Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

PROPOSED RESCISSION

12 CSR 10-3.098 Drugs and Medicines. This rule interpreted the sales tax law as it applied to sales of drugs and medicines, and interpreted and applied sections 144.010 and 144.030, RSMo.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.270, RSMo 1994. This rule was previously filed as rule no. 69 Jan. 22, 1973, effective Feb. 1, 1973. S.T. regulation 010-42 was last filed Oct. 28, 1975, effective Nov. 7, 1975. Refiled March 30, 1976. Amended: Filed Aug. 13, 1980, effective Jan. 1, 1981. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

PROPOSED RESCISSION

12 CSR 10-3.516 Application for Refund/Credit—Amended Returns. This rule interpreted the sales tax law as it applied to the procedure for recovering an overpayment of tax.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.270, RSMo 1994. S.T. regulation 190-2 was last filed Dec. 31, 1975, effective Jan. 10, 1976. Refiled March 30, 1976. Amended: Filed Aug. 13, 1980, effective Jan. 1, 1981. Amended: Filed Sept. 7, 1984, effective Jan. 12, 1985. Emergency amendment filed Aug. 18, 1994, effective Aug. 28, 1994, expired Dec. 25, 1994. Emergency amendment filed Dec. 9, 1994, effective Dec. 26, 1994, expired April 24, 1995. Amended: Filed Aug. 18, 1994, effective Feb. 26, 1995. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

PROPOSED RESCISSION

12 CSR 10-3.518 Claim Form. This rule provided instructions for obtaining the proper claim for refund/credit form.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.270, RSMo 1994. S.T. regulation 190-3 was last filed Dec. 31, 1975, effective Jan. 10, 1976. Refiled March 30, 1976. Amended: Filed Aug. 13, 1980, effective Jan. 1, 1981. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

PROPOSED RESCISSION

12 CSR 10-3.520 Who Should Request Refund. This rule was a guideline for determining who should request the refund of an overpayment of tax.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.270, RSMo 1994. S.T. regulation 190-4 was last filed Dec. 31, 1975, effective Jan. 10, 1976. Refiled March 30, 1976. Amended: Filed Aug. 13, 1980, effective Jan. 1, 1981. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

PROPOSED RESCISSION

12 CSR 10-3.526 Refund Rather Than Credit. This rule interpreted the sales tax law as it applied to refunds.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.270, RSMo 1994. S.T. regulation 190-7 was last filed Dec. 31, 1975, effective Jan. 10, 1976. Refiled March 30, 1976. Amended: Filed Sept. 7, 1984, effective Jan. 12, 1985. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

PROPOSED RESCISSION

12 CSR 10-3.528 No Interest on Refund/Credit. This rule interpreted the sales tax law as it applied to interest on a refund/credit.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.270, RSMo 1994. S.T. regulation 190-8 was last filed Dec. 31, 1975, effective Jan. 10, 1976. Refiled March 30, 1976. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

PROPOSED RESCISSION

12 CSR 10-3.530 Unconstitutional Taxes. This rule provided when taxes unconstitutionally imposed may be recovered.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

*AUTHORITY: section 144.270, RSMo 1994. Based on the 1952 Supreme Court Decision **Kleban v. Morris**, 363 Mo. 7, 247 SW2d 832. S.T. regulation 200-1 was last filed Dec. 31, 1975, effective Jan. 10, 1976. Refiled March 30, 1976. Amended: Filed Aug.13, 1980, effective Jan. 1, 1981. Rescinded: Filed April 19, 2000.*

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 3—State Sales Tax

PROPOSED RESCISSION

12 CSR 10-3.852 Orthopedic and Prosthetic Devices, Insulin and Hearing Aids. This rule interpreted the sales tax law as it applied to the sale of insulin, prosthetic and orthopedic devices, and hearing aids, and interpreted and applied section 144.030, RSMo.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.270, RSMo 1994. Original rule filed Aug. 23, 1988, effective Jan. 27, 1989. Amended: Filed Dec. 12, 1989, effective May 24, 1990. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 4—State Use Tax

PROPOSED RESCISSION

12 CSR 10-4.255 Who Should Request Refund. This rule defined who was authorized to request a refund and interpreted and applied section 144.695, RSMo.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.705, RSMo 1994. U.T. regulation 695-1 originally filed Oct. 28, 1975, effective Nov. 7, 1975. Refiled March 30, 1976. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 4—State Use Tax

PROPOSED RESCISSION

12 CSR 10-4.260 Claim Form. This rule provided where the claim form could be obtained and interpreted and applied section 144.695, RSMo.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.705, RSMo 1994. U.T. regulation 695-2 originally filed Oct. 28, 1975, effective Nov. 7, 1975. Refiled March 30, 1976. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 4—State Use Tax

PROPOSED RESCISSION

12 CSR 10-4.265 Refund Rather Than Credit. This rule indicated when a refund would be made rather than a credit and interpreted and applied section 144.695, RSMo.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.705, RSMo 1994. U.T. regulation 695-3 originally filed Oct. 28, 1975, effective Nov. 7, 1975. Refiled March 30, 1976. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 4—State Use Tax

PROPOSED RESCISSION

12 CSR 10-4.275 Application Required. This rule contained information as to how and when to file a claim, approval of a claim and whether a credit or refund was applicable, and interpreted and applied section 144.695, RSMo.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.705, RSMo 1994. U.T. regulation 695-5 originally filed Oct. 28, 1975, effective Nov. 7, 1975. Refiled March 30, 1976. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 4—State Use Tax

PROPOSED RESCISSION

12 CSR 10-4.330 Application for Refund/Credit-Amended Returns. This rule interpreted the use tax law as it applied to the procedure for recovering an overpayment of tax and interpreted and applied section 144.695, RSMo.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 144.705, RSMo 1994. Original rule filed Sept. 7, 1984, effective Jan. 12, 1985. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 5—City Sales Tax, Transportation Sales Tax and Public Mass Transportation Tax

PROPOSED RESCISSION

12 CSR 10-5.080 Refund Procedures. This rule indicated the requirements of a claim for overpayment and whether a refund or credit was appropriate and interpreted and applied section 94.550.2, RSMo 1986.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: section 94.530, RSMo 1986. C.S.T. regulation 550-1 originally filed Oct. 28, 1975, effective Nov. 7, 1975. Refiled Dec. 31, 1975, effective Jan. 10, 1976. Amended: Filed Sept. 7, 1984, effective Jan. 12, 1985. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 11—County Sales Tax

PROPOSED RESCISSION

12 CSR 10-11.150 Refund Procedure. This rule set forth the requirements of a claim for overpayment and whether a refund or credit was appropriate.

PURPOSE: This rule is being rescinded because it is superseded by other rules.

AUTHORITY: sections 67.515 and 67.706, RSMo 1986. Original rule filed Sept. 7, 1984, effective Jan. 12, 1985. Rescinded: Filed April 19, 2000.

PUBLIC COST: This proposed rescission will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rescission will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rescission with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 24—Drivers License Bureau Rules

PROPOSED AMENDMENT

12 CSR 10-24.050 Deletion of Traffic Convictions and Suspension or Revocation Data From Missouri Driver Records. The director proposes to amend section (1).

