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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."

JOHN R. ASHCROFT
SECRETARY OF STATE

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Documents will be accepted for filing on all regular workdays from 8:00 a.m. until 5:00 p.m. We encourage early filings to facilitate the timely publication of the *Missouri Register*. Orders of Rulemaking appearing in the *Missouri Register* will be published in the *Code of State Regulations* and become effective as listed in the chart above. Advance notice of large volume filings will facilitate their timely publication. We reserve the right to change the schedule due to special circumstances. Please check the latest publication to verify that no changes have been made in this schedule. To review the entire year's schedule, please check out the website at http://www.sos.mo.gov/adrules/pubsched.asp

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The rules are codified in the *Code of State Regulations* in this system—

Title	***Code of State Regulations***	**Division**	**Chapter**	**Rule**
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation , i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 2—Income Maintenance

EMERGENCY AMENDMENT

13 CSR 40-2.030 Definitions Relating to Real and Personal Property. The division is amending sections (7)–(10) and (12) and renumbering thereafter.

PURPOSE: This amendment provides for updates to the asset limits that define the real and personal property considered in determining eligibility for assistance and how the value of that property is determined.

*EMERGENCY STATEMENT: The Department of Social Services, Family Support Division (FSD), finds that this emergency amendment is necessary to preserve a compelling governmental interest in determining eligibility of MO HealthNet (Medicaid) benefits for the Aged, Blind, and Disabled (MHABD) according to House Bill 1565 that was passed in 2016. This proposed emergency amendment specifies which assets, in general, FSD must consider in the eligibility determination, and states the maximum amount of countable assets a person can have and still be eligible for MHABD. This proposed amendment also implements House Bill 1565 (2016), which increased the asset limits for MHABD incrementally until it reaches five thousand dollars ($5000) for a single person and ten thousand dollars ($10,000) for a married couple, in Fiscal Year 2021. After that, the limits will increase each year based on increases in the Consumer Price Index. This proposed amendment states the dates on which the increases will occur, and how they will be calculated. This proposed emergency amendment is necessary to preserve a compelling governmental interest that requires an early effective date as permitted pursuant to section 536.025, RSMo. Changes to the asset limit are required by statute to take effect on July 1, 2017; therefore, the emergency amendment is needed. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The FSD believes this emergency amendment to be fair to all interested persons and parties under the circumstances. The emergency amendment was filed June 20, 2017, becomes effective July 1, 2017, and expires February 22, 2018.*

(7) In those programs applying the OAA, PTD criteria, in GR cases, and in Aid to Families with Dependent Children (AFDC) cases, in certain instances as defined in sections (8)—*[(12)]***(13)** of this rule, the property will be considered as a resource which the applicant or recipient can and should use in meeting his/her needs and will not be eligible for public assistance. *(Original rule filed Feb. 6, 1975, effective Feb. 16, 1975.)* The eligibility factor of property as an available resource applies under the OAA criteria to an applicant, recipient**,** and spouse. In AFDC cases, the policy applies to a child and to a parent(s) or, as allowed by federal law or regulation, to stepparents or, if included in the grant, a needy nonparent caretaker relative or legal guardian with whom the child is living. In cases receiving GR, the policy applies to an applicant or recipient and spouse and children in the home under the age of twenty-one (21). If the GR applicant or recipient is under age twenty-one (21), it applies to his/her parent(s) in the home. In programs applying the PTD criteria, the policy applies to the applicant or recipient and spouse. *(Original rule filed Nov. 3, 1950, effective Nov. 13, 1950. Amended: Oct. 20, 1967, effective Oct. 30, 1967. Amended: July 8, 1969, effective July 18, 1969. Amended: Feb. 6, 1975, effective Feb. 16, 1975.)*

(8) When an applicant or recipient of programs applying the OAA, PTD**, or Aid to the Blind (AB)** criteria *[or GR]*, or the spouse with whom s/he lives *[or, when the GR applicant or recipient is under age twenty-one (21), the parent(s) with whom s/he lives,]* owns real property which is not furnishing shelter for him/her**,** *[and]* its current market value *[is one thousand dollars ($1000) or more if owned by a single person or more than two thousand dollars ($2000) if owned by a married person living with spouse, it shall be considered as a resource and the claimant will not be eligible for assistance on the basis of need; provided, all of the following criteria which apply are met (the value of an equity in a life estate and of burial lots shall be excluded from this computation). In GR cases involving two (2) or more persons eligible for GR, the limitation will be more than two thousand dollars ($2000).]* **shall be considered an available asset and subject to the limits of section (12) of this regulation. When an applicant or recipient of programs applying the OAA, PTD, or AB criteria is under age eighteen (18) and the parent(s) with whom s/he lives owns real property which is not furnishing shelter for him/her, its current market value shall be considered an available asset and subject to the limits of section (12) of this regulation. For GR, when an applicant or recipient or the spouse with whom s/he lives owns real property which is not furnishing shelter for him/her, its current market value shall be considered an available asset and subject to the limits of section (13) of this regulation. When an applicant or recipient of GR is under age twenty-one (21) and the parent(s) with whom s/he lives owns real property which is not furnishing shelter for him/her, its current market value**

shall be considered an available asset and subject to the limits of section (13) of this regulation. In programs applying the OAA, PTD, AB criteria, or GR, the claimant will not be eligible for assistance on the basis of need; provided, all of the following criteria which apply are met (the value of an equity in a life estate and of burial lots shall be excluded from this computation). For AFDC cases, the limitation will be one thousand dollars ($1000), except that burial lots must be excluded from this computation. If the value of real property *[is less than the amounts stated previously,]* **does not exceed the asset limits of section (12) or (13) of the rule,** it shall be counted as a part of the combination of available resources in determining eligibility*[, as stated in section (12) of this rule]*.

