RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Direct Service Worker Registry Training Curriculum
(LAC 48:I.9215)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 48:I.9215 as authorized by R.S. 40:2179-2179.1. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Title 48
PUBLIC HEALTH—GENERAL
Part I. General Administration
Subpart 3. Health Standards
Chapter 92. Direct Service Worker Registry
Subchapter B. Training and Competency Requirements
§9215. Training Curriculum

A. - B.3. ...

C. Curriculum Approval. Effective March 1, 2009, licensed providers and other state-approved training entities that wish to offer training for direct service workers, and do not have a training curriculum approved by the department, must use the training curriculum developed by Health Standards. Training curriculums approved by Health Standards prior to March 1, 2009 may continue to be used.

1. To obtain approval to use the Health Standards training curriculum, an entity (provider or school) must submit the following documentation to the Health Standards Section:

a. the name of the training coordinator and his/her qualifications; and

b. a list of any other instructors.

c. Repealed.

2. If a school is applying for approval, it must identify the place(s) used for classroom instruction and clinical experience.

3. If a provider or school that has an approved curriculum ceases to provide training and/or competency evaluations, it must notify the department within 10 days. Prior to resuming the training program and/or competency evaluations, the provider or school must reapply to the department for approval to resume the program.

4. Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2179-2179.1.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2060 (November 2006), amended LR 33:96 (January 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2437 (November 2009).

Alan Levine
Secretary

0911#087

RULE

Department of Health and Hospitals
Bureau of Health Services Financing

Facility Need Review—Exception Criteria
for Bed Approval and Home and
Community-Based Service Providers
(LAC 48:I.12501-12505, 12513,
12523, 12527, 12533, and 12541)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 48:I.12501-12505, 12513, 12527, 12533 12523 and adopted §§12541-12553 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 40:2116. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq.

Title 48
PUBLIC HEALTH—GENERAL
Part 1. General Administration
Subpart 5. Health Planning
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.

* * *

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.

* * *

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), amended LR 28:2190 (October 2002), amended LR 30:1023 (May 2004), amended 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).

§12503. General Information

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

1. nursing facilities;

2. skilled nursing facilities; and

3. intermediate care facilities for persons with developmental disabilities.

4. Repealed.

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

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

1. adult residential care providers or facilities; and

2. home and community-based service providers, as defined under this Chapter.

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

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

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

b. - d. …

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

1. - 4. Repealed.

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

1. all valid Section 1122 approved health care facilities/beds;

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

3. all valid approvals for health care facilities issued under the Facility Need Review Program; or

4. all nursing facility beds which were enrolled in Medicaid as of January 20, 1991.

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

1. HCBS providers which were licensed by January 31, 2009 or had a completed initial licensing application submitted to the department by June 30, 2008; or

2. existing licensed ICFs-DD that are converting to the proposed Residential Options Waiver.

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

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

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

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

HISTORICAL NOTE: Repealed and repromulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), amended LR 28:2190 (October 2002), LR 30:1023 (May 2004), amended LR 32:845 (May 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 34:2612 (December 2008), amended LR 35:2437 (November 2009).

§12505. Application and Review Process

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

1. - 3.e.i. …

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. - B.3.b. …

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

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

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

§12513. Alternate Use of Licensed Approved Title XIX Beds

A. - D. …

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

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

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

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

§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).

Subchapter C. Revocation of Facility Need Review Approvals

§12527. General Provisions

A. - C. …

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

D.1. - 2. …

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

F. The facility need review approval for licensed nursing facilities or ICF/DDs located in an area(s) which have been affected by an executive order or proclamation of emergency or disaster due to Hurricanes Katrina and/or Rita, and which were operating at the time the executive order or proclamation was issued under R.S. 29:794, shall be revoked or terminated unless the nursing facility or ICF/DD re-licenses and re-enrolls its beds in the Medicaid Program within 120 days from January 1, 2010.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 21:806 (August 1995), amended LR 25:1250 (July 1999), amended LR 28:2190 (October 2002), amended LR 30:1023 (May 2004), amended LR 32:845 (May 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing LR 34:2619 (December 2008), amended LR 35:2439 (November 2009).

Subchapter F. Exception Criteria for Bed Approvals

§12533. General Provisions

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

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

a. the nursing facility or ICF/DD has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

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

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

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

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

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

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

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

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

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

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

C.1. – M. Repealed.