PURPOSE: The proposed amendment reflects procedure changes required for maintaining convictions on the driver record and for ensuring appropriate assessment of points for convictions relating to no driver license and no motorcycle qualifications.

(1) The Department of Revenue, when otherwise not prohibited by law, may delete from a Missouri driver record a previously recorded traffic conviction, suspension or revocation of a driving privilege if all of the following conditions are met:

(B) The conviction is not for a state violation of "no driver license," a state violation of "no motorcycle qualified" or a state, county or municipal violation of "driving while suspended/revoked*[.]*"**;**

(E) The suspension or revocation on the driver record did not involve an alcohol-related offense or enforcement contact; **except when the offense was committed by a person under the age of twenty-one (21), who had a blood alcohol content of .02 through .099 and an expungement of the records is provided for in section 302.545, RSMo;**

*AUTHORITY: sections 302.304 [and], 302.309[, RSMo Supp. 1999] and 303.041, RSMo [(1994)] **Supp. 1999**. Original rule filed May 27, 1986, effective Aug. 25, 1986. Amended: Filed Sept. 8, 1989, effective Jan. 26, 1990. Amended: Filed Jan. 31, 1992, effective June 25, 1992. Amended: Filed Nov. 4, 1999, effective May 30, 2000. Amended: Filed May 1, 2000.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than $500 in the aggregate.

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered, comments must be received within thirty days after publication of this notice in the **Missouri Register**. No public hearing is scheduled.*

Title 12—DEPARTMENT OF REVENUE
Division 10—Director of Revenue
Chapter 115—Sales/Use Tax—Statute of Limitations

PROPOSED RULE

12 CSR 10-115.100 Bad Debts Credit or Refund

PURPOSE: sections 144.190 and 144.696, RSMo provide for refund of overpayments. Section 144.220, RSMo sets forth the law on the statute of limitations. This rule explains how to claim a credit or refund for tax paid on a sale that has become a bad debt.

(1) In general, a seller may file for a credit or refund within the three-year statute of limitations when sales are written off as bad debts.

(2) Definition of Terms.

(A) Bad debt is a sale that has been written off for state or federal income tax purposes. In order to qualify for a bad debt deduction for sales or use tax purposes, a sale must have been previously reported as taxable.

(B) Accrual or gross sales reporting method means a seller reports the sale and remits the tax at the time of the sale. The receipts are not received from the buyer until a later date. Therefore, a timing difference occurs between the time that the sale, with applicable sales tax, is reported to the state and the time that the seller receives payment from the buyer.

(3) Basic Application of the Law.

(A) A seller may file for a refund or credit within the three-year statute of limitations for those sales written off as bad debts if the sales were reported using the accrual or gross sales method. This period is calculated from the due date of the return or the date the tax was paid, whichever is later.

(B) If a bad debt credit or refund is given and the debt is later collected, that amount must be reported on the next return as a taxable sale.

(4) Examples.

(A) A retailer reports and pays sales tax on the accrual or gross sales method. The retailer determines some sales to customers are not collectible and writes them off as bad debts for income tax purposes. The retailer requests a credit or refund from the state within the three-year statute of limitations. The credit or refund would be granted.

(B) A retailer reports and pays sales tax on the accrual or gross sales method. The retailer determines some sales to customers are not collectible and writes them off as bad debts for income tax purposes. The retailer requests a credit or refund from the state four years after the sale was reported and the tax was remitted to the state. The credit or refund would be denied.

AUTHORITY: section 144.270, RSMo 1994. Original rule filed April 19, 2000.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than $500 in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than $500 in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Revenue, Office of Legislation and Regulations, P.O. Box 629, Jefferson City, MO 65105. To be considered comments must be received within thirty days after publication of this notice on the ***Missouri Register****. No public hearing is scheduled.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 15—Division of Aging
Chapter 15—Residential Care Facilities I and II

PROPOSED RULE

13 CSR 15-15.045 Standards and Requirements for Residential Care Facilities II Which Provide Services to Residents with Alzheimer's Disease or Other Dementia

PURPOSE: This rule establishes the additional standards for those residential care facilities II designed and licensed to care for residents who are physically capable but mentally incapable of negotiating a pathway to safety due to Alzheimer's disease or other dementia.

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) Definitions. For the purposes of this rule, the following definitions shall apply:

(A) Activities of daily living (ADLs) mean a resident's ability to eat, bathe, toilet, dress, transfer and ambulate.

(B) Chemical restraint means a psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms.

(C) Convenience means any action taken by the facility to control resident behavior or maintain residents with a lesser amount of effort by the facility and not in the resident's best interests.

(D) Discipline means any action taken by the facility for the purpose of punishing or penalizing residents.

(E) Individual service plan means the planning document which outlines and describes:

1. The unique characteristics, strengths, and needs of a particular resident;

2. The services to be provided which meet the resident's needs; and

3. The outcomes expected as a result of meeting the resident's needs.

(F) Licensed professional means any of the following:

1. Physician, as defined in and licensed under the provisions of Chapter 334, RSMo;

2. Nurse, as defined in and licensed under the provisions of Chapter 335, RSMo;

3. Psychologist, as defined in and licensed under the provisions of Chapter 337, RSMo;

4. Professional counselor, as defined in and licensed under the provisions of Chapter 337, RSMo; and

5. Clinical social worker, as defined in and licensed under the provisions of Chapter 337, RSMo.

(G) Physical restraint means any physically applied method, or mechanical device which the resident cannot easily remove, that restricts the free movement or normal functioning of any portion of the resident's body, or the resident's normal access to common areas and his or her personal spaces.

(H) Resident, only for the purpose of this rule, means an individual who is mentally incapable of negotiating a pathway to safety due to Alzheimer's disease or other dementia.

(I) Safe Unit means a designated, separated area where residents with Alzheimer's disease or other dementia reside and receive services and which is secured by limited access.

(J) Significant change means any change in the resident's physical, emotional or psychosocial condition or behavior that would require an adjustment or modification in the resident's treatment or services.

(2) General Requirements.

(A) A residential care facility II which admits or continues to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, shall not care for any person unless:

1. The person has been diagnosed with Alzheimer's disease or other dementia by a physician licensed to practice medicine; and

2. The facility is able to provide appropriate services for and meet the needs of the resident. I/II

(B) A residential care facility II may admit or continue to care for residents who have been diagnosed with Alzheimer's disease or

other dementia if the residents are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, providing the facility is in compliance with the provisions of Chapter 198, RSMo and all regulations under which the facility is licensed by the Division of Aging. I/II

(C) A residential care facility II which admits or continues to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, shall comply with the provisions of the Alzheimer's Special Care Disclosure Act pursuant to sections 198.500 to 198.515, RSMo. II

(D) A residential care facility II which admits or continues to care for persons who have been diagnosed with Alzheimer's disease or other dementia who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids when necessary, shall not admit, retain or continue to care for any resident who is mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids who:

1. Has exhibited behaviors which indicate that the resident is a danger to self or others;

2. Is at constant risk of elopement and, despite repeated interventions which have not altered the resident's behavior, continues to be a danger to self;

3. Requires physical or chemical restraint as defined in this rule;

4. Requires skilled nursing services as defined in section 198.006(17), RSMo for which the facility is not licensed or able to provide;

5. Requires more than one person to simultaneously provide physical assistance to the resident with any activity of daily living, with the exception of bathing; or

6. Is bed-bound or chair-bound and is unable to ambulate due to a debilitating or chronic condition. I/II

(3) Physical Design and Fire Safety Requirements.

