



Rules of
Department of Mental Health
Division 10—Director, Department of Mental Health
Chapter 31—Reimbursement for Services

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**Title 9—DEPARTMENT OF
MENTAL HEALTH**

**Division 10—Director, Department of
Mental Health**

Chapter 31—Reimbursement for Services

**9 CSR 10-31.010 Determination of the
Charges for Mental Health Services Based
Upon Ability to Pay**

(Rescinded January 1, 1982)

AUTHORITY: section 202.330, RSMo Supp. 1980. Original rule filed Dec. 23, 1975, effective Jan. 2, 1976. Rescinded: Filed Aug. 13, 1981, effective Jan. 1, 1982.

Op. Atty. Gen. No. 228, Robb (6-28-73). The Division of Mental Health has the authority and the duty to charge for the care and treatment of a juvenile committed to the Division of Mental Health by the juvenile court or transferred to the Division of Mental Health from the State Board of Training Schools pursuant to section 211.201, RSMo, if this person is determined to be a private patient pursuant to the provisions of section 202.863, RSMo.

*Op. Atty. Gen. No. 66, Nanson (6-18-58). The Division of Mental Diseases may charge pay patients in state hospitals the maximum amount fixed by the division for each institution or any amount below that maximum based upon the ability, or means of the patient, to pay. A husband is liable for the support of his wife unless she has abandoned him without good cause or has abandoned him with cause and has contracted an adulterous relationship consequently; that a husband is liable for the support of his minor children; that in the absence of the husband or his inability to support minor children the same obligation devolves upon his wife. Persons who adopt a child and persons who stand in the position of *in loco parentis* have the same duty to support as do natural parents.*

9 CSR 10-31.011 Standard Means Test

PURPOSE: This rule prescribes a standard means test as required by section 630.210, RSMo, to determine amounts to be charged for services provided or procured by the Department of Mental Health.

(1) Definitions. The terms defined in section 630.005, RSMo, are incorporated by reference as though set out in this rule. The fol-

lowing other terms used in this rule, unless the text clearly requires otherwise, shall mean:

(A) Adjusted gross monthly income—the income remaining after allowable deductions permitted by this rule;

(B) Community psychiatric rehabilitation center (CPR provider or CPR program)—an organization which provides or arranges for, at the minimum, the following core services: intake and annual evaluations, crisis intervention and resolution, medication services, consultation services, medication administration, community support, and psychosocial rehabilitation in a nonresidential setting for individuals with serious mental illness in conjunction with standards set forth in 9 CSR 30-4.031-9 CSR 30-4.047;

(C) Community services—any services purchased or provided by the department that are not included in the definition of “long-term care”;

(D) Community support services—for the Division of Developmental Disabilities (DD), this means all Purchase of Service (POS) services, case management services for clients residing in Community Placement Program (CPP) facilities and in their natural homes, Choices for Families services, and all voucher services; for the Division of Comprehensive Psychiatric Services (CPS), this means Family Preservation services, Intensive Case Management services for children and adults, Supported Housing Voucher Program or Housing and Urban Development (HUD) Housing Voucher Program services, and Integrated Employment Support services; for the Division of Alcohol and Drug Abuse (ADA), this applies to drug-free counseling services provided to clients participating in a methadone maintenance program who have become drug-free;

(E) Early intervention services—developmental services provided by qualified personnel to meet infant’s or toddler’s developmental needs in one (1) or more of the following areas: physical development, cognitive development, language and speech development, psychosocial development, or self-help skills. Early intervention services must be provided in conformity with an individualized family service plan. Early intervention services may include, but are not limited to:

1. Family training, counseling, and home visits;
2. Special instructions;
3. Speech pathology and audiology;
4. Occupational therapy;
5. Physical therapy;
6. Transportation;

7. Psychological services;
8. Social work;
9. Case management services;
10. Nursing services;
11. Nutrition services;
12. Medical services for diagnostic or evaluation purposes;

13. Early identification, screening, and assessment services; and

14. Health services which enable infants or toddlers to benefit from other early intervention services;

(F) Financially responsible person—the individual who is obligated by law or this rule to pay charges for services;

(G) Gross monthly income (earned and unearned)—the total monthly income from all sources before payroll deductions, other withholdings, and expenses incurred in earning the income. Examples would include salaries and wages, dividends, annuities, interest, rents, pensions, disability and survivor benefits, Workers’ Compensation, unemployment compensation, maintenance and child support payments, bonuses, tips and gratuities, income from business or profession, and any other taxable and nontaxable income;

(H) Household size—the number of persons dependent upon the income of the financially responsible person including the person (recipient) receiving services, except for a blended family situation. Dependency for family members, other than the recipient, must meet the dependency test in the federal *Internal Revenue Code*;