(9) A single individual applying for or receiving assistance in programs applying the OAA or PTD criteria who owns insurance (over and above the first one thousand five hundred dollars ($1500) in face value) with a cash or loan value of one thousand dollars ($1000) or more **through June 30, 2017,** will not be considered eligible for assistance on the basis of available resources. **Effective July 1, 2017, the cash or loan value in excess of the one thousand five hundred dollars ($1500) shall be considered an available asset and subject to the limits of section (12) of this regulation.** A husband or wife living together may own insurance (over and above the first one thousand five hundred dollars ($1500) each in face value) in any combination with a total cash or loan value up to and including two thousand dollars ($2000) **through June 30, 2017**. **Effective July 1, 2017, the cash or loan value in excess of the one thousand five hundred dollars ($1500) for each spouse shall be considered an available asset and subject to the limits of section (12) of this regulation.** In GR cases, the one thousand five hundred dollar ($1500) face value exemption will apply to each person included in the GR case. When the claimant has deposited money with an individual, firm**,** or corporation as an advance payment for a funeral and the payment is safeguarded by burial insurance, trust fund or joint bank account, the amount of money over one thousand five hundred dollars ($1500) deposited under such a plan will be considered a resource in the same manner as the cash or loan value of life insurance policies, if the contract is revocable. If the burial/funeral contract is irrevocable, the entire amount of money deposited will be excluded from available resources. If the claimant has both life insurance and prepaid burial (revocable or irrevocable), the one thousand five hundred dollar ($1500) exemption will apply to either or to any combination. The face value of an irrevocable burial contract will always be counted toward the one thousand five hundred dollar ($1500) exemption. If the cash or loan value of insurance is less than the amounts stated in this section, it shall be counted as part of the combination of available resources in determining eligibility as stated in section (12) **for OAA or PTD, or in section (13) for GR** of this rule. An individual applying for or receiving assistance in programs applying the OAA or PTD criteria may designate separately identifiable funds as set aside for burial for the individual or spouse up to a maximum of one thousand five hundred dollars ($1500). The amount of one thousand five hundred dollars ($1500) shall be reduced by—1) the total face value of insurance policies on the life of the individual or spouse which are owned by him/her or his/her spouse, the cash surrender value of which has been excluded in determining eligibility on available resources as provided in this section and in section (12) **for OAA or PTD, or in section (13) for GR** of this rule and 2) the value of any burial/funeral contract on the life of the individual or spouse. When this fund has been designated and all or a portion is excluded in determining available resources eligibility as provided in this section and in section (12) **for OAA or PTD, or section (13) for GR** of this rule, the interest or appreciation to the excluded portion of this fund (if left to accumulate) also shall be excluded in determining available resources eligibility, starting with interest or appreciation accrued on or after the beginning date of Medicaid eligibility. In AFDC cases, there shall be disregarded any prearranged funeral or burial contract, or any two (2) or more contracts, which provides for the payment of one thousand five hundred dollars ($1500) or less per family member. The face value of an irrevocable burial contract will always be counted toward the one thousand five hundred dollar ($1500) exemption. In AFDC cases, any family who owns revocable prepaid burials (over and above the first one thousand five hundred dollars ($1500) in equity value) or insurance with cash surrender value over one thousand dollars ($1000) will not be eligible for assistance. If the cash surrender value of revocable prepaid burials (over and above the first one thousand five hundred dollars ($1500) in equity value) or insurance is one thousand dollars ($1000) or less, it shall be counted as a part of the combination of available resources in determining eligibility as stated in section *[(12)]* **(13)** of this rule. *(Original rule filed Jan. 1, 1952, effective Jan. 10, 1952. Amended: July 29, 1959, effective Aug. 29, 1959. Amended: Oct. 19, 1959, effective Oct. 29, 1959. Amended: July 8, 1969, effective July 18, 1969. Amended: July 23, 1970, effective Aug. 2, 1970. Amended: Dec. 22, 1972, effective Jan. 1, 1973.)*

(10) In programs applying the OAA, PTD**, or AB** criteria**,** and GR cases, salable personal property, such as livestock, farm surplus, jewelry (except wedding and engagement rings owned by claimant or spouse), machinery, automobiles and trucks, and the like, shall be considered as an available resource when the following criteria are present:

(A) In programs applying the OAA, PTD**, or AB** criteria**,** and GR cases, the equity based on current market value is one thousand dollars ($1000) or more, or more than two thousand dollars ($2000) in the case of a married person living with spouse. In GR cases involving two (2) or more persons eligible for GR, the limitation is more than two thousand dollars ($2000)**. Effective July 1, 2017, the equity value for programs applying the OAA, PTD, or AB criteria shall be considered an available asset and subject to the limits of section (12) of this rule**;

(C) Household furnishings shall not be considered as available resources unless they are not being used by the applicant, in which case *[the limits of one thousand dollar ($1000) value will apply]* **they are subject to the limitations in section (12) for OAA, PTD, or AB criteria, and section (13) for GR**; *[and]*

(D) Effective July 1, 2017, in programs applying the OAA, PTD, or AB criteria, the first five thousand dollars ($5000) of medical savings accounts and independent living accounts shall be limited to deposits of earned income and earnings on that income while the individual is a participant; and

*[(D)]***(E)** If the value of the personal property is less than the amounts stated in subsections (10)(A)—*[(C)]***(D)**, it shall be counted as a part of the combination of available resources in determining eligibility as stated in section (12) **for OAA, PTD, or AB, or section (13) for GR** of this rule. *(Original rule filed Jan. 11, 1952, effective Jan. 21, 1952. Amended: Dec. 3, 1952, effective Dec. 13, 1952. Amended: July 29, 1959, effective Aug. 29, 1959. Amended: Oct. 19, 1959, effective Oct. 29, 1959. Amended: July 8, 1969, effective July 18, 1969. Amended: July 23, 1970, effective Aug. 2, 1970. Amended: Dec. 22, 1972, effective Jan. 1, 1973.)*

(12) *[In programs applying the OAA, PTD criteria and GR cases, a]***A**ny combination of available resources—real property, personal property, cash or securities, or cash surrender or loan value of life insurance (including money deposited in revocable prepaid burials)*[, the combined value of which is one thousand dollars ($1000) or more, will result in ineligibility for a single person. For a married person living with spouse, any combination of available resources which exceeds a value of two thousand dollars ($2000) will result in ineligibility for both persons.]* **shall be considered in regards to the asset limits set below. The following asset limits apply to every MHABD program, except Blind Pension, the Breast and Cervical Cancer Treatment program, and the Qualified Medicare Beneficiary**

(QMB) or Specified Low-Income Medicare Beneficiary (SLMB) programs:

(A) This subsection identifies the asset limits for MHABD before July 1, 2017.

1. A household that is applying for or receiving MHABD on the basis of being over age sixty-five (65) or permanently and totally disabled does not qualify for MHABD if—

A. It is a one- (1-) person household, and the household has countable assets of one thousand dollars ($1,000) or more; or

B. It is a two- (2-) person household, and the household has countable assets of two thousand dollars ($2,000) or more.

2. A household that is applying for or receiving MHABD on the basis of being blind does not qualify for MHABD if—

A. It is a one- (1-) person household, and the household has countable assets of two thousand dollars ($2,000) or more; or

B. It is a two- (2-) person household, and the household has countable assets of four thousand dollars ($4,000) or more;

(B) Effective July 1, 2017, a household is not eligible for MHABD, regardless of whether eligibility is determined based on age, blindness, or permanent and total disability, if it has countable assets at or in excess of the following limits:

Dates Effective	One- (1-) person Household	Two- (2-) person Household
July 1, 2017 – June 30, 2018	$2,000	$4,000
July 1, 2018 – June 30, 2019	$3,000	$6,000
July 1, 2019 – June 30, 2020	$4,000	$8,000
July 1, 2020 – June 30, 2021	$5,000	$10,000

(C) Effective July 1, 2021 (Fiscal Year 2022), the asset limit identified in section (5) of this rule shall increase every July thereafter at the same rate as the increase in the cost-of-living percentage of the Consumer Price Index for All Urban Consumers (CPI-U), or its successor, as determined by the U.S. Department of Labor. The asset limit shall be rounded to the nearest five cents (5¢).