(A) The facility shall be equipped with a complete sprinkler system installed and maintained in accordance with the 1996 edition of the National Fire Protection Association (NFPA) 13, *Standard for the Installation of Sprinkler Systems*, or the 1996 edition of NFPA 13R, *Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height,* which are incorporated by reference in this rule. I/II

(B) The facility shall be equipped with a complete electrically supervised fire alarm system in accordance with the provisions of the 1997 *Life Safety Code for Existing Health Care Occupancy*, incorporated by reference in this rule. The system shall include smoke detectors located no more than thirty feet (30') apart in corridors with no point in the corridor located more than fifteen feet (15') from a smoke detector. The fire alarm system shall be equipped to automatically transmit an alarm to the fire department. I/II

(C) Each floor used for resident bedrooms shall be divided into at least two (2) smoke sections by one (1)-hour rated smoke stop partitions. No smoke section shall exceed one hundred fifty feet (150') in length. If, however, neither the length nor width of a floor exceeds seventy-five feet (75'), no smoke stop partitions are required. Openings in smoke stop partitions shall be protected by one and three-fourths inches (1 3/4")-thick solid core wood doors or metal doors with an equivalent fire rating. The doors shall be equipped with closers and magnetic hold-open devices. Any duct passing through this smoke wall shall be equipped with automatic resetting smoke dampers that are activated by the fire alarm system. Smoke partitions shall extend from outside wall-to-outside wall and from floor-to-floor or floor-to-roof deck. II

(D) In a multilevel facility, residents who are mentally incapable of negotiating a pathway to safety shall be housed only on the ground floor. All required exits shall be at grade, or have no more than two steps to grade, or have a ramp to grade. The ramp shall have a maximum slope of one to twelve (1:12) leading to grade. II

(E) The facility shall take necessary measures to provide residents with the opportunity to explore the facility and, if appropriate, its grounds. If enclosed or fenced courtyards are provided, residents shall have free access to such courtyards. Enclosed or fenced courtyards that are accessible through a required exit door shall be large enough to provide an area of refuge for fire safety at least thirty feet (30') from the building. Enclosed or fenced courtyards that are accessible through a door other than a required exit shall have no size requirements. II

(F) The facility shall provide freedom of movement for the residents to common areas and to their personal spaces. The facility shall not lock residents out of or inside their rooms. Key operated locks shall not be permitted on resident room doors. I/II

(G) Every facility shall use a personal electronic monitoring device for any resident whose physician recommends the use of such device. II

(H) The facility may provide Safe Units for residents who are mentally incapable of negotiating a pathway to safety if the following conditions are met:

1. Dining rooms, living rooms, activity rooms, and other such common areas shall be provided within the Safe Unit. The total area for common areas within Safe Units shall be equal to at least forty (40) square feet per resident; II/III

2. Doors separating the Safe Unit from the remainder of the facility or building shall not be equipped with locks that require a key to open; I/II

3. If locking devices are used on exit doors egressing the facility or on doors accessing Safe Units, delayed egress magnetic locks shall be used. These delayed egress devices shall comply with the following:

A. The lock must unlock when the fire alarm is activated;

B. The lock must unlock when the power fails;

C. The lock must unlock within thirty (30) seconds after the release device has been pushed for at least three (3) seconds, and an alarm must sound adjacent to the door;

D. The lock must be manually reset and cannot automatically reset; and

E. A sign shall be posted on the door that reads: PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 30 SECONDS; and I/II

4. The delayed egress magnetic locks may also be released by a key pad located adjacent to the door for routine use by staff. I/II

(4) Staffing Requirements.

(A) The facility shall be staffed twenty-four (24) hours a day by the adequate number and type of personnel necessary for the proper care of residents and upkeep of the facility in accordance with the staffing requirements found in 13 CSR 15-15.042. In meeting such staffing requirements, every resident who is mentally incapable of negotiating a pathway to safety shall count as three (3) residents. I/II

(B) All on-duty staff of the facility shall, at all times, be awake, dressed in on-duty work attire, and prepared to assist residents in case of emergency. I/II

(5) Assessments and Individual Service Plans.

(A) Prior to admitting or continuing to care for a resident diagnosed with Alzheimer's disease or other dementia, a family member or legal representative of the resident, in consultation with the resident's primary physician, shall meet with a facility representative to determine if the facility can meet the needs of the resident. The facility shall document the decisions regarding admission or

continued placement in the facility through written verification by the family member, physician and the facility representative. II

(B) The facility shall use the information obtained from the Minimum Data Set (MDS) assessment to determine if it can meet the needs of each resident who is mentally incapable of negotiating a pathway to safety. II/III

(C) Each resident shall be assessed by a licensed professional, as defined in subsection (1)(F) of this rule, by use of the MDS:

1. Within ten (10) days of admission; and

2. Every one hundred eighty (180) days thereafter; or

3. Whenever a significant change occurs in the resident's condition as defined in subsection (1)(J) of this rule. I/II

(D) Based on the MDS assessment, an interdisciplinary team shall develop an individual service plan for each resident who is mentally incapable of negotiating a pathway to safety. Whenever possible and appropriate, the resident, family members or other individuals instrumental in identifying the needs of, or providing treatment or services to, the resident shall be involved in the development or revision of the individual service plan. Every individual service plan shall be signed by each person participating in its development. II/III

(E) An individual service plan shall be completed and implemented within twenty (20) days after the completion of an MDS assessment of a resident. I/II

(F) An individual service plan shall describe the resident's needs and preferences, the specific methods and services, desired outcomes or interventions, and the names of the staff, service provider, and if applicable, family members who are primarily responsible for implementing the individual service plan. At a minimum, the individual service plan for each resident shall identify:

1. The resident's capabilities, strengths, potential, preferences and customary behaviors;

2. The resident's behavioral, medical and social needs based on the assessment;

3. The services provided to meet the needs of the resident;

4. The expected outcomes of the services provided; and

5. Staff or other persons responsible for providing the services to meet the needs of the resident. II/III

(G) The facility shall make each resident's individual service plan available for use to all persons providing services to residents. II/III

(6) Staff Training and Orientation.

(A) All facility personnel who provide direct care to residents who are mentally incapable of negotiating a pathway to safety shall receive at least twenty-four (24) hours of training within the first thirty (30) days of employment.

1. At least twelve (12) hours of the twenty-four (24) hours of training shall be classroom instructions; and

2. Six (6) classroom instruction hours and two (2) on-the-job training hours shall be related to the special needs, care and safety of residents with dementia. II

(B) All facility personnel, regardless of whether such personnel provide direct care to residents who cannot negotiate a pathway to safety, shall receive on a quarterly basis at least four (4) hours of in-service training, with at least two (2) such hours relating to the care and safety of residents who are mentally incapable of negotiating a pathway to safety. II

(C) Any training related to the special needs, treatment and safety of residents with dementia shall include, but not be limited to, the following:

1. An overview of Alzheimer's disease and other dementia;

2. Communication techniques which are effective in enhancing and maintaining communication skills for residents with dementia;

3. Components of or techniques for creating a safe, secure and socially oriented environment for residents with dementia;

4. Provision of structure, stability and a sense of routine for residents based on their needs;

5. Effective management of different or difficult behaviors; and

6. Issues involving families and caregivers. II/III

(D) All in-service or orientation training relating to the special needs, care and safety of residents who are mentally incapable of negotiating a pathway to safety shall be conducted by a training instructor who is qualified by education, experience or knowledge in the care of individuals with Alzheimer's disease or other dementia. II/III

(7) Programs and Services for Residents Who Are Mentally Incapable of Negotiating a Pathway to Safety.