(I) Long-term care—continuous residential care (excluding supportive housing) which meets any of the following conditions:

1. Admission to a habilitation center;
2. Admission to a community placement facility;
3. A statement signed by a physician or a qualified mental health professional that the care is for an indeterminate period; or

4. The care has been provided for at least twenty-four (24) months without any documentation in the recipient’s individualized treatment, habilitation, or rehabilitation plan indicating discharge is imminent (within ninety (90) days);

(J) Monthly rate—the amount determined by application of the sliding fee scale to be charged for services provided in a month;

(K) Provider—a public or private agency offering services to individuals approved for Department of Mental Health (DMH)-funded services;

(L) Recipient-client, patient, or resident—the person receiving services;

(M) Representative payee—guardian,



trustee, conservator, or other fiduciary appointed to receive a beneficiary's benefits (for example, Social Security, Railroad Retirement);

(N) Sliding fee scale—a table for determining the monthly rate to be charged to a financially responsible person for services; and

(O) Unearned income—income that is not derived from employment. Examples would include maintenance and child support monies, interests, pensions, unemployment benefits, Workers' Compensation, and benefits from the Social Security Administration, Railroad Retirement Board, Civil Service Commission, Veterans Administration, and other similar types of income.

(2) Charges Not to Exceed Costs. The charges determined by the application of this rule shall not exceed costs. For providers operated by the department, the costs are determined annually as required by section 630.210, RSMo. For other providers, the costs are authorized by contract with the department. If more than one (1) source of reimbursement is being charged, then collectively the charges shall not exceed costs.

(3) Community Support Incentives/POS. The following financial incentives shall be provided to clients and families receiving less costly community support services:

(A) Clients or their financially responsible parties shall be assessed at a rate of one-fourth (1/4) their monthly ability to pay, for community support services which are received by the client, except for the case management services specified in subsection (3)(B). Insurance companies and other third-party payers shall be billed at actual cost for all community support services, including the case management services specified in subsection (3)(B); and

(B) For case management services reimbursed by the Division of Developmental Disabilities and intensive case management services reimbursed by the Division of Comprehensive Psychiatric Services, only clients or their financially responsible parties with annual adjusted gross incomes exceeding one hundred thousand dollars (\$100,000) in 1991 dollars, adjusted annually for inflation using the Consumer Price Index (CPI), shall be assessed a charge, and the charge shall be the lesser of actual cost or one-fourth (1/4) their monthly ability to pay.

(4) Health Insurance. The provider shall apply to the costs incurred for providing ser-

vices to the recipient the benefits received or available on behalf of or to the recipient from private and public health insurance, health services corporation and health maintenance organization plans, policies and contracts including individual, company, fraternal, group, Medicare, Medicaid, and similar plans to the extent and limits of the coverage for the recipient. If a federal program requires the department to accept federal reimbursement as full payment as a condition of participation in the program for certain services, the provider shall not charge the financially responsible person for the services except the federally permitted deductibles or coinsurances.

(5) Financial Responsibility. As set out in section 630.205, RSMo, the following are jointly and severally liable to pay under this rule for services rendered to a recipient:

- (A) The recipient;
- (B) The recipient's estate only to the extent of the assets in the estate, if the recipient has a conservator or is deceased;
- (C) The recipient's spouse unless otherwise provided for in a separation agreement or dissolution order approved by a court of competent jurisdiction;
- (D) The recipient's natural parents' ability to pay is based separately on their own income with each claiming the children from that marriage as dependents. All child support, even if it is for other children that were a result of that marriage that are not our clients, will be considered in total income;
- (E) Any fiduciary, such as a trustee, only to the extent of the assets the fiduciary is holding on behalf of or for the recipient, which assets may be used according to law; except for any assets held in the Missouri Family Trust Fund on behalf of or for the recipient;

(F) Any representative payee to the extent of the benefits and assets under the law governing and permitting payment of benefits and assets for the recipient;

(G) The recipient's parents if the recipient is a minor (under age eighteen (18)), except the following:

- 1. The parents of a minor recipient who has been emancipated;
- 2. The parents of a minor recipient if the parents have relinquished parental responsibility through legal adoption or have had parental rights terminated by an action of a juvenile court;
- 3. The parents of a recipient age three to eighteen (3-18), a recipient age three to twenty-one (3-21), or the spouse or estate of

a recipient age three to twenty-one (3-21) are not liable for the cost of education, special education, or related services. The parents of a recipient age birth to three (0-3) are not liable for the cost of prevention and early intervention services provided through P.L. 102-119 Part H First Steps. The term special education, as used in this rule, is defined in 34 CFR Section 300a.14. The term related services, as used in this rule, is defined in 34 CFR 300a.13;