1. The percentage increase shall be based on changes in the CPI-U between July of two (2) years prior to the year in which the current fiscal year begins, and July of the immediately preceding year.

A. Example: To determine the asset limit for Fiscal Year 2022 (FY22), the department shall measure the increase in the CPI-U between July 2019 and July 2020. If the CPI-U increased by one percent (1%) during that period, the asset limit for FY22 shall also increase by one percent (1%); and

(D) Notwithstanding the provisions of this section, a person is not eligible for QMB or SLMB if the person's household has countable assets in excess of the maximum resource level applied for the applicable year under 42 U.S.C. section 1395w-114(a)(3)(D), pursuant to 42 U.S.C. section 1396d(p)(1)(C).

(13) In GR cases, any combination of one thousand dollars ($1000) or more for the applicant or recipient of GR would make that person ineligible (except that a husband and wife or two (2) or more persons in the household eligible for GR could have up to two thousand dollars ($2000) together). In AFDC cases, any combination of more than one thousand dollars ($1000) would make the family ineligible. *(Original rule filed Jan. 11, 1952, effective Jan. 21, 1952. Amended: July 29, 1959, effective Aug. 29, 1959. Amended: Oct. 19, 1959, effective Oct. 29, 1959. Amended: July 8, 1969, effective July 18, 1969. Amended: July 23, 1970, effective Aug. 2, 1970.)*

*[(13)]***(14)** Notwithstanding the previously mentioned eligibility requirements with respect to resources, the following will apply to individuals meeting the definition of institutionalized spouses who begin a period of continuous institutionalization on or after September 30, 1989:

(A) As used in this section, the definitions for the following terms shall apply:

1. Assessment shall mean a determination by the FSD of the total equity value of available resources (as stated in sections (6)-*[(12)]***(13)**) owned by the institutionalized spouse, the community spouse, or both, which may be requested at the beginning of a period of continuous institutionalization expected to last at least thirty (30) days or more;

2. Community spouse shall mean the husband or wife of an institutionalized spouse who does not reside in a medical hospital or a Medicaid-certified bed in a nursing facility (NF) and, if the institutionalized spouse is one who meets the definition in subparagraph *[(13)]***(14)**(A)3.C., the community spouse may not be one who meets those criteria;

3. Institutionalized spouse shall mean a claimant who resides in—

A. A medical hospital;

B. A Medicaid-certified bed in an NF, with an expected stay of at least thirty (30) days; or

C. His/her own home and is assessed by the Division of Disability and Senior Services as needing both an NF level-of-care as defined in 19 CSR 30-81.030 and home- and community-based waiver services and is assessed to need these services for at least thirty (30) days, and is married to a person who meets the definition of a community spouse in paragraph *[(13)]***(14)**(A)2.; and

4. Period of continuous institutionalization shall mean a stay in a medical hospital or Medicaid-certified bed in an NF or when the Division of Disability and Senior Services determines a need for home- and community-based waiver services which is expected to last thirty (30) days or more; and

(B) The following shall apply with regard to resource eligibility for institutionalized spouses who begin a period of continuous institutionalization on or after September 30, 1989:

1. When an individual meets the criteria in subparagraph *[(13)]***(14)**(A)3.C., his/her gross monthly income shall be compared to one thousand twelve dollars ($1,012). If his/her gross monthly income is equal to or less than one thousand twelve dollars ($1,012), the FSD shall complete an assessment of assets as defined in paragraph *[(13)]***(14)**(B)2. When his/her gross monthly income is greater than one thousand twelve dollars ($1,012), s/he is not eligible for an assessment of assets as defined in paragraph *[(13)]***(14)**(B)2. The one thousand twelve dollar ($1,012) income limit shall be increased each year effective January 1 in accordance with the Social Security cost-of-living adjustment (COLA), beginning in 2006;

2. At the beginning of the first period of continuous institutionalization, the institutionalized spouse, the community spouse**,** or a representative acting on behalf of either may request an assessment by the FSD of total equity in available resources owned by either or both in the month in which the period of institutionalization began or, in the case of an institutionalized spouse who meets the definition in subparagraph *[(13)]***(14)**(A)3.C. and who met that definition prior to January 1, 1993, January 1993 shall be substituted for the month in which the period of institutionalization began;

3. From this total, the FSD shall compute the spousal share, which shall be the greater of—1) twelve thousand dollars ($12,000) or 2) one-half (1/2) of the total, not to exceed sixty thousand dollars ($60,000). The twelve thousand dollar ($12,000) minimum and the sixty thousand dollar ($60,000) maximum shall be increased each January in accordance with the increase in the Consumer Price Index, beginning in 1990;

4. In determining initial Medicaid eligibility for the institutionalized spouse in this continuous period of institutionalization, the FSD again shall determine the total equity in available resources owned by the institutionalized spouse, the community spouse, or both, at the time of Medicaid request. From this total, the FSD shall deduct the amount of the spousal share as computed in paragraphs *[(13)]***(14)**(B)2. and 3. If the remainder is equal to or less than the appropriate resource maximum for a single person, the institutionalized individual, to the extent the individual expresses intent to transfer any excess resources to the community spouse, shall be initially

eligible for Medicaid on the factor of available resources. Eligibility for Medicaid for individuals described in subparagraph *[(13)]***(14)**(A)3.C. who become resource eligible using the assessment described in paragraph *[(13)]***(14)**(B)2. cannot begin prior to the date the individual actually receives home- and community-based waiver services;

5. Any such individual who is determined initially eligible for Medicaid must transfer any resources above the appropriate resource maximum which are held in the individual's name to the community spouse within ninety (90) days of notification of initial eligibility, unless good cause exists;

6. If good cause does not exist, the FSD shall consider any resources held in the name of the institutionalized spouse, including any jointly-owned resources, in determining continued Medicaid eligibility, effective ninety (90) days after notification of initial eligibility;

7. After the determination of initial eligibility for the institutionalized spouse, no resources of the community spouse not jointly owned with the institutionalized spouse shall be considered available to the institutionalized spouse in Medicaid determinations in that continuous period of institutionalization;

8. If either spouse establishes in a fair hearing that the spousal share (in relation to the amount of income generated by that amount) is inadequate to raise the community spouse's own income to the amount determined in 13 CSR 40-2.200(5)(A), the spousal share may be adjusted to an amount adequate to provide the additional income. At the fair hearing the maximum amount of the institutionalized spouse's income that may be made available to the community spouse under 42 U.S.C.1396r-5(d), shall be considered the community spouse's own income; and

9. If a court has entered an order against an institutionalized spouse for the support of the community spouse, the amount of the order shall be substituted for the spousal share.