(A) Each facility shall make available and implement self-care, productive and leisure activity programs for persons with dementia which maximize and encourage the resident's optimal functional ability. The facility shall provide activities that are appropriate to the resident's individual needs, preferences, background and culture. Individual or group activity programs may consist of the following:

1. Gross motor activities, such as exercise, dancing, gardening, cooking and chores;

2. Self-care activities, such as dressing, grooming and personal hygiene;

3. Social and leisure activities, such as games, music and reminiscing;

4. Sensory enhancement activities, such as auditory, olfactory, visual and tactile stimulation;

5. Outdoor activities, such as walking and field trips;

6. Creative arts; or

7. Other social, leisure or therapeutic activities that encourage mental and physical stimulation or enhance the resident's well-being. II/III

(B) The facility shall develop and implement written policies and procedures which address, at a minimum:

1. The facility's admission, transfer and discharge criteria taking into account the individual's needs and the facility's ability to meet those needs;

2. The basic services provided or offered to residents with Alzheimer's disease or other dementia;

3. The procedures and actions to be taken in the event of resident elopement;

4. The development and implementation of individual service plans;

5. The assignment of staff to residents based on the resident's needs which minimize resident confusion and maintain familiarity with environment;

6. Staff orientation and in-service training relating to the special needs, care and safety of residents with dementia;

7. Fire drill and emergency evacuation procedures for residents who are mentally incapable of negotiating a pathway to safety; and

8. The protection of the rights, privacy and safety of residents and the prevention of financial exploitation of residents. II/III

AUTHORITY: section 198.073, RSMo Supp. 1999. Original rule filed April 28, 2000.

PUBLIC COST: This proposed rule will cost participating county/nursing home district residential care facilities II $12,012 in FY-01, and $5,208 in FY-02 and annually thereafter for the life of the rule. A detailed fiscal note containing the estimated cost of compliance has been filed with the secretary of state.

PRIVATE COST: This proposed rule will cost participating private entities $98,208 in FY-01, $249,942 in FY-02, $446,490 in FY-03,

and $290,400 annually thereafter for the life of the rule. This proposed rule will cost participating private entities with Safe Units $768,350 in FY-02, and $124,080 thereafter for the life of the rule. The annual impact will include some costs to small businesses. A detailed fiscal note containing the estimated cost of compliance has been filed with the secretary of state.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with Richard C. Dunn, Director, Division of Aging, 615 Howerton Court, P.O. Box 1337, Jefferson City, MO 65102-1337. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC ENTITY COST

I. RULE NUMBER

Title: 13 - Department of Social Services

Division: 15 - Division of Aging

Chapter: 15 - Residential Care Facilities I and II

Type of Rulemaking: Proposed Rule

Rule Number and Name: 13 CSR 15-15.045—Standards and Requirements for Residential Care Facilities II Which Provide Services to Residents with Alzheimer's Disease or Other Dementia.

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
2	County/Nursing Home District Residential Care Facilities II	FY-01 - $12,012
2	County/Nursing Home District Residential Care Facilities II	FY-02 - $5,208*

*Annually for the life of the rule

III. WORKSHEET

- Staff Training: Eleven (11) full-time employees of one (1) LPN @ $11/hr., four (4) Med. Aides @ $6.25/hr., three (3) CNAs @ $10/hr., three (3) non-direct care staff @ $5.35/hr., and five (5) part-time employees of one (1) RN @ $18/hr., three (3) Med. Aides @ $6.25/hr., and one (1) CNA @ $10/hr. Total direct care wages/hr. = $112.75; total staff wages/hr. = $129.00/hr. Twenty percent (20%) staff turnover rate @ avg hr rate = Three (3) staff @ $8/hr.= $24/hr.
  24 hrs. Orientation x $112.75 = $2,706 (first year only); 24 hrs. Orientation x $24 = $576 (ongoing); 16 hrs. In-service training x $129/hr. = $2,064. Total training costs/RCF II for first year: $2,706 + $576 + $2,064 = $5,346. Ongoing training costs/RCF II: $576 + $2,064 = $2,640.

- Fire Safety Requirements: One and three-fourths inches solid core doors @ $300/door. Non-locking door knobs @ $20/resident room door. Average cost per affected RCF II = $660

IV. ASSUMPTIONS

1. All rules in 13 CSR 15 are integrally related. All Chapter 15 rules should be considered collectively to obtain a complete assessment of the costs related to Residential Care Facilities (RCFs).

2. There are 14 Nursing Home Districts with approximately 30 RCF IIs. For the purposes of completing this fiscal note, it is assumed that the average RCF II has 27 residents with 11 full-time staff and 5 part-time staff. Three of the 11 staff do not provide direct care. The turnover rate among staff is assumed to be 20%.

3. Assumes that all employees, both full-time and part-time, attend required orientation and training.

4. In the first year (FY-01) it is assumed that two RCF IIs shall decide to admit or continue to care for residents who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids due to Alzheimer's disease or other dementia. It is assumed that this number will remain constant for the life of the rule, as this rule does not require RCFs to participate.

5. Assumes that each participating RCF II will have three (3) residents with Alzheimer's disease or other dementia who cannot mentally negotiate a pathway to safety.

6. Assumes that both of the participating facilities will need to meet the additional fire safety standards. In FY-01 it will cost the (2) RCF IIs $1,320 for doors and hardware.

7. This rule is mandated by section 198.073, RSMo (Supp. 1999); therefore, the life of the rule cannot be determined by the Division of Aging.

8. As this rule is substantially based on the statutory requirements of Chapter 198, RSMo (Supp. 1999), a takings analysis is not required under section 536.017, RSMo (Supp. 1999). However, a takings analysis has occurred and a determination made that the proposed rule does not constitute a taking of real property under relevant state and federal laws.

9. Any other costs not identified within this fiscal note are unforeseen and unquantifiable.

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 13 - Department of Social Services

Division: 15 - Division of Aging

Chapter: 15 - Residential Care Facilities I and II

Type of Rulemaking: Proposed Rule

Rule Number and Name: 13 CSR 15-15.045—Standards and Requirements for Residential Care Facilities II Which Provide Services to Residents with Alzheimer's Disease or Other Dementia.