4. The adoptive parents of a minor recipient who had been, before the adoption, court committed to the legal custody of the department, the Department of Social Services, or a charitable organization; and

5. Stepparents' income;

(H) If two (2) or more members of a household receive services in the same month, the provider shall charge no more than the amounts determined by application of the sliding fee scale for one (1) recipient. Before this shall apply, the financially responsible person shall notify the provider when services are provided to more than one (1) member of the household in the same month;

(I) If the recipient is eligible for Medicaid (under any state entitlement program), Supplemental Security Income (SSI), General Relief (GR), or Food Stamps, the Standard Means Test (SMT) is not required to be implemented, with the exceptions that are found in other parts of this rule. Documentation of the eligibility must be placed in the financial file in lieu of an SMT;

(J) If the recipient is eligible for Title IV-A, the SMT will not need to be implemented. Documentation of eligibility must be placed in the financial file in lieu of an SMT;

(K) If it appears from the application of the SMT that the recipient could be assessed under more than one (1) client identifier, the formula which requires the least amount of client pay will be used; and

(L) The department shall consider non-custodial parents court orders regarding support payments and medical coverage obligations.

(6) Charges for Nonresidents. If a recipient of any age is not domiciled in this state, as defined in 9 CSR 10-31.016, then those responsible to pay, the parents, school district, special district or state department or agency of the recipient's domicile, under this rule are liable to pay the full cost of the services.

(7) Sliding Fee Scale. The scale determines



the monthly rate to be charged to a financially responsible person for services. The scale was developed using three hundred percent (300%) of the federal poverty guidelines for the year 2009 and income withholding tables for federal and state taxes. The scale shall be updated annually when changes have occurred in the federal poverty guidelines or the tax withholding tables. The adjusted gross monthly income on the sliding fee scale is determined by deducting the following expenses from gross income:

(A) Business expenses and expenses incurred on income-producing property when the income is included in gross income under this rule and the expenses were deducted on the federal income tax return;

(B) Business expenses which have no history and are now being claimed will be based on federal tax guidelines; if a review finds business expenses were invalid, then the rate will be adjusted to their ability to pay, retroactively;

(C) Medical expenses deducted by the taxpayer (financially responsible person) on the most recent filed tax year that exceed the federal percentage rate allowable of the federal adjusted gross income in (1996) or medical expenses that exceed the federal percentage and cannot be claimed on the federal tax return due to inability to itemize deductions, proof of payment must be presented;

(D) Medical expenses, anticipated or unanticipated, that will be scheduled as a monthly payment. Documentation must be presented that the payments have been or are being made. If a review finds that payments were not or are not being made, then the rate will be adjusted to their actual ability to pay, retroactively; and

(E) Child support paid by a parent, whether the parent can claim the child as a dependent or not, shall be a deduction to income. Documentation must be provided that payments are being made.

(8) Charges for Long-Term Care. The charges shall be determined under this section, and only under this section, when the recipient requires long-term care.

(A) If the recipient is with his/her spouse or dependents, the provider shall charge the recipient, his/her estate, fiduciary, or representative payee as follows: If the recipient is with his/her spouse or dependents, all unearned income should be treated as earned income and assessed according to the sliding fee scale, except in those cases where the spouses are estranged.

(B) If the recipient in a residential care or

inpatient facility purchased or operated by DMH is without spouse or dependents, then the provider shall consider all of a recipient's real and personal property when the provider has obtained and filed an annual statement from a licensed physician or a qualified mental health professional indicating that the recipient requires full-time residential services or, if the recipient has been in full-time residential services, twenty-four (24) or more continuous months previously. The provider shall charge all costs until the recipient's estate is reduced to the allowable amount for Medicaid eligibility, except cash and securities shall not exceed ninety-five percent (95%) of the Medicaid limit on cash and securities. The provider (DMH-operated or purchased facility) shall apply all unearned income to the cost of services, except that the provider shall make an allowance of thirty dollars (\$30) or more per month for personal spending as specified in the recipient's individualized treatment, habilitation, or rehabilitation plan. If the representative payee is the conservator, then the court-ordered costs shall be a reduction in the amount assessed upon the recipient's benefits.

(C) Subsections (8)(A) and (B) of this rule may be waived whenever the release of the recipient is imminent (within ninety (90) days), the unmet needs of the recipient have been documented and the recipient's existing funds are inadequate to pay the costs of the needs documented in the recipient's individualized habilitation, rehabilitation, or treatment plan.

(9) Charges for Community Services. Only financially responsible persons whose income is equal to, or greater than, three hundred percent (300%) of the federal poverty guidelines shall be assessed a monthly rate using the sliding fee scale, except that no financially responsible person shall be assessed a monthly rate for services received through a Community Psychiatric Rehabilitation Center or Compulsive Gambling services as defined in 9 CSR 30-3.134(1).