*AUTHORITY: sections [207.020, RSMo 2000] **207.022 and 660.017, RSMo 2016**. Filing dates for original rules are shown in the text of the rule. This version filed March 24, 1976. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 20, 2017, effective July 1, 2017, expires Feb. 22, 2018. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 40—Family Support Division
Chapter 8—MO HealthNet for the Aged, Blind, and Disabled

EMERGENCY RULE

13 CSR 40-8.020 Ways of Treating Income and Assets

PURPOSE: This rule defines the asset limits, the ways in which assets are treated in determining eligibility for MO HealthNet (Medicaid) for the Aged, Blind, and Disabled (MHABD), and programs with which MHABD coverage is provided.

*EMERGENCY STATEMENT: The Department of Social Services, Family Support Division (FSD), finds that this emergency rule is necessary to preserve a compelling governmental interest in determining eligibility of MO HealthNet benefits for MHABD according to House Bill 1565 that was passed in 2016. This new emergency rule governs how FSD should treat a person's assets or income when FSD is determining whether that person is eligible for MO HealthNet for MHABD. It specifies which assets, in general, FSD must consider in the eligibility determination, and states the maximum amount of countable assets a person can have and still be eligible for MHABD. This new regulation also implements House Bill 1565 (2016), which increased the asset limits for MHABD incrementally until they reach five thousand dollars ($5,000) for a single person and ten thousand dollars ($10,000) for a married couple, in Fiscal Year 2021. After that, the limits will increase each year based on increases in the Consumer Price Index. This rule states the dates on which the increases will occur, and how they will be calculated. This emergency rule is necessary to preserve a compelling governmental interest that requires an early effective date as permitted pursuant to section 536.025, RSMo. Changes to the asset limit are required by statute to take effect on July 1, 2017; therefore, the emergency rule is needed. A proposed rule, which covers the same material, is published in this issue of the **Missouri Register**. This emergency rule limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The FSD believes this emergency rule to be fair to all interested persons and parties under the circumstances. The emergency rule was filed June 20, 2017, becomes effective July 1, 2017, and expires February 22, 2018.*

(1) Scope. This rule describes the general requirements related to how assets affect eligibility for MHABD. This regulation does not apply to the Blind Pension program pursuant to Chapter 209, RSMo 2016, unless noted otherwise. Any provisions in this rule control over similar provisions in 13 CSR 40-2.030, including, but not limited to, the asset limits defined in that rule.

(2) The division shall treat income and assets in a way that is no more restrictive than the way income and assets are treated for the Supplemental Security Income (SSI) program, with the exception of the asset limits described in section (4) of this rule, and as provided for in the Medicaid State Plan.

(3) In determining eligibility for MHABD, the division shall consider—

(A) Any kind of asset that is owned by a household member, or in the name of someone on behalf of the household member;

(B) Any kind of asset that is owned by a trust or any other entity, but which a household member, or someone acting on behalf of a household member, has the legal power to use for the general benefit of the household; or

(C) Any kind of asset that is owned by a self-settled trust, as defined in, determined by, and subject to the rules of 42 U.S.C. section 1396p(d).

(4) The following asset limits apply to every MHABD program, except Blind Pension, the Breast and Cervical Cancer Treatment program, and the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) programs:

(A) This subsection identifies the asset limits for MHABD before July 1, 2017.

1. A household that is applying for or receiving MHABD on the basis of being over age sixty-five (65) or permanently and totally disabled does not qualify for MHABD if—

A. It is a one- (1-) person household, and the household has countable assets of one thousand dollars ($1,000) or more; or

B. It is a two- (2-) person household, and the household has countable assets of two thousand dollars ($2,000) or more.

2. A household that is applying for or receiving MHABD on the basis of being blind does not qualify for MHABD if—

A. It is a one- (1-) person household, and the household has countable assets of two thousand dollars ($2,000) or more; or

B. It is a two- (2-) person household, and the household has countable assets of four thousand dollars ($4,000) or more;

(B) Effective July 1, 2017, a household is not eligible for MHABD, regardless of whether eligibility is determined based on age, blindness, or permanent and total disability, if it has countable assets at or in excess of the following limits:

Dates Effective	One- (1-) person Household	Two- (2-) person Household
July 1, 2017 – June 30, 2018	$2,000	$4,000
July 1, 2018 – June 30, 2019	$3,000	$6,000
July 1, 2019 – June 30, 2020	$4,000	$8,000
July 1, 2020 – June 30, 2021	$5,000	$10,000

(C) Effective July 1, 2021 (Fiscal Year 2022), the asset limit identified in section (4) of this rule shall increase every July thereafter at the same rate as the increase in the cost-of-living percentage of the Consumer Price Index for All Urban Consumers (CPI-U), or its successor, as determined by the U.S. Department of Labor. The asset limit shall be rounded to the nearest five cents (5¢).

1. The percentage increase shall be based on changes in the CPI-U between July of two (2) years prior to the year in which the current fiscal year begins and July of the immediately preceding year.

A. Example: To determine the asset limit for Fiscal Year 2022 (FY22), the department shall measure the increase in the CPI-U between July 2019 and July 2020. If the CPI-U increased by one percent (1%) during that period, the asset limit for FY22 shall also increase by one percent (1%);

(D) Notwithstanding the provisions of this section, a person is not eligible for QMB or SLMB if the person's household has countable assets in excess of the maximum resource level applied for the applicable year under 42 U.S.C. section 1395w-114(a)(3)(D), pursuant to 42 U.S.C. section 1396d(p)(1)(C).

AUTHORITY: sections 207.022 and 660.017, RSMo 2016. Emergency rule filed June 20, 2017, effective July 1, 2017, expires Feb. 22, 2018. A proposed rule covering this same material is published in this issue of the ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending subsections (3)(B) and (15)(B).

PURPOSE: This amendment provides for updates to the calculation of the Direct Medicaid payments made on or after May 1, 2017. Additionally, this amendment provides for the State Fiscal Year (SFY) 2018 trend factor to be applied in determining Federal Reimbursement Allowance (FRA) funded hospital payments for SFY 2018.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency amendment is necessary to preserve a compelling governmental interest of collecting state revenue in order to provide health care to individuals eligible for the MO HealthNet program and for the uninsured. An early effective date is required because this emergency amendment establishes the Federal Reimbursement Allowance (FRA) funded hospital payments for dates of service beginning May 1, 2017 in regulation to ensure that quality health care continues to be provided to MO HealthNet participants and indigent patients at hospitals that have relied on MO HealthNet payments to meet those patients' needs. An early effective date is required because this emergency amendment provides for updates to the calculation of the Direct Medicaid payments made on or after May 1, 2017. These payments are impacted by the change in how Direct Medicaid payments are calculated and by the trend applied to historical cost data to adjust the cost for the upcoming state fiscal year. The division also uses the best information available for the trend for the upcoming state fiscal year so it is using the trend published in the ***First Quarter Healthcare Cost Review*** *publication which is generally not available until May. The division must also analyze hospital data, which is not complete until near the end of the state fiscal year, in conjunction with the trend and funding to determine the appropriate level of payments. Without this information, the trends cannot be determined; therefore, due to timing of the receipt of this information and the necessary May 1, 2017 effective date, an emergency regulation is necessary. As a result, the MHD finds an immediate danger to public health and welfare which requires emergency actions. If this emergency amendment is not enacted, there would be significant cash flow shortages causing a financial strain on Missouri hospitals which serve over nine hundred ninety-one thousand (991,000) MO HealthNet participants plus the uninsured. This financial strain, in turn, will result in an adverse impact on the health and welfare of MO HealthNet participants and uninsured individuals in need of medical treatment. A proposed amendment, which covers the same material, will be published in this issue of the* ***Missouri Register****. This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions****. The MHD believes this emergency amendment to be fair to all interested persons and parties under the circumstances. The emergency amendment was filed June 20, 2017, becomes effective July 1, 2017, and expires February 22, 2018.*