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

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

Subchapter G. Administrative Appeals

§12541. General Provisions

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

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

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

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

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

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

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

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

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

a. date of the hearing;

b. time of the hearing; and

c. place of the hearing.

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

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

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

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

4. Each party shall have the right to:

a. call and examine parties and witnesses;

b. introduce exhibits;

c. question opposing witnesses and parties on any matter relevant to the issue, even though the matter was not covered in the direct examination;

d. impeach any witness, regardless of which party first called him to testify; and

e. rebut the evidence against him/her.

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

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

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

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

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

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

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

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

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

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

a. his/her name;

b. address;

c. telephone number; and

d. the party being represented.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2440 (November 2009).

§12543. Preliminary Conferences

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

1. clarification, formulations and simplifications of issues;

2. resolution of controversial matters;

3. exchange of documents and information;

4. stipulations of fact to avoid unnecessary introduction of witnesses;

5. other matters which may aid disposition of the issues; and

6. scheduling a hearing date that is convenient to all parties.

B. When the Bureau of Appeals schedules a preliminary conference, all parties shall be notified in writing. The notice shall direct any parties and their attorneys to appear on a specific date and at a specific time and place.

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2441 (November 2009).

§12545. Responsibilities of the Administrative Law Judge

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

1. administer oaths and affirmations;

2. regulate the course of the hearings;

3. set the time and place for continued hearings;

4. fix the time for filing briefs and other documents; and

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

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

1. take the matter under advisement; and

2. prepare a written proposed decision which will contain:

a. findings of fact;

b. a determination of the issues presented;

c. a citation of applicable policy and regulations; and

d. an order.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2441 (November 2009).

§12547. Witnesses and Subpoenas

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

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

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

D. No subpoena shall be issued until the party (other than the department) who wishes to subpoena a witness first deposits with the hearing officer a sum of money sufficient to pay all fees and expenses to which a witness in a civil case is entitled pursuant to R.S. 13:3661 and R.S. 13:3671.

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

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

1. give the name and address of the person or entity upon whom the subpoena is to be served.

2. precisely describe the material that is desired to be produced;

3. state the materiality thereof to the issued involved in the proceedings; and

4. include a statement that, to the best of applicant's knowledge, the witness has such items in his possession or under his control.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2441 (November 2009).

§12549. Continuances or Further Hearings

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

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

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

1. continue the hearing to a later date and order the party(s) to produce additional evidence; or

2. close the hearing and hold the record open in order to permit the introduction of additional documentary evidence.

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

C. Written notice of the time and place of a continued or further hearing shall be given. When a continuance of further

hearing is ordered during an administrative hearing, oral notice of the time and place of the continued hearing may be give to each party present.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2441 (November 2009).

§12551. Proposed and Final Decisions

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

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

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

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

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

D. Motions for Rehearing, Reopening or Reconsideration.

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

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

a. The decision or order is clearly contrary to the law and the evidence;

b. The party has discovered since the hearing evidence important to the issues which he could not have with due diligence obtained before or during the hearing;

c. There is a showing that issues no previously considered ought to be examined in order to properly dispose of the matter; or

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2442 (November 2009).

§12553. Failure to Appear at Administrative Hearings

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

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:2442 (November 2009).

Alan Levine
Secretary

0911#088

RULE

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

Home and Community-Based Services Waivers
Adult Residential Care (LAC 50:XXI.Chapters 301-309)

The Department of Health and Hospitals, Bureau of Health Services Financing, and the Office of Aging and Adult Services has adopted LAC 50:XXI.Chapters 301-309 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXI. Home and Community-Based Services Waivers
Subpart 15. Adult Residential Care

Chapter 301. General Provisions

§30101. Introduction

A. These standards for participation specify the requirements of the Adult Residential Care (ARC) Waiver Program. The program is funded as a waiver service under the provisions of Title XIX of the Social Security Act and is administrated by the Department of Health and Hospitals (DHH).

B. Waiver services are provided under the provisions of the approved waiver agreement between the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Medicaid Program.

C. Any provider of services under the ARC Waiver shall abide by and adhere to any federal or state laws, rules or any policy, procedures, or manuals issued by the department. Failure to do so may result in sanctions.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:2442 (November 2009).

§30103. Target Population

A. The target population for the Adult Residential Care (ARC) Waiver shall be individuals who are:

1. 65 years of age or older or 21 or over with an adult onset disability (onset at age 21 or over);
2. meet the criteria for admission to a nursing facility; and