(10) Working Clients. If the recipient is a working client and is without a spouse, dependents, or both, the provider shall apply to costs of services forty percent (40%) of all net earned income exceeding one hundred dollars (\$100) per month, except in cases where DMH is not paying room and board costs. In these cases, the sliding fee scale shall be applied.

(11) Documentation Requirements. For com-

munity services, the financially responsible persons shall certify their income to the provider. If the provider has reasons to believe that the income certified by the financially responsible persons is inaccurate, then the provider shall request the documentation required below for individuals receiving long-term care. For long-term care, the financially responsible persons shall furnish the provider written statements of their income (for example, most recent year's filed complete federal tax return) or other supporting documentation requested by the provider for income verification. If the provider applies the long-term care provisions under this rule, then the provider shall obtain a statement of the recipient's personal and real assets and other supporting documentation. Documentation must be provided for any deductions to gross income.

(12) Failure to Comply. The provider shall have the recipient or financially responsible person apply for benefits and entitlements described in this rule if it appears the recipient is eligible. The provider may charge the financially responsible person all costs of providing or procuring the services when the recipient or financially responsible person—

(A) Deliberately fails to divulge financial resources upon request of the provider;

(B) Fails to apply or permit the provider to apply for benefits; or

(C) Fails to assign benefits.

(13) Failure to Pay. The provider may take action to collect any unpaid amounts charged based on the sliding fee scale or the full cost based on the failure to comply. These actions may include, but are not limited to, Missouri State Income Tax Intercept and any further action allowable under state and federal law.

(14) Voluntary Payments. The provider may accept voluntary payments from individuals not legally obligated to pay and payments made in addition to the amounts determined by application of this rule. Providers operated by the department shall receive gifts, donations, devises, or bequests as set out in section 630.330, RSMo. For services to clients, vendors or department-operated providers may set a minimal charge for services to clients which may exceed the monthly charge applicable under this rule. The charge shall not exceed five dollars (\$5) per visit and shall be an offset against any charges determined as otherwise applicable under this rule, per program, per provider. If one (1) client is assessed a minimal charge, all clients



in that program must be assessed the same minimal charge. The provider can determine that an urgent need for immediate services overrides any inability or refusal to pay.

(15) Test Application Procedures. The director delegates his/her authority to complete the SMT to any provider operated by the department. Other providers (for example, nonstate community mental health centers or substance abuse programs) which serve recipients directly without having them go through department case management shall apply the test if the providers agree to do so under the terms of contracts with the department.

(A) The provider shall apply the SMT contained in this rule at admission, annually after admission if the recipient is still receiving services, upon request from the recipient or responsible party, or by the initiative of the provider or the department director due to any significant change in financial status.

(B) The provider shall apply the test in this rule on all recipients as of February 26, 1993.

(C) Upon request for review, the provider shall change the monthly rate, if warranted, effective to the first day of the month of the date of request.

(D) As other substantial changes occur in income or asset status, the provider shall reapply the test and the changes shall be effective as of the first day of the month following the date of the reapplication of the test. If inaccurate or fraudulent information was provided for determining charges, or if the recipient is entitled to retroactive benefits, the provider shall retroactively change the amount charged.

(16) Appeal Procedures. The application of the SMT may be appealed by the financially responsible person to the chief administrative officer of the provider and then the department director as follows:

(A) The chief administrative officer of the provider shall review upon appeal the application of the test as to the verification of financial resources, the determination of charges, and issue a decision to the financially responsible person;

(B) The decision of the chief administrative officer of the provider may be appealed to the department director within fifteen (15) days of the receipt of the decision. The director will review appeals only if the recipient or responsible party alleges the incorrect application of the test. Upon completion of the review, the director shall issue a decision

which may alter application of the test;

(C) As set out in section 630.210, RSMo, the decision of the director may be reviewed in the circuit court of Cole County or the circuit court in the county where the financially responsible person legally obligated to pay resides according to the procedure set out in Chapter 536, RSMo; and

(D) Pending the decision upon appeal by the provider's chief administrative officer, the decision of the department director, if appealed, or decision of a court of competent jurisdiction, if judicially reviewed, whichever is later, the department shall hold the provider harmless and shall pay disputed amounts to the provider, if necessary, to continue services to the recipient. If the financially responsible person is deemed obligated to pay any of the disputed amounts after the appeal is completed, then the financially responsible person shall pay the amounts to the provider as an offset to the department's future support or to the department if no future department support is to be provided.

(17) Probation and Parole Clients. For services provided under terms and conditions of probation and parole, the provider may determine charges related to income and consistent with the treatment and rehabilitation goals of the terms and conditions of probation and parole as approved in writing by the department and the supervising court.

