will comply with the licensing regulation; and

ii. acknowledgement that failure to meet the time-frames established in this Chapter will result in automatic expiration of the FNR approval for the ARCP units.

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

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

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

a. The application fee is non-refundable.

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:812 (August 1995), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), , amended LR 35:2438 (November 2009), LR 36:323 (February 2010), LR 38:1593 (July 2012).

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

**§12508. Pediatric Day Health Care Providers**

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

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

C. Determination of Need/Approval

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

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

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

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

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

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

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

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

1. A PDHC provider undergoing a change of location in the same licensed service area shall submit a written

attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. A PDHC provider undergoing a change of location outside of the licensed service area shall submit a new FNR application and appropriate fee and undergo the FNR approval process.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 41:136 (January 2015).

**§12511. Nursing Facilities**

A. The service area for proposed or existing nursing facilities or beds is the parish in which the site is located.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. appointment of a temporary manager;

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

iii. license revocation or non-renewal.

2. When average annual occupancy for the four most recent quarters (as reported in the LTC-2) exceeds 95 percent in a parish, the department will determine whether additional beds are needed, and if indicated, may issue a Request for Proposals (RFP) to develop the needed beds.

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

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

i. special needs in an area;

ii. information received from other health care providers and other knowledgeable sources in the area;

iii. waiting lists in existing facilities;

iv. requests from the community;

v. patient origin studies;

vi. appropriateness of placements in an area;

vii. remoteness of an area;

viii. occupancy rates in adjoining and/or adjacent parishes;

ix. availability of alternatives;

x. reasonableness of distance to facilities;

xi. distribution of beds within a service area or geographical area; and

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

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

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

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

b. The RFP will indicate the parish and/or area in need of beds, the number of beds needed, the date by which the beds are needed to be available to the target population (enrolled in Medicaid), and the factors which the department considers relevant in determining need for the additional beds. The RFP will specify the LTC-2 on which the determination of need is based.

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

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

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

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

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

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

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

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

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

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

i. 0 = inadequate response;

ii. 5 = marginal response;

iii. 10 = satisfactory response;

iv. 15 = above average response; and

v. 20 = outstanding response.

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

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

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

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

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

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

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

HISTORICAL NOTE: Repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:808 (August 1995), amended LR 28:2190 (October 2002), LR 30:1483 (July 2004), LR 34:2615 (December 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:3264 (November 2011).

**§12523. Home and Community-Based Service Providers**

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

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

C. Determination of Need/Approval

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Determination of Need/Approval

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

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

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

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

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

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

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

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

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

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

3. FNR approval of a licensed ADHC provider shall automatically expire if the ADHC provider moves or relocates, if the ADHC provider sells, transfers, or conveys ownership of the ADHC provider to another party or entity, or if the ADHC provider sells, transfers or conveys the FNR

**§12525. Adult Day Health Care Providers**

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

approval to another party, entity, or location, unless the ADHC provider has submitted application to and received approval from the FNR Program.

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

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

**§12526. Hospice Providers**

A. 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 Program 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 service area for proposed or existing hospice providers is within a 50 mile radius of the proposed geographic location where the provider is or will be licensed.

C. Determination of Need/Approval

1. The department will review the application to determine if there is a need for an additional hospice provider within a 50 mile radius of the proposed geographic location for which the application is submitted.

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

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

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

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

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

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

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

1. A hospice provider undergoing a change of location within a 50 mile radius of the licensed geographic location shall submit a written attestation of the change of location and the department shall re-issue the FNR approval with the name and new location. A hospice provider undergoing a change of location outside of the 50 mile radius of the licensed geographic 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. FNR approval for the new owner shall be granted upon submission of the new application and proof of the change of ownership, which must show the seller's or transferor's intent to relinquish the FNR approval.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:1593 (July 2012).