(3) Per Diem Reimbursement Rate Computation. Each hospital shall receive a MO HealthNet per diem rate based on the following computation:

(B) Trend Indices (TI). Trend indices are determined based on the four- (4-) quarter average DRI Index for DRI-Type Hospital Market Basket as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in *Health Care Costs* by DRI/McGraw-Hill, or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY). Trend indices starting in SFY 2016 will be determined based on the Hospital Market Basket index as published in *Healthcare Cost Review* by Institute of Health Systems (IHS), or equivalent publication, regardless of any changes in the name of the publication or publisher, for each State Fiscal Year (SFY).

1. The TI are—

A. SFY 1994—4.6%
B. SFY 1995—4.45%
C. SFY 1996—4.575%
D. SFY 1997—4.05%
E. SFY 1998—3.1%
F. SFY 1999—3.8%
G. SFY 2000—4.0%
H. SFY 2001—4.6%
I. SFY 2002—4.8%
J. SFY 2003—5.0%
K. SFY 2004—6.2%
L. SFY 2005—6.7%
M. SFY 2006—5.7%
N. SFY 2007—5.9%
O. SFY 2008—5.5%
P. SFY 2009—5.5%
Q. SFY 2010—3.9%
R. SFY 2011—3.2%—The 3.2% trend shall not be applied in determining the per diem rate, Direct Medicaid payments, or uninsured payments.
S. SFY 2012—4.0%
T. SFY 2013—4.4%
U. SFY 2014—3.7%
V. SFY 2015—4.3%
W. SFY 2016—2.5%
X. SFY 2017—2.7%
Y. SFY 2018—3.2%

2. The TI for SFY 1996 through SFY 1998 are applied as a full percentage to the OC of the per diem rate and for SFY 1999 the OC of the June 30, 1998, rate shall be trended by 1.2% and for SFY 2000 the OC of the June 30, 1999, rate shall be trended by 2.4%. The OC of the June 30, 2000, rate shall be trended by 1.95% for SFY 2001.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid payments computed in accordance with subsection (15)(B).

4. A facility previously enrolled for participation in the MO HealthNet Program, which either voluntarily or involuntarily terminates its participation in the MO HealthNet Program and which reenters the MO HealthNet Program, will receive the same inpatient rate and outpatient rate as the previous owner/operator. Such facility will also receive the same Direct Medicaid Add-On Payment and Uninsured Add-On Payment as the previous owner/operator if the facility reenters the MO HealthNet Program during the same state fiscal year. If the facility does not reenter during the same state fiscal year, the Direct Medicaid Add-On Payment and Uninsured Add-On Payment will be determined based on the applicable base year data (i.e., fourth prior year cost report for the Direct Medicaid Payment; see 13 CSR 70-15.220 for the applicable data for the Uninsured Add-On Payment). If the facility does not have the applicable base year data, the Direct Medicaid Add-On Payment and the Uninsured Add-On Payment will be based on the most recent audited data available and will include annual trend factor adjustments from the year subsequent to the cost report period through the state fiscal year for which the payments are being determined.

(15) Direct Medicaid Payments.

(B) Direct Medicaid payment will be computed as follows:

1. The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital's base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment*[;]***.**

A. Effective for payments made on or after May 1, 2017, only the Fee-for-Service and Out-of-State components of the MO HealthNet share of both the inpatient and outpatient FRA assessment will be included in the Direct Medicaid add-on payment.

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The estimated MO HealthNet patient days for the current SFY shall be the better of the sum of the Fee-for-Service (FFS) days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective January 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2010, prior SFY would be SFY 2009) adjusted downward by twenty-five percent (25%) of the difference between the sum of the FFS days plus managed care days and the days used in the prior SFY's Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as follows: The FFS days are determined by applying a trend to the second prior Calendar Year (CY) days (i.e., for SFY 2010, second prior CY would be 2008) as determined from the state's Medicaid Management Information System (MMIS). The trend is determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by twenty-five percent (25%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by twenty-five percent (25%), and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

B. Effective July 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the SFY 2009 Direct Medicaid payment calculation adjusted downward by fifty percent (50%) of the difference between the sum of the FFS days plus managed care days and the days used in the SFY 2009 Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by fifty percent (50%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by fifty percent (50%) and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

C. Effective July 1, 2011, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the SFY 2009 Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) of the difference between the sum of the FFS days plus managed care days and the days used in the SFY 2009 Direct Medicaid payment calculation.

(I) The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation are compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital has greater estimated days as used in the prior SFY's Direct Medicaid payment calculation than the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days is multiplied by seventy-five percent (75%)

and this amount is removed from the estimated days used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

D. Effective July 1, 2012, the estimated MO HealthNet patient days shall be the sum of the FFS days plus managed care days. The FFS days plus managed care days are determined as set forth in part (15)(B)2.A.(I).

E. Effective for payments made on or after May 1, 2017, the estimated MO HealthNet patient days for the SFY shall be determined by adjusting the FFS days from the state's MMIS for the second prior Calendar Year (CY) (i.e., for SFY 2017, second prior CY would be 2015) by:

(I) The trend determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY; and

(II) The days estimated to shift from FFS to managed care effective May 1, 2017. The estimated managed care days for populations added to managed care beginning May 1, 2017 will be subtracted from the trended FFS days to yield the estimated MO HealthNet patient days.

*[E.]***F.** The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A). In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of MO HealthNet residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospital's base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend, and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

(I) Effective for dates of service beginning July 1, 2010, the Missouri Specific Trend shall no longer be applied to inflate base period costs.

*[F.]***G.** For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2., and (6)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year operating costs may be the third or fourth prior year cost report. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve- (12-) month cost report and a partial year cost report, its base period cost report for that year will be the twelve- (12-) month cost report.

*[G.]***H.** The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization, as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost per day is multiplied by the estimated MO HealthNet days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective January 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B) will receive sixty-seven percent (67%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

B. Effective July 1, 2010, hospitals other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P) will receive thirty-four percent (34%) of the utilization adjustment calculated in accordance with paragraph (15)(B)4. Children's hospitals and specialty pediatric hospitals will receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.