(18) Waiver Authority. The director may waive the application of the SMT to specific services, programs, or populations, or for specific purposes, or in specific situations, when the director determines that it is in the best interests of the state, the department, and the individuals served by the department to do so. Examples of situations in which waivers may be deemed appropriate include natural or man-made disasters, temporary services or programs which are not suited to the current SMT process, specific situations in which collections do not justify the administrative burden of applying the SMT, and situations in which the cost of providing services is fully covered by another funding source.

AUTHORITY: sections 630.050 and 630.210, RSMo Supp. 2009. Original rule filed May 12, 1981, effective Jan. 1, 1982. Emergency amendment filed March 19, 1982, effective April 1, 1982, expired July 11, 1982. Amended: Filed April 14, 1982, effective July 11, 1982. Emergency amendment filed Dec. 20, 1982, effective Jan. 1, 1983, expired April 1,*

1983. Emergency amendment filed June 20, 1983, effective July 1, 1983, expired Nov. 1, 1983. Amended: Filed June 20, 1983, effective Nov. 1, 1983. Emergency amendment filed Sept. 13, 1983, effective Oct. 1, 1983, expired Jan. 1, 1984. Amended: Filed Sept. 13, 1983, effective Jan. 1, 1984. Amended: Filed Oct. 11, 1984, effective Jan. 14, 1985. Amended: Filed Aug. 15, 1985, effective Nov. 11, 1985. Emergency amendment filed June 17, 1986, effective June 27, 1986, expired Oct. 15, 1986. Amended: Filed July 14, 1986, effective Nov. 28, 1986. Emergency amendment filed Dec. 20, 1990, effective Dec. 30, 1990, expired April 28, 1991. Amended: Filed Dec. 21, 1990, effective April 29, 1991. Emergency amendment filed May 21, 1991, effective July 1, 1991, expired Oct. 28, 1991. Amended: Filed Feb. 15, 1991, effective Aug. 30, 1991. Emergency rule filed Oct. 13, 1992, effective Oct. 23, 1992, expired Feb. 19, 1993. Emergency amendment filed Oct. 23, 1992, effective Nov. 2, 1992, expired Feb. 19, 1993. Rescinded and readopted: Filed May 15, 1992, effective Feb. 26, 1993. Emergency rule filed Feb. 10, 1993, effective Feb. 20, 1993, expired June 19, 1993. Amended: Filed Nov. 4, 1992, effective May 6, 1993. Amended: Filed July 17, 1995, effective Jan. 30, 1996. Amended: Filed Dec. 1, 2009, effective May 30, 2010.

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 630.210, RSMo 1980, amended 1981, 1982, 1993, 2004.*

9 CSR 10-31.012 State Income Tax Refund Intercept Hearing Procedure

PURPOSE: This rule prescribes a hearing procedure for taxpayers who protest, in writing, the application of their state income tax refunds to debts owed to the Department of Mental Health.

(1) If a taxpayer does not request a hearing, in writing, within thirty (30) days of the receipt of the Notice of Mental Health Debt Offset from the Department of Revenue, then—

A) The taxpayer is forever barred from asserting a defense to the application of the tax refund to a debt owed to the Department of Mental Health; and

(B) The state income tax refund shall be applied as an offset to the debt owed to the Department of Mental Health.



(2) A request for a hearing shall be denied when the request for the hearing—

(A) Is not within thirty (30) days of the receipt of the Notice of Mental Health Debt Offset from the Department of Revenue;

(B) Is not in writing;

(C) Raises issues only which have been previously litigated; and

(D) Does not raise any factual issues on the amount of the debt or the responsibility for the debt.

(3) A taxpayer's intercepted state income tax refund shall be relinquished to the taxpayer when the taxpayer asserts and proves any of the following defenses:

(A) The debt is for a child under age eighteen (18) and the taxpayer is not the natural or adoptive parent;

(B) The debt is for a debtor spouse and the taxpayer was not married to the debtor spouse at the time the debt was incurred;

(C) The debt is outlawed by the statute of limitations;

(D) The debt is barred from collection by a United States bankruptcy court;

(E) The taxpayer was erroneously identified as the debtor because of a mistake in the Social Security number; and

(F) Any other valid defense in fact or law appropriate for consideration.

(4) In the case of a joint or combined return, the taxpayer named in the return against whom no debt is claimed must file with the Department of Mental Health for an apportionment of the refund within thirty (30) days of the date of receipt of the Notice of Intent to Offset. The Department of Mental Health shall mail to the taxpayer a determination of apportionment within ninety (90) days after the filing of the taxpayer's application for apportionment of the refund. The department's decision on apportionment shall be final upon the expiration of thirty (30) days from the date on which the determination of apportionment is mailed, unless within the thirty (30)-day period from the mailing date of the determination, the taxpayer applies to the Department of Mental Health for a hearing with the Department of Mental Health on the issue of apportionment. The hearing shall be conducted by the director or his/her designee.