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
18	Residential Care Facilities II	FY-01 - $98,208
55	Residential Care Facilities II	FY-02 - $249,942
110	Residential Care Facilities II	FY-03 - $446,490
110	Residential Care Facilities II	FY-04 - $290,400*
55	RCF IIs with Safe Units	FY-02 - $768,350
55	RCF IIs with Safe Units	FY-03 - $124,080*

*Annually for the life of the rule

III. WORKSHEET

- Staff Training: Eleven (11) full-time employees of one (1) LPN @ $11/hr., four (4) Med. Aides @ $6.25/hr., three (3) CNAs @ $10/hr., three (3) non-direct care staff @ $5.35/hr., and five (5) part-time employees of one (1) RN @ $18/hr., three (3) Med. Aides @ $6.25/hr., and one (1) CNA @ $10/hr. Total direct care wages/hr. = $112.75; total staff wages/hr. = $129.00/hr. Twenty percent (20%) staff turnover rate @ avg hr rate = Three (3) staff @ $8/hr.= $24/hr.
  24 hrs. Orientation x $112.75 = $2,706 (first year only); 24 hrs. Orientation x $24 = $576 (ongoing); 16 hrs. In-service training x $129/hr. = $2,064. Total training costs/RCF II for first year: $2,706 + $576 + $2,064 = $5,346. Ongoing training costs/RCF II: $576 + $2,064 = $2,640.
- Staff Training for RCF II Safe Unit: For six (6) residents/Safe Unit - one (1) LPN; two (2) Med. Aides; two (2) CNAs; and three (3) part-time Med. Aides. Unit hourly wage = $62.25 x 24 hrs training = $1,494 (first year only); turnover rate of 20% = one x $8/hr x 24 hrs. = $192; in-service training for all staff = $2,064.
  FY-02: $1,494 + $192 + $2,064 = $3,750; FY-03: $192 + $2,064 = $2,256

- Fire Safety Requirements: One and three-fourths inches solid core doors @ $300/door. Non-locking door knobs @ $20/resident room door. Average cost per affected RCF II = $660
- For RCF II with Safe Unit - Delayed egress locking systems @ $2,000/door; Additional square feet (15 ft @ $82/sq ft = $1,230/resident x 6 residents = $7,380
  FY-02 cost for six (6) resident Safe Unit = $3,750 (training) + $600 (doors) + $240 (door knobs) + $2,000 (delayed egress door) + $7,380 = $13,970/RCF II x 55 RCF II = $768,350 FY-03 cost for ongoing and in-service training = $2,256/RCF II x 55 RCF II = $124,080

IV. ASSUMPTIONS

1. All rules in 13 CSR 15 are integrally related. All Chapter 15 rules should be considered collectively to obtain a complete assessment of the costs related to Residential Care Facilities (RCFs).

2. There are 356 RCF IIs with 15,556 beds and 9,966 residents. The occupancy rate is 56%. For the purposes of completing this fiscal note, it is assumed that the average RCF II has 27 residents with 11 full-time staff and 5 part-time staff. Three of the 11 staff do not provide direct care. The turnover rate among staff is assumed to be 20%.

3. Assumes that all employees, both full-time and part-time, attend required orientation and training.

4. In the first year (FY-01) it is assumed that five percent (5%) of the RCF IIs (18 RCF IIs) shall decide to admit or continue to care for residents who are physically capable but mentally incapable of negotiating a pathway to safety with the use of assistive devices or aids due to Alzheimer's disease or other dementia. In FY-02 the number of RCF IIs will increase by 37 facilities to 55 facilities (15%). In FY-03 the number of RCF IIs will increase by 55 facilities to 110 facilities (30%). It is assumed that the 30% rate will remain constant for the life of the rule, as this rule does not require RCFs to participate.

5. Assumes that each participating RCF II will have three (3) residents with Alzheimer's disease or other dementia who cannot mentally negotiate a pathway to safety.

6. Assumes that twenty percent (20%) of participating facilities will need to meet the additional fire safety standards. In FY-01 it will cost three (3) RCF IIs $1,980 for doors and hardware; in FY-02 it will cost seven (7) RCF IIs $4,620 in doors and hardware; and in FY-03 it will cost eleven (11) RCF IIs $7,260 for doors and hardware.

7. This rule is mandated by section 198.073, RSMo (Supp. 1999); therefore, the life of the rule cannot be determined by the Division of Aging.

8. As this rule is substantially based on the statutory requirements of Chapter 198, RSMo (Supp. 1999), a takings analysis is not required under section 536.017, RSMo (Supp. 1999). However, a takings analysis has occurred and a determination made that the proposed rule does not constitute a taking of real property under relevant state and federal laws.

9. Any other costs not identified within this fiscal note are unforeseen and unquantifiable.

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending sections (1), (2), (3), (5), (6), (15), (16), (18) and (21).

PURPOSE: The proposed amendment to section (1) clarifies the types of Medicaid reimbursement hospitals may receive, the proposed amendment to section (2) corrects the citation to a subsection in the regulation that has been amended, the proposed amendment to section (3) provides for the trend factor for State Fiscal Year (SFY) 2001, the proposed amendment to section (5) corrects the citation to a subsection in the regulation that has been amended and updates certain citations to federal regulations formerly appearing in the Title 42, part 405, which were redesigned as part 413 of Title 42, the proposed amendment to section (6) adds an additional category of hospital which shall be provided a safety net adjustment, the proposed amendment to section (15) provides for using a base year cost report that is the most representative of costs for safety net hospitals, the proposed amendment to section (16) redefines the safety net adjustment and adds paragraph (16)(A)2. to authorize use of certified funds as the state share of the safety net adjustment, the authorization which was inadvertently deleted in a prior amendment, the proposed amendment to section (18) adjusts the percent of uninsured costs paid for SFY 2001 and the proposed amendment to section (21) provides for an add-on payment to all teaching hospitals for graduate medical education.

(1) General Reimbursement Principles.

(C) The Title XIX reimbursement for hospitals, excluding those located outside Missouri and in-state federal hospitals, shall include per-diem **payments**, outpatient **payments**, *[and]* disproportionate share payments**; various Medicaid Add-On payments, as described in this rule; or a safety net adjustment, paid in lieu of Direct Medicaid Payments described in section (15) and Uninsured Add-Ons described in subsection (18)(B)**. Reimbursement shall be subject to availability of federal financial participation (FFP).

1. Per-diem reimbursement—The per-diem rate is established in accordance with section (3).

2. Outpatient reimbursement is described in section (13).

3. Disproportionate share reimbursement—The disproportionate share payments described in *[paragraph (16)(A)1.]* **section (16)**, and *[section]* **subsection** (18)**(B)** include both the federally mandated reimbursement for hospitals which meet the federal requirements **listed** in *[subsection (6)(A)]* **section (6)** and the discretionary disproportionate share payments which are allowable but not mandated under federal regulation**.** *[are described in paragraph (16)(A)1., and section (18). These]* **A** Safety Net **Adjustment, section (16),** and *[Medicaid]* **Uninsured** Add-Ons**, subsection (18)(B),** are subject to federal limitation described in Omnibus Reconciliation Act of 1993 (OBRA 93) and section (17) **of this regulation**.

4. Medicaid Add-Ons—Medicaid Add-Ons are described in sections (15), (19) and (21) and are in addition to Medicaid per-diem payments. These payments are subject to the federal Medicare Upper Limit test.

5. Safety Net Adjustment—The payments described in subsection (16)(A) are paid in lieu of Direct Medicaid Payments described in section (15) and Uninsured Add-Ons described in subsection (18)(B).

(2) Definitions.