C. Effective July 1, 2011, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (6)(B), children's hospitals as defined in subsection (2)(S), and specialty pediatric hospitals as defined in subsection (2)(P). Children's hospitals and specialty pediatric hospitals will continue to receive fifty percent (50%) of the adjustment calculated in accordance with paragraph (15)(B)4. Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment calculated in accordance with paragraph (15)(B)4.;

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Prior to July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

AUTHORITY: sections ***208.152,*** *208.153,* ***and*** *208.201, RSMo [Supp. 2013, and section 208.152, RSMo Supp. 2015]* ***2016****. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed June 20, 2017, effective July 1, 2017, expires Feb. 22, 2018. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA). The division is amending subsection (1)(A) and adding section (21).

PURPOSE: This amendment provides for the State Fiscal Year (SFY) 2018 trend factor to be applied to the inpatient and outpatient adjusted net revenues determined from the Federal Reimbursement Allowance (FRA) fiscal year cost report to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment. Additionally, this amendment establishes the FRA assessment effective July 1, 2017 at a rate of five and seventy hundredths percent

(5.70%) of each hospital's inpatient and outpatient adjusted net revenues along with further changes to the FRA assessment if the disproportionate share hospital allotment reductions are implemented during SFY 2018.

EMERGENCY STATEMENT: The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency amendment is necessary to preserve a compelling governmental interest of collecting state revenue in order to provide health care to individuals eligible for the MO HealthNet program and for the uninsured. An early effective date is required because the emergency amendment is necessary to establish the Federal Reimbursement Allowance (FRA) assessment rate effective for dates of service beginning July 1, 2017 in regulation in order to collect the state revenue to ensure access to hospital services for MO HealthNet participants and indigent patients at hospitals that have relied on MO HealthNet payments to meet those patients' needs. The Missouri Partnership Plan between the Centers for Medicare and Medicaid Services (CMS) and the Missouri Department of Social Services (DSS), which establishes a process whereby CMS and DSS determine the permissibility of the funding source used by Missouri to fund its share of the MO HealthNet program, is based on a state fiscal year. In order to determine the trends for State Fiscal Year (SFY) 2018, all relevant information from the necessary sources must be available to MHD. The division uses the best information available when it starts calculating the assessment so it uses the trend published in the ***Fourth Quarter Healthcare Cost Review*** *publication which is generally not available until January. The division must also analyze hospital revenue data, which is not complete until near the end of the state fiscal year, in conjunction with the trend and hospital FRA funded payments to determine the appropriate level of assessment. Without this information, the trends cannot be determined. Therefore, due to timing of the receipt of this information and the necessary July 1, 2017 effective date, an emergency regulation is necessary. The MHD also finds an immediate danger to public health and welfare which requires emergency actions. If this emergency amendment is not enacted, hospitals will be over-assessed causing a financial strain on Missouri hospitals which serve over nine hundred ninety-one thousand (991,000) MO HealthNet participants plus the uninsured. This financial strain, in turn, will result in an adverse impact on the health and welfare of MO HealthNet participants and uninsured individuals in need of medical treatment. This emergency amendment will result in a savings of FRA Assessment of approximately $49.3 million to $78.8 million to the hospital industry. A proposed amendment, which covers the same material, will be published in this issue of the* ***Missouri Register****. This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions****. The MHD believes this emergency amendment to be fair to all interested persons and parties under the circumstances. The emergency amendment was filed June 20, 2017, becomes effective July 1, 2017, and expires February 22, 2018.*

(1) Federal Reimbursement Allowance (FRA). FRA shall be assessed as described in this section.

(A) Definitions.

1. Bad debts—Amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. Allowable bad debts include the costs of caring for patients who have insurance, but their insurance does not cover the particular service procedures or treatment rendered.

2. Base cost report—Desk-reviewed Medicare/Medicaid cost report. The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. When a hospital has more than one (1) cost report with periods ending in the base year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of months reflected in the base cost report, to a twelve- (12-) month period.

3. Charity care—Those charges written off by a hospital based on the hospital's policy to provide health care services free of charge or at a reduced charge because of the indigence or medical indigence of the patient.

4. Contractual allowances—Difference between established rates for covered services and the amount paid by third-party payers under contractual agreements. The Federal Reimbursement Allowance (FRA) is a cost to the hospital, regardless of how the FRA is remitted to the MO HealthNet Division, and shall not be included in contractual allowances for determining revenues. Any redistributions of MO HealthNet payments by private entities acting at the request of participating health care providers shall not be included in contractual allowances or determining revenues or cost of patient care.

5. Department—Department of Social Services.

6. Director—Director of the Department of Social Services.

7. Division—MO HealthNet Division, Department of Social Services.

8. Engaging in the business of providing inpatient health care—Accepting payment for inpatient services rendered.

9. Federal Reimbursement Allowance (FRA)—The fee assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA is an allowable cost to the hospital.

10. Fiscal period—Twelve- (12-) month reporting period determined by each hospital.

11. Gross hospital service charges—Total charges made by the hospital for inpatient and outpatient hospital services that are covered under 13 CSR 70-15.010.

12. Hospital—A place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not fewer than twenty-four (24) hours in any week of three (3) or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or a place devoted primarily to provide, for not fewer than twenty-four (24) hours in any week, medical or nursing care for three (3) or more nonrelated individuals. The term hospital does not include convalescent, nursing, shelter, or boarding homes as defined in Chapter 198, RSMo.

13. Hospital revenues subject to FRA assessment effective July 1, 2008—Each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues subject to the FRA assessment will be determined as follows:

A. Obtain "Gross Total Charges" from Worksheet G-2, Line 25, Column 3 from CMS 2552-96, or Worksheet G-2, Line 28, Column 3 from CMS 2552-10, of the third prior year cost report (i.e., FRA fiscal year cost report) for the hospital. Charges shall exclude revenues for physician services. Charges related to activities subject to the Missouri taxes assessed for outpatient retail pharmacies and nursing facility services shall also be excluded. "Gross Total Charges" will be reduced by the following:

(I) "Nursing Facility Charges" from Worksheet C, Part I, Line 35, Column 6 from CMS 2552-96, or Worksheet C, Part I, Line 45, Column 6 from CMS 2552-10;

(II) "Swing Bed Nursing Facility Charges" from Worksheet G-2, Line 5, Column 1 from CMS 2552-96, or Worksheet G-2, Line 6, Column 1 from CMS 2552-10;

(III) "Nursing Facility Ancillary Charges" as determined from the Department of Social Services, MO HealthNet Division, nursing home cost report. (Note: To the extent that the gross hospital charges, as specified in subparagraph (1)(A)13.A. above, include long-term care charges, the charges to be excluded through this step shall include all long-term care ancillary charges including skilled

nursing facility, nursing facility, and other long-term care providers based at the hospital that are subject to the state's provider tax on nursing facility services.);