(5) An evidentiary hearing shall be scheduled when the amount of the debt or the responsibility for the debt can not be resolved, except by a hearing. If an evidentiary hearing is required, the Department of Mental Health

shall set the time and place for the hearing. Failure of the taxpayer to appear at the time and place scheduled for the hearing shall be deemed an acknowledgement of the debt by the taxpayer and shall result in debt offset. The hearing, if held, shall be conducted in accordance with the provisions of Chapter 536, RSMo.

AUTHORITY: sections 143.787 and 630.050, RSMo 1986. Original rule filed April 26, 1991, effective Sept. 30, 1991.*

**Original authority: 143.787, RSMo 1982 and 630.050, RSMo 1980.*

9 CSR 10-31.014 Waiver of Standard Means Test for Children in Need of Mental Health Services

PURPOSE: This rule implements a revision to section 630.210, RSMo requiring the department to promulgate a rule waiving the Standard Means Test for a child in need of mental health services.

(1) Definitions.

(A) The terms defined in 9 CSR 10-31.011 Standard Means Test are incorporated by reference as though set out in this rule.

(B) A "child in need of mental health services," as used in this rule, is any child who qualifies to receive services from the Department of Mental Health under Chapters 630, 631, 632 or 633, RSMo.

(2) Request for Waiver. At the time of initial application of the Standard Means Test (SMT) for a child in need of mental health services, and at the time of any subsequent reapplication, the provider shall inform the financially responsible person that the SMT may be waived.

(A) The provider shall make available to the financially responsible person information on how to submit a request for SMT waiver.

(B) The financially responsible person shall submit the request in writing to the department director, with a copy to the provider.

(C) For the initial waiver request made on behalf of a child, the provider shall not charge the monthly rate as determined by application of the SMT for services provided during any month in which the request is under review or appeal. This provision applies only to the first waiver request made on behalf of the child.

(D) A waiver may be approved, or

approved with conditions, for up to one (1) year. It is the responsibility of the financially responsible person to notify the provider of any significant change in financial status. A waiver may be reevaluated at the initiative of the department director due to any significant change in financial status.

(3) Review of Request for Waiver. Upon receipt of a request for SMT waiver the department director shall designate an individual or individuals to review the request. The designee or designees shall approve, approve with conditions, or deny the request within seven (7) working days of receipt of the written request. The designee or designees shall provide notice of the decision to the requestor by certified mail with copy to the provider.

(4) Consideration of Request. In making the decision to approve, approve with conditions, or deny the request, the designee or designees will consider information presented by the requestor. The requestor may, but is not required to, include information regarding one or more of the items listed below, or any other information in support of their request:

(A) The recommendation of the local care team, or other designated local or regional children's mental health authority that waiving the SMT will contribute to the therapeutic needs of the child by allowing the child to remain in the custody of the parent or custodian;

(B) History of the child being in state custody due exclusively to the need for mental health services;

(C) Statement from the financially responsible person that their primary motivation for requesting the waiver is to avoid loss of custody because they are unable to pay the monthly amount as determined by application of the Standard Means Test;

(D) Past efforts of the financially responsible person to obtain needed medical care, and expenses incurred by the financially responsible person for the treatment of the mental health condition or for the physical health of the child necessitated by the onset of the mental health condition;

(E) The parent or custodian's history of insurance benefits expended for physical and mental health treatment of the child and their current attempts to obtain commercial or government-sponsored insurance coverage; and

(F) The parent or custodian's overall wherewithal to pay for the child's mental health treatment needs at the time of requesting the waiver, including gross income, medical



expenses, assets, liabilities, and financial responsibility for other dependents in the home.

(5) Denial of Request. A request for waiver shall be denied when the request for waiver—

(A) Is not submitted in writing;

(B) Does not raise factual issues sufficient to show that inappropriate transfer of custody to the Children’s Division is likely to occur absent the waiver; or

(C) Does not present persuasive, factual evidence that the financially responsible person cannot afford to pay the monthly amount required by the application of the Standard Means Test.

(6) Appeal of Denial. Within seven (7) working days of receipt of notice of approval with conditions or denial of a request, the financially responsible person may appeal the approval with conditions or denial in writing to the department director, with copy to the provider.

(7) Review of Appeal. Within seven (7) working days of receipt of the written appeal, and upon completion of review, the department director shall issue a decision which may alter the approval with conditions or denial. The department director shall provide notice of the decision by certified mail to the financially responsible person with copy to the provider. The decision of the department director shall be the final decision of the department.