(G) Disproportionate share reimbursement. The disproportionate share payments described in *[paragraph (16)(A)1.]* **section (16)**, and *[section]* **subsection** (18)**(B)** include both the federally mandated reimbursement for hospitals which meet the federal requirements **listed** in *[subsection (6)(A)]* **section (6)** and the discretionary disproportionate share payments which are allowed but not mandated under federal regulation**.** *[are described in paragraph (16)(A)1., and section (18) of this regulation. These]* **A** Safety Net **Adjustment, section (16),** and *[Medicaid]* **Uninsured** Add-Ons**, subsection (18)(B),** are subject to federal limitation as described in Omnibus Reconciliation Act of 1993 (OBRA 93) and section (17) of this regulation.

(3) Per-Diem Reimbursement Rate Computation. Each hospital shall receive a Medicaid 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 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 2001–3.9%.

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 not be trended for SFY 2001.**

(5) Administrative Actions.

(B) Records.

1. All hospitals are required to maintain financial and statistical records in accordance with 42 CFR *[405.406]* **413.20**. For purposes of this plan, statistical and financial records shall include beneficiaries' medical records and patient claim logs separated for inpatient and outpatient services billed to and paid for by Missouri Medicaid (excluding cross-over claims) respectively. Separate logs for inpatient and outpatient services should be maintained for Medicaid recipients covered by managed care (MC+). All records must be available upon request to representatives, employees or contractors of the Missouri Medical Assistance Program, Missouri Department of Social Services, General Accounting Office (GAO) or the United States Department of Health and Human Services (HHS). The content and organization of the inpatient and outpatient logs shall include the following:

A. A separate Medicaid log for each fiscal year must be maintained by either date of service or date of payment by Medicaid for claims and all adjustments of those claims for services provided in the fiscal period. Lengths of stay covering two (2) fiscal periods should be recorded by date of admission. The information from the Medicaid log should be used to complete the Medicaid worksheet in the hospital's cost report;

B. Data required to be recorded in logs for each claim include:

(I) Recipient name and Medicaid number;

(II) Dates of service;

(III) If inpatient claim, number of days paid for by Medicaid, classified by adults and peds, each subproviders, newborn or specific type of intensive care;

(IV) Charges for paid inpatient days and inpatient ancillary charges for paid days classified by cost center as reported in the cost report or allowed outpatient services, classified by cost center as reported on cost report;

(V) Noncovered charges combined under a separate heading;

(VI) Total charges;

(VII) Any partial payment made by third-party payers (claims paid equal to or in excess of Medicaid payment rates by third-party payers shall not be included in the log);

(VIII) Medicaid payment received or the adjustment taken; and

(IX) Date of remittance advice upon which paid claim or adjustment appeared;

C. A year-to-date total must appear at the bottom of each log page or after each applicable group total or a summation page of all subtotals for the fiscal year activity must be included with the log; and

D. Not to be included in the outpatient log are claims or line item outpatient charges denied by Medicaid or claims or charges paid from an established Medicaid fee schedule. This would include payments for General Relief (GR) recipients, payments for hospital-based physicians and certified registered nurse anesthetists billed by the hospital on a professional services claim, payments for certain specified clinical diagnostic laboratory services, or payments for services provided by the hospital through enrollment as a Medicaid provider-type other than hospital outpatient.

2. Records of related organizations, as defined by 42 CFR *[405.427(a)]* **413.17**, must be available upon demand to those individuals or organizations as listed in paragraph (5)(B)1. of this rule.

3. The Missouri Division of Medical Services shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the record keeping requirements of 42 CFR 413.20. If an audit by, or on behalf of, the state or federal government has begun but is not completed at the end of the three (3)-year period, or if audit findings have not been resolved at the end of the three (3)-year period, the reports shall be retained until resolution of the audit findings.

4. The Missouri Division of Medical Services shall maintain any responses received on this plan, subsequent changes to this plan and rates for a period of three (3) years from the date of receipt.

(F) Rate Reconsideration.

1. Rate reconsideration may be requested under this subsection for changes in allowable cost which occur subsequent to the base period described in *[subsection (2)(C)]* **subsection (3)(A)**. The effective date for any increase granted under this subsection shall be no earlier than the first day of the month following the Division of Medical Services' final determination on rate reconsideration.

2. The following may be subject to review under procedures established by the Medicaid agency:

A. Substantial changes in or costs due to case mix;

B. New, expanded or terminated services as detailed in subsection (5)(C); and

C. When the hospital experiences extraordinary circumstances which may include, but are not limited to, an act of God, war or civil disturbance.

3. The following will not be subject to review under these procedures:

A. The use of Medicare standards and reimbursement principles;

B. The method for determining the trend factor;

C. The use of all-inclusive prospective reimbursement rates; and

D. Increased costs for the successor owner, management or leaseholder that result from changes in ownership, management, control, operation or leasehold interests by whatever form for any hospital previously certified at any time for participation in the Medicaid program, except a review may be conducted when a hospital changes from nonprofit to proprietary or vice versa to recognize the change in its property taxes, see paragraph (5)(E)4.

4. As a condition of review, the Missouri Division of Medical Services may require the hospital to submit to a comprehensive operational review.The review will be made at the discretion of the state Medicaid agency and may be performed by it or its designee. The findings from any such review may be used to recalculate allowable costs for the hospital.

5. The request for an adjustment must be submitted in writing to the Missouri Division of Medical Services and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by generally acceptable accounting principles. The hospital shall demonstrate the adjustment is necessary, proper and consistent with efficient and economical delivery of covered patient care services. The hospital will be notified in writing of the agency's decision within sixty (60) days of receipt of the hospital's written request or within sixty (60) days of receipt of any additional documentation or clarification which may be required, whichever is later. Failure to submit requested information within the sixty (60)-day period shall be grounds for denial of the request. If the state does not respond within the sixty (60)-day period, the request shall be deemed denied.

(6) Disproportionate Share.

(A) Inpatient hospital providers may qualify as a */d/***D**isproportionate */s/***S**hare */h/***H**ospital (DSH) based on the following criteria. Hospitals shall qualify as */d/***D**isproportionate */s/***S**hare */h/***H**ospitals for a period of only one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue their disproportionate share classification—

1. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be a least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;

2. As determined from the *[third]* **fourth** prior year desk-reviewed cost report, the facility must have either—

A. A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) provided under a state plan divided by the provider's total number of inpatient days (TNID). The state's mean MIUR will be expressed as the ratio of the sum of the total number of the Medicaid days for all Missouri hospitals divided by the sum of the total patient days for the same Missouri hospitals. Data for hospitals no longer participating in the program will be excluded;

$$\text{MIUR} = \frac{\text{TMD}}{\text{TNID}}$$

or

B. A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). The LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

(I) Total Medicaid patient revenues (TMPR) paid to the hospital for patient services under a state plan plus the amount of the cash subsidies (CS) directly received from state and local governments, divided by the total net revenues (TNR) (charges, minus contractual allowances, discounts and the like) for patient services plus the CS; and

(II) The total amount of the hospital's charges for patient services attributable to charity care (CC) (care provided to individuals who have no source of payment, third-party or personal resources) less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for medical assistance under a state plan;

$$\text{LIUR} = \frac{\text{TMPR} + \text{CS} + \text{CC} - \text{CS}}{\text{TNR} + \text{CS} \qquad \text{THC}}$$