(IV) "Distinct Part Ambulatory Surgical Center Charges" from Worksheet G-2, Line 22, Column 2 from CMS 2552-96, or Worksheet G-2, Line 25, Column 2 from CMS 2552-10;

(V) "Ambulance Charges" from Worksheet C, Part I, Line 65, Column 7 from CMS 2552-96, or Worksheet C, Part I, Line 95, Column 7 from CMS 2552-10;

(VI) "Home Health Charges" from Worksheet G-2, Line 19, Column 2 from CMS 2552-96, or Worksheet G-2, Line 22, Column 2 from CMS 2552-10;

(VII) "Total Rural Health Clinic Charges" from Worksheet C, Part I, Column 7, Lines 63.50–63.59 from CMS 2552-96, or Worksheet C, Part I, Column 7, Line 88 and subsets from CMS 2552-10; and

(VIII) "Other Non-Hospital Component Charges" from Worksheet G-2, Lines 6, 8, 21, 21.02, 23, and 24 from CMS 2552-96, or Worksheet G-2, Lines 5, 7, 9, 21, 24, 26, and 27 from CMS 2552-10;

B. Obtain "Net Revenue" from Worksheet G-3, Line 3, Column 1. The state will ensure this amount is net of bad debts and other uncollectible charges by survey methodology;

C. "Adjusted Gross Total Charges" (the result of the computations in subparagraph (1)(A)13.A.) will then be further adjusted by a hospital-specific collection-to-charge ratio determined as follows:

(I) Divide "Net Revenue" by "Gross Total Charges"; and

(II) "Adjusted Gross Total Charges" will be multiplied by the result of part (1)(A)13.C.(I) to yield "Adjusted Net Revenue";

D. Obtain "Gross Inpatient Charges" from Worksheet G-2, Line 25, Column 1 from CMS 2552-96, or Worksheet G-2, Line 28, Column 1 from CMS 2552-10, of the most recent cost report that is available for a hospital;

E. Obtain "Gross Outpatient Charges" from Worksheet G-2, Line 25, Column 2 from CMS 2552-96, or Worksheet G-2, Line 28, Column 2 from CMS 2552-10, of the most recent cost report that is available for a hospital;

F. Total "Adjusted Net Revenue" will be allocated between "Net Inpatient Revenue" and "Net Outpatient Revenue" as follows:

(I) "Gross Inpatient Charges" will be divided by "Gross Total Charges";

(II) "Adjusted Net Revenue" will then be multiplied by the result to yield "Net Inpatient Revenue"; and

(III) The remainder will be allocated to "Net Outpatient Revenue"; and

G. The trend indices listed below will be applied to the apportioned inpatient adjusted net revenue and outpatient adjusted net revenue in order to inflate or trend forward the adjusted net revenues from the FRA fiscal year cost report to the current state fiscal year to determine the inpatient and outpatient adjusted net revenues subject to the FRA assessment.

(I) SFY 2009 = 5.50%
(II) SFY 2009 Missouri Specific Trend = 1.50%
(III) SFY 2010 = 3.90%
(IV) SFY 2010 Missouri Specific Trend = 1.50%
(V) SFY 2011 = 3.20%
(VI) SFY 2012 = 5.33%
(VII) SFY 2013 = 4.4%
(VIII) SFY 2014 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—3.70%
(IX) SFY 2015 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—4.30%
(X) SFY 2016 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—3.90%
(XI) SFY 2017 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—4.10%
(XII) SFY 2018 =
(a) Inpatient Adjusted Net Revenues—0%
(b) Outpatient Adjusted Net Revenues—0%

14. Net operating revenue—Gross charges less bad debts, less charity care, and less contractual allowances times the trend indices listed in 13 CSR 70-15.010(3)(B).

15. Other operating revenues—The other operating revenue is total other revenue less government appropriations, less donations, and less income from investments times the trend indices listed in 13 CSR 70-15.010(3)(B).

(21) Beginning July 1, 2017, the FRA assessment shall be determined at the rate of five and seventy hundredths percent (5.70%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and seventy hundredths percent (5.70%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

(A) If the reduction of disproportionate share hospital allotments for federal fiscal year 2018 is implemented as provided in section 1923(f)(7) of the Social Security Act, the FRA assessment shall be set, effective on the date of such reduction, at the rate of five and fifty hundredths percent (5.50%) of each hospital's inpatient adjusted net revenues and outpatient adjusted net revenues as set forth in paragraph (1)(A)13. The FRA assessment rate of five and fifty hundredths percent (5.50%) will be applied individually to the hospital's inpatient adjusted net revenues and outpatient adjusted net revenues. The hospital's total FRA assessment is the sum of the assessment determined from its inpatient adjusted net revenue plus the assessment determined for its outpatient adjusted net revenue.

*AUTHORITY: sections 208.201, [and] 208.453, [RSMo Supp. 2013,] and [section] 208.455, RSMo [2000] **2016**. Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 20, 2017, effective July 1, 2017, expires Feb. 22, 2018. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 2233—State Committee of Marital and Family Therapists
Chapter 1—General Rules

EMERGENCY AMENDMENT

20 CSR 2233-1.040 Fees. The committee is amending subsection (1)(C).

PURPOSE: This emergency amendment is increasing the biennial renewal fee based on the state committee's five- (5-) year projections and due to the passage of House Bill 12 in 2017.

EMERGENCY STATEMENT: The State Committee of Marital and Family Therapists is statutorily obligated to set all fees, by regulation, necessary to administer the provisions of sections 337.700 to

337.739, RSMo. Pursuant to section 337.712, RSMo, the state committee shall, by regulation, set the amount of fees authorized by sections 337.700 to 337.739, RSMo, to produce revenue which shall not substantially exceed the cost and expense of administering the provisions of sections 337.700 to 337.739. On May 4, 2017, House Bill 12 (HB 12) was truly agreed to and finally passed. On May 22, 2017, the bill was delivered to the governor. House Bill 12 is the budget bill for statewide elected officials, the Judiciary, Office of the State Public Defender, and the General Assembly. HB 12 contains a twenty-five thousand dollar ($25,000) appropriation to be paid from the marital and family therapist fund in fiscal year 2018, for an actuarial analysis of the cost impact to MO HealthNet if the state required the MO HealthNet Division to reimburse marital and family therapist services provided to MO HealthNet participants. In order for the state committee to pay the cost of administering the licensure law and the twenty-five thousand dollar ($25,000) appropriation mandated by the Missouri legislature, a fee increase is required. Therefore, the state committee is proposing to increase the biennial renewal fee from one hundred twenty-five dollars ($125) to two hundred fifty dollars ($250).

The marital and family therapist license expires on February 28, 2018. The renewal notice for marital and family therapists will be mailed December 1, 2017 and any marital and family therapist renewing a license beginning December, 2017 will be assessed the increased renewal fee. Without this emergency amendment, the increased fee requirement will not be effective in time for the renewal notice and the state committee will not collect the revenue required to administer the statute.