AUTHORITY: sections 630.050, RSMo 2000 and 630.210, RSMo Supp. 2004. Emergency rule filed Sept. 2, 2004, effective Sept. 15, 2004, expired March 13, 2005. Original rule filed Sept. 2, 2004, effective March 30, 2005.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995 and 630.210, RSMo 1980, amended 1981, 1982, 1993, 2004.*

9 CSR 10-31.016 Determining State of Domicile

PURPOSE: This rule prescribes department procedures for determining the domiciliary state of any patient resident or client receiving services from a facility, program or service operated or funded by the department as required by section 630.210, RSMo.

(1) A person domiciled in Missouri is one who resided in Missouri not for a mere special or temporary purpose, but with intent to remain in Missouri permanently or for an indefinite time which may be demonstrated, but not necessarily determined by—owner-

ship of a residence in Missouri, filing of a Missouri state income tax return, voter registration in Missouri, registration of a motor vehicle in Missouri, employment in Missouri or the receipt of public assistance from Missouri.

(2) A person and a person’s dependents are domiciled in Missouri when the person is a member of the armed services and stationed in Missouri. Domicile shall continue to be conferred upon dependents of a member, if they remain in Missouri, after the member of the armed services is transferred from Missouri.

(3) A person is considered incapable of forming intent to be domiciled in Missouri when—

(A) The person is under age eighteen (18) and not emancipated;

(B) The person’s Intelligence Quotient (IQ) is forty-nine (49) or less, or has a mental age of seven (7) or less based on tests administered by the Division of Mental Retardation and Developmental Disabilities;

(C) The person is declared legally incapacitated as defined in section 475.010, RSMo; or

(D) Medical documentation or other documentation acceptable to the department supports a finding that the person is incapable of forming intent to be domiciled in Missouri.

(4) If a person is determined under section (3) of this rule to be incapable of forming intent to be domiciled in Missouri, then the state of domicile shall be—

(A) The domicile of the parents of a minor under age eighteen (18) if the minor is not emancipated and parental rights have not been terminated;

(B) The state appointing a guardian for a minor under age eighteen (18) when the parents are deceased or parental rights have been terminated;

(C) The state in which the person is living at the time the person becomes incapable of forming intent when incapability occurs at or after age eighteen (18); or

(D) The state in which the parents or legal guardian reside when incapacity to form intent of the person aged eighteen (18) and older occurs prior to the person’s eighteenth birthday.

(5) Domiciliary status shall not be conferred on persons placed in institutions in Missouri by another state.

(6) Missouri is not the state of domicile when

the person—

(A) Removes him/herself and his/her personal effects from Missouri with an intent to establish domicile elsewhere;

(B) Accepts employment, other than on a temporary basis, in another state and does not retain a residence in Missouri;

(C) Accepts public assistance from another state;

(D) Becomes a registered voter in another state;

(E) Renounces Missouri as his/her state of domicile;

(F) Licenses his/her motor vehicle in another state; or

(G) Performs any other act which indicates intent to abandon Missouri as state of domicile.

AUTHORITY: sections 630.050 and 630.120, RSMo 1986. Original rule filed Nov. 22, 1983, effective April 15, 1984. Amended: Filed Dec. 4, 1990, effective April 29, 1991.*

**Original authority: 630.050, RSMo 1980 and 630.120, RSMo 1980.*

9 CSR 10-31.020 Determination of the Charges for Outpatient Services Provided or Procured

(Rescinded January 1, 1982)

AUTHORITY: section 202.330, RSMo Supp. 1980. Original rule filed June 16, 1977, effective Oct. 13, 1977. Rescinded: Filed Aug. 13, 1981, effective Jan. 1, 1982.

9 CSR 10-31.030 Intermediate Care Facility for the Mentally Retarded Federal Reimbursement Allowance

PURPOSE: This rule establishes the formula to determine the Federal Reimbursement Allowance for each Intermediate Care Facility for the Mentally Retarded (ICF/MR) operated primarily for the care and treatment of mental retardation/developmental disabilities. This rule applies to both private ICF/MRs and ICF/MR facilities operated by the Department of Mental Health and requires these facilities to pay for the privilege of engaging in the business of providing ICF/MR services to individuals in Missouri.