3. As determined from the *[third]* **fourth** prior year desk-reviewed cost report, the hospital—

A. Has an unsponsored care ratio of at least ten percent (10%). The unsponsored care ratio is determined as the sum of bad debts and CC divided by TNR and also meets either of the criteria in paragraph (6)(A)2.; or

B. Ranks in the top fifteen (15) in the number of Medicaid inpatient days provided by that hospital compared to Medicaid patient days provided by all hospitals, and the hospitals also have a Medicaid nursery utilization ratio greater than thirty-five percent (35%) as computed by dividing Title XIX nursery and neonatal days by total nursery and neonatal days; or

C. Operated a neonatal intensive care unit with a ratio of Missouri Medicaid neonatal patient days to Missouri Medicaid total patient days in excess of nine percent (9%) reported or verified by the division from the *[third]* **fourth** prior year cost report;

4. As determined from the *[third]* **fourth** prior year desk-reviewed cost report—

A. The acute care hospital has an unsponsored care ratio of at least sixty-five percent and is licensed for less than fifty inpatient beds; or

*[A.]***B**. The **acute care** hospital has an unsponsored care ratio of at least sixty-five percent (65%) **and is licensed for fifty inpatient beds or more and has an occupancy rate of more than forty percent (40%)**; or

*[B.]***C.** The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo and the Missouri Rehabilitation Center created by Chapter 199, RSMo or their successors; or

*[C.]***D.** The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders; and

5. As determined from the *[third]* **fourth** prior year desk-reviewed cost report, hospitals which annually provide more than five thousand (5,000) Title XIX days of care and whose Title XIX nursery days represent more than fifty percent (50%) of the hospital's total nursery days.

(B) Those hospitals which meet the criteria established in paragraphs (6)(A)1., **(6)(A)**2. and **(6)(A)**4. shall be deemed *[first tier ten percent (10%) add-on DSH]* **safety net hospitals**. Those hospitals which meet the criteria established in (6)(A)1. and **(6)(A)**3. shall be deemed first tier **Disproportionate Share Hospitals (**DSH**)**. Those hospitals which meet only the criteria established in paragraphs (6)(A)1. and **(6)(A)**2. or (6)(A)1. and **(6)(A)**5. shall be deemed second tier DSH.

(15) Direct Medicaid Payments.

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

1. The Medicaid share of the FRA assessment will be calculated by dividing the hospital's Medicaid patient days by total hospital's patient days to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the FRA assessment for the current SFY to arrive at the increased allowable Medicaid costs;

2. The unreimbursed Medicaid costs are determined by subtracting the hospital's per-diem rate from its trended per-diem costs. The difference is multiplied by the estimated Medicaid patient days for the current SFY.

A. The trended cost per day is calculated by trending the base year operating costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A).

B. 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, based on the determination of the Division of Medical Services exercising its sole discretion as to which report is most representative of costs incurred. 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 shall be based on the third prior year cost report. For all other hospitals, the base year operating costs are based on the fourth prior year cost report.

[B.] **C.** 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 Medicaid patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of Medicaid inpatient days the hospital will not provide as a result of the MC+ 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 Medicaid days for the current SFY to arrive at the Medicaid utilization adjustment; and

5. The poison control cost shall reimburse the hospital for the prorated Medicaid managed care cost. It will be calculated by multiplying the estimated Medicaid share of the poison control costs by the percentage of MC+ recipients to total Medicaid recipients.

(16) Safety Net Adjustment. A safety net adjustment**, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons,** shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph (6)(A)4.*[,]* **The safety net adjustment payment shall be made** prior to the end of each federal fiscal year.

(A) The safety net adjustment **for facilities not operated by the Department of Mental Health primarily for the care and treatment of mental disorders** shall be computed in accordance with the *[OBRA 93 Limitation identified in section (17)]* **Direct Medicaid Payment calculation described in section (15) and the Uninsured Add-Ons calculation in subsection (18)(B)** of this regulation. **The safety net adjustment will include the last three quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.**

(B) *[Adjustments provided under this section shall be considered reasonable costs for purpose of the determinations described in paragraph (5)(D)2.]* **The safety net adjustment for facilities operated by the Department of Mental Health primarily for the care and treatment of mental disorders shall be computed in accordance with the Direct Medicaid Payment calculation described in section (15) and one hundred percent (100%) of the Uninsured costs calculation described in subsection (18)(B) of this regulation. The safety net adjustment will include the last three quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.**

(C) The state share of the safety net adjustment for hospitals described in subparagraphs (6)(A)4.A. and (6)(A)4.D. shall come from cash subsidy (CS) certified by the hospitals. If the aggregate CS are less than the state match required, the total aggregate safety net adjustment will be adjusted downward accordingly, and distributed to the hospitals in the same proportions as the original safety net adjustments.

(18) In accordance with state and federal laws regarding reimbursement of unreimbursed costs and the costs of services provided to uninsured patients, reimbursement for each State Fiscal Year (SFY) (July 1–June 30) shall be determined as follows:

(B) Uninsured Add-Ons. The hospital shall receive *[eighty-one percent (81%)]* **sixty-five percent (65%)** of the Uninsured costs prorated over the SFY. Hospitals which contribute through a plan approved by the director of health to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) shall receive *[eighty-two percent (82%)]* **sixty-six percent (66%)** of its uninsured costs prorated over the SFY. The uninsured Add-On will include:

1. The Add-On payment for the cost of the Uninsured **will be based on a three year average of the fourth, fifth, and sixth prior base year cost reports. Cost of the uninsured** *[This]* is determined by multiplying the charges for charity care and allowable bad debts by the hospital's total cost-to-charge ratio for allowable hospital services from the base year cost report's desk review. The cost of the Uninsured is then trended to the current year using the trend indices reported in subsection (3)(B). Allowable bad debts do not include the costs of caring for patients whose insurance covers the particular service, procedure or treatment;

2. An adjustment to recognize the Uninsured patients share of the FRA assessment not included in the desk-reviewed cost. The FRA assessment for Uninsured patients is determined by multiplying the current FRA assessment by the ratio of uninsured days to total inpatient days from the base year cost report;

3. The difference in the projected General Relief per-diem payments and trended costs for General Relief patient days;

4. The increased costs per day resulting from the utilization adjustment in subsection (15)(B) is multiplied by the estimated uninsured days; and

5. In order to maintain compliance with the Balanced Budget Act of 1997 (BBA) DSH cap and the budget neutrality provisions contained in Missouri's Medicaid Section 1115 Health Care Reform Demonstration Proposal, the Uninsured Add-On for SFY *[2000]* **2001** has been established at *[eighty-two percent (82%)]* **sixty-five percent (65%)** of the cost of the uninsured as computed in accordance with this subsection. *[One factor in determination of the payment percentage is an estimate that fifty-four ($54) million dollars shall be paid from July 1, 1999 thru April 30, 2000 related to previously uninsured parents covered under the Medicaid Section 1115 Health Care Reform Demonstration Proposal. The SFY 2000 payment percentage shall be increased by an additional one percent (1%) for every three point five ($3.5) million dollars increment not paid for parents covered under the Medicaid Section 1115 Health Care Reform Demonstration Proposal as of April 30, 2000. For example, if total spending on the Medicaid Section 1115 Health Care Reform Demonstration Proposal parent population is forty-seven ($47) million dollars, as of April 30, 2000, the Uninsured Add-On percentage from SFY 2000 shall be increased by two percent (2%).]*

A. The payment percentage in paragraph (18)(B)5. has been determined based on the estimate that one hundred four (104) million dollars shall be paid from July 1, 2000 through June 30, 2001, related to previously uninsured parents covered under the Medicaid Section 1115 Health Care Reform Demonstration Proposal.