*The scope of the emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the **Missouri** and **United States Constitutions**. In developing this emergency amendment, the state committee discussed the fee increase during its June 5, 2017 open meeting after posting proper public notice. The state committee received notification of a twenty-five thousand dollar ($25,000) appropriation, contained within House Bill 12, for an actuarial analysis to be paid from marital and family therapist fund in fiscal year 2018. The state committee believes this emergency amendment to be fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 28, 2017, becomes effective August 1, 2017, and expires February 22, 2018.*

(1) The following fees are established by the Division of Professional Registration and are payable in the form of a cashier's check, personal check, or money order:

(C) Biennial License Renewal Fee	*[$125.00]* **$250.00**
and in addition—	
1. One day to sixty (1–60) days late (an additional)	$ 75.00
2. Sixty-one (61) days to two (2) years late (an additional)	$100.00

*AUTHORITY: sections 337.712 and 337.727, RSMo [Supp. 2011] **2016**. This rule originally filed as 4 CSR 233-1.040. Original rule filed Dec. 31, 1997, effective July 30, 1998. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 28, 2017, effective Aug. 1, 2017, expires Feb. 22, 2018. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

The Secretary of State shall publish all executive orders beginning January 1, 2003, pursuant to section 536.035.2, RSMo 2016.

EXECUTIVE ORDER
17-17

WHEREAS, Missouri must provide for the safety and security of its people by improving its criminal justice system, reducing its prison population, and decreasing recidivism rates; and

WHEREAS, in 2011, Missouri joined the United States Department of Justice Bureau of Justice Assistance, Justice Reinvestment Initiative; and

WHEREAS, in 2001, Missouri launched the Missouri Working Group on Sentencing and Corrections; and

WHEREAS, Missouri's Working Group on Sentencing and Corrections recommended changes to Missouri's criminal justice system, which culminated in the passage and adoption of House Bill No. 1525, known as Missouri's Justice Reinvestment Act; and

WHEREAS, Missouri's Working Group on Sentencing and Corrections has since disbanded; and

WHEREAS, more work is needed to align our State with evidence-based practices that will improve the efficiency of our criminal justice system; and

WHEREAS, Missouri leaders and stakeholders should work across agencies to leverage lessons learned and apply research on what works from other state models to recommend needed reforms; and

WHEREAS, Missouri should undertake an independent analysis of the State's corrections and criminal justice landscape to help identify prison population factors and develop recommendations for legislation and other policy changes to improve public safety while reducing the need for increased prison capacity; and

WHEREAS, Missouri must continue to be an effective agent for change in criminal justice policy.

NOW THEREFORE, I, ERIC R. GREITENS, GOVERNOR OF THE STATE OF MISSOURI, hereby create the Missouri State Justice Reinvestment Taskforce as follows:

1. The Task Force shall consist of the following members:
    a. The Governor of Missouri or his designee;
    b. The Director of the Missouri Department of Corrections or her designee;

c. A member of Missouri's Probation and Parole Board appointed by the Governor;
d. The Director of the Missouri Department of Public Safety or his designee;
e. The Director of the Missouri Department of Mental Health or his designee;
f. The Chief Justice of the Supreme Court of Missouri or her designee;
g. A circuit court judge appointed by the Governor;
h. A member of the Missouri Senate from the majority caucus;
i. A member of the Missouri Senate from the minority caucus;
j. A member of the Missouri House of Representatives from the majority caucus;
k. A member of the Missouri House of Representatives from the minority caucus;
l. The Chair of the Appropriations Committee of the Missouri Senate;
m. The Chair of the Budget Committee of the Missouri House of Representatives;
n. A representative appointed by the Missouri Association of Counties;
o. A prosecutor appointed by the Missouri Association of Prosecuting Attorneys;
p. A public defender appointed by the Missouri Public Defender Commission;
q. A law enforcement representative appointed by the Missouri Police Chiefs Association;
r. A law enforcement representative appointed by the Missouri Sheriffs Association;
s. A representative from a victim services organization appointed by the Governor;
t. A former offender appointed by the Governor; and
u. A member of the public appointed by the Governor.

2. All Task Force members shall serve at the pleasure of their appointing authority. The chair of the Taskforce shall be the Director of the Missouri Department of Corrections or her designee. The chair shall develop a work plan, set the agenda, and provide leadership and direction for the Task Force.

3. A quorum for the Task Force meetings shall consist of a majority of the members. The Task Force shall make recommendations on an affirmative vote of a majority of its members.

4. The Task Force shall develop recommendations utilizing data, research, and the following principles and goals:
   a. Maintain a safe and effective correctional system;

b. Maintain capacity for our most violent offenders;
c. Provide evidence-based interventions to reduce recidivism and deter crime;
d. Achieve justice for victims;
e. Ensure accountability and set clear performance measures for our criminal justice system;
f. Minimize the need to increase prison capacity; and
g. Increase public safety through a reinvestment of a portion of any identified savings resulting from these recommendations into other areas of the criminal justice system, or other public systems, which have been proven to reduce recidivism.

5. In developing their recommendations, the Task Force may form working groups.

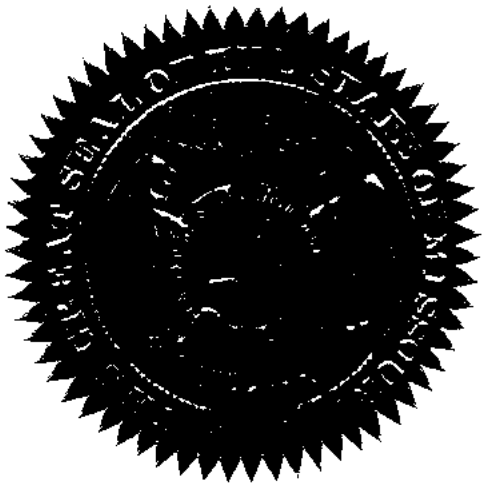
6. The Task Force shall produce a written report of their recommendations by December 31, 2017.

7. The Task Force shall develop omnibus legislation based on their recommendations for the 2018 legislative session.

8. The Task Force shall participate in the United States Department of Justice Bureau of Justice Assistance, Justice Reinvestment Initiative ("JRI"). The JRI may provide data analysis; information on evidence-based practices in sentencing and corrections polices; assistance with Taskforce facilitation and engagement of the public, interested parties, and public safety stakeholders; development of policy options and modeling the impact of those options; development of a communications plan; and assistance in building public and policymaker support for recommendations.

9. In addition to JRI assistance, the Missouri Department of Corrections shall provide staff support for the Task Force. If the Task Force requires assistance or non-privileged data from any other state agency, board, or commission, then such agency, board, or commission shall provide assistance or non-privileged data to the Taskforce upon request.

10. The members of the Task Force shall not receive any compensation for their activities as members of the group, but members may be reimbursed for expenses incurred in attending Task Force meetings, subject to the availability of funds.



IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 28th day of June, 2017.

Eric R. Greitens
Governor

ATTEST:

John R. Ashcroft
Secretary of State