B. The payment percentage in paragraph (18)(B)5. shall be increased by an additional one percent (1%) for each increment of three and one-half (3.5) million dollars of actual spending less than the estimate set forth in subparagraph (18)(B)5.A. For example, if total spending on the Medicaid Section 1115 Health Care Reform Demonstration Proposal for the parent population is eighty (80) million dollars, as of June 30, 2001, the Uninsured Add-On percentage for SFY 2001 shall be increased by two percent (2%).

C. The actual payments for the Medicaid Section 1115 Health Care Reform Demonstration Proposal for the parent population shall be reviewed on a quarterly basis to determine whether the annual estimate in subparagraph (18)(B)5.A. appears accurate or whether an increase in the payment percentage for uninsured costs is appropriate under subparagraph (18)(B)5.B.

(21) Enhanced Graduate Medical Education (GME) Payment—An enhanced GME payment shall be made to *[an]* **any** acute care hospital that provides graduate medical education (teaching hospital) *[if the hospital is a children's hospital or is a safety net hospital. A safety net hospital for purposes of this section is a hospital that has an unsponsored care ratio of at least sixty-five percent (65%) or the hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo and the Missouri Rehabilitation Center created by Chapter 199, RSMo or their successors]*.

(A) The enhanced GME payment shall be *[fifty percent (50%) of the teaching hospital's remaining unreimbursed aggregate approved amount for direct GME.]* **computed in accordance with subsection (21)(B).** The payment shall be made at the end of the state fiscal year. The enhanced GME payment for each state fiscal year shall be computed using the most recent cost data *[available from the Medicare cost report]* available when the enhanced GME payment is computed. If the cost report is less than or more than a twelve (12)-month period, the cost report data will be adjusted to reflect a twelve (12)-month period. **The state share of the enhanced GME payment to a hospital that has cash subsidies shall come from funds certified by the hospital.**

(B) *[The remaining unreimbursed aggregated approved amount for direct GME shall be calculated by subtracting the current state fiscal year Medicare and Medicaid GME payments based on the Medicare methodology on worksheet E-3 Part IV from the Medicare cost report (HCFA 2552-96), the provisions of which are incorporated by reference and made part of this rule, from the total unreimbursed aggregate approved amount from direct GME. The Medicaid GME payments will include both non-managed care and managed care payments from the hospital's base year cost report trended forward.]* **The enhanced GME payment will be computed by first determining the percentage difference between the McGraw-Hill CPI index for hospital services and Medicare update factors applied to the per resident amounts from 1986 to the most recent SFY. For example, the percentage difference has been computed to be eighty-five and sixty-two-one-hundredth percent (85.62%) for SFY 2000. The**

percentage difference is then multiplied by the Medicaid share of the aggregate approved amount reported on worksheet E-3 part IV of the Medicare cost report (HCFA 2552-96) for the fourth prior fiscal year and trended to the current state fiscal year. The resulting product is the enhanced GME payment.

AUTHORITY: sections 208.152, 208.153, [208.159,] 208.201 and 208.471, RSMo 1994. 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 May 1, 2000, effective May 11, 2000, expires Nov. 6, 2000. Amended: Filed May 1, 2000.*

PUBLIC COST: This proposed amendment is expected to cost state agencies or political subdivisions a total of $438,490,944 in state fiscal year 2001 which is an additional $94,962,519 over state fiscal year 2000. A fiscal note containing a detailed estimated cost of compliance has been filed with the secretary of state.

PRIVATE COST: This proposed amendment will reduce payments that would have been paid to private entities by $70,374,292. A fiscal note containing a detailed estimated cost of compliance has been filed with the secretary of state.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Division of Medical Services, Director of Medicaid, 615 Howerton Court, Jefferson City, MO 65102. To be considered, comments must be received within thirty days after publication of this notice in the ***Missouri Register****. No public hearing is scheduled.*

FISCAL NOTE
PUBLIC ENTITY COST

I. RULE NUMBER

Title: 13 – Department of Social Services

Division: 70 – Division of Medical Services

Chapter: 15 – Hospital Program

Type of Rulemaking Proposed Amendment

Rule Number and Name: 13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Department of Social Services	$438,490,944

III. WORKSHEET

The estimated annual impact is based on Direct Medicaid payments of $212,997,186. The Direct Medicaid Payments will be established for Safety Net hospitals based on the determination of the Division of Medical Services, exercising its sole discretion, as to which report is most representative of costs incurred; First Tier DSH hospitals based on the 1998 cost reports; and all other hospitals will use the 1997 cost report. The FRA funded uninsured payments of $209,796,460 are based on sixty-five percent (65%) of the three year average costs using the 1995, 1996 and 1997 cost reports for all hospitals. It includes increased Enhanced GME payments for all acute care teaching hospitals of $15,697,298. The estimated cost reflects all planned payments for SFY 2001 in the aggregate. The total payments include the proposed changes for SFY 2001 and continuing core payments from SFY 2000.

IV. ASSUMPTIONS

The hospital's uninsured payments will be based on sixty-five percent (65%) of the three year average cost of the uninsured from the 1995, 1996 and 1997 cost reports trended to 2001. The Division will pay sixty-five percent (65%) of the uninsured cost to comply with federal limits on the State's expenditures of disproportionate share funds. The Direct Medicaid Payments will be established for Safety Net hospitals based on the determination of the Division of Medical Services, exercising its sole discretion, as to which report is most representative of costs incurred; First Tier DSH hospitals based on the 1998 cost reports; and all other hospitals will use the 1997 cost report. Enhanced GME payments will be expanded to pay all acute teaching hospitals an additional payment by adjusting the inflation indices by the percentage difference between the Medicare update factors applied to the per resident amounts from 1986 to the most recent cost report filed as of April 5 each year and the McGraw-Hill CPI (CPI) index for hospital services for the same time period.

FISCAL NOTE
PRIVATE ENTITY COST

I. RULE NUMBER

Title: 13 – Department of Social Services

Division: 70 – Division of Medical Services

Chapter: 15 – Hospital Program

Type of Rulemaking: Proposed Amendment

Rule Number and Name: 13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
132	Hospitals	$70,374,292

III. WORKSHEET

The estimated annual impact is based on using a three year average of charity care and bad debts to estimate SFY 2001 costs and reducing the percent of uninsured payments made to hospitals to 65% of the uninsured costs.

IV. ASSUMPTIONS

The assumptions are that to stay within the disproportionate share limit required by federal law, we must reduce our uninsured payments to 65% of uninsured costs. This will reduce the uninsured cost paid to hospitals by $70,374,292. This estimated cost to the private entities will be offset by new payment methodologies proposed by the public entity - Please see Public Entity Fiscal Note. Total add-on payments to hospital funded by the FRA Program will be $438,490,944. These payments include Enhanced GME Payments, Direct Medicaid Payments, and Uninsured Payments.