(1) The following words and terms, as used in this rule, mean:

(A) Base cost report. MO HealthNet cost report for the second prior fiscal year relative to the State Fiscal Year (SFY) for which the



assessment is being calculated (For example, the SFY 2009 Federal Reimbursement Allowance (FRA) assessment will be determined using the Intermediate Care Facility for the Mentally Retarded (ICF/MR) cost report from FY 2007.);

(B) Department. Department of Mental Health;

(C) Director. Director of the Department of Mental Health;

(D) Division. Division of Mental Retardation/Developmental Disabilities, Department of Mental Health;

(E) Engaging in the business of providing residential habilitation care. Accepting payment for ICF/MR services rendered;

(F) Fiscal period. Twelve (12)-month reporting period determined by the State Fiscal Year;

(G) Intermediate Care Facility for the Mentally Retarded (ICF/MR). A private or department facility that admits persons who are mentally retarded or developmentally disabled for residential habilitation and other services pursuant to Chapter 630, RSMo, and that has been certified to meet the conditions of participation under 42 CFR 483, Subpart I;

(H) Intermediate Care Facility for the Mentally Retarded Federal Reimbursement Allowance (ICF/MRFRA). The assessment paid by each ICF/MR;

(I) Net revenues. Gross revenues less bad debts, less charity care, and less contractual allowances; and

(J) Trend factor. Centers for Medicare and Medicaid Services (CMS) Prospective Payment System Skilled Nursing Facility Input Price Index (SNF IPI) four (4) quarter moving average (Source: GLOBAL INSIGHT, INC, 4th Qtr, 2007) (4 Quarter Moving Average Percent Changes in the CMS Prospective Payment System Skilled Nursing Facility Input Price Index (SNF IPI) using Forecast Assumptions, by Expense Category: 1990-2017).

(2) Each ICF/MR operated primarily for the care and treatment of mental retardation/developmental disabilities engaging in the business of providing residential habilitation and other services in Missouri shall pay an ICF/MRFRA. The ICF/MRFRA shall be calculated by the department as follows:

(A) Beginning on July 1, 2008, and each year thereafter, the ICF/MRFRA annual assessment shall be five and forty-nine hundredths percent (5.49%) of the ICF/MR's net revenues determined from the base cost report relative to the State Fiscal Year for

which the assessment is being calculated. The cost report shall be trended forward from the second prior year to the current fiscal year by applying the SNF IPI trend factor for each year under the ICF/MRFRA calculation;

(B) Beginning on October 1, 2011, and each year thereafter, the ICF/MRFRA annual assessment shall be five and ninety-five hundredths percent (5.95%) of the ICF/MR's net revenues determined from the base cost report relative to the State Fiscal Year for which the assessment is being calculated. The cost report shall be trended forward from the second prior year to the current fiscal year by applying the SNF IPI trend factor for each year under the ICF/MRFRA calculation;

(C) The annual assessment shall be divided into twelve (12) equal amounts and collected over the number of months the assessment is effective. The assessment is made payable to the director of the Department of Revenue to be deposited in the state treasury in the ICF/MRFRA Fund;

(D) If the assessment amount determined using the second prior year cost report trended forward for the same year is greater than the actual assessment maximum amount on the current year ICF/MR provider tax revenues in the aggregate, then the department will offset the tax collections for the next year by each provider's pro-rata share of the difference between the amount of the tax as determined in subsection (2)(A) of 9 CSR 10-31.030 and the actual SFY amount determined from the current year ICF/MR cost report;

(E) If an ICF/MR does not have a base cost report, net revenues shall be estimated as follows:

1. Net revenues shall be determined by computation of the ICF/MR's projected annual patient days multiplied by its interim established per diem rate; and

(F) The ICF/MRFRA assessment for ICF/MRs that merge operation under one (1) MO HealthNet provider number shall be determined as follows:

1. The previously determined ICF/MRFRA assessment for each ICF/MR shall be combined under the active MO HealthNet provider number for the remainder of the State Fiscal Year after the division receives official notification of the merger; and

2. The ICF/MRFRA assessment for subsequent fiscal years shall be based on the combined data for both facilities.

(3) The department shall prepare a notification schedule of the information from each ICF/MR's second prior year cost report and provide each ICF/MR with this schedule.

(A) The schedule shall include:

1. Provider name;
2. Provider number;
3. Fiscal period;
4. Total number of licensed beds;
5. Total bed days;
6. Net revenues; and

7. Total amount of the assessment for the State Fiscal Year for which the assessment is being calculated and monthly assessment amount due each month.

(B) Each ICF/MR required to pay the ICF/MRFRA shall review this information, and if it is not correct, the ICF/MR must notify the department of such within fifteen (15) days of receipt of the notification schedule. If the ICF/MR fails to submit the corrected data within the fifteen (15)-day time period, the ICF/MR shall be barred from submitting corrected data later to have its ICF/MRFRA assessment adjusted.

(4) Payment of ICF/MRFRA Assessment.

(A) Each ICF/MR may request that its ICF/MRFRA be offset against any MO HealthNet payment due. A statement authorizing the offset must be on file with the MO HealthNet Division before any offset may be made relative to the ICF/MRFRA. Any balance due after the offset shall be remitted by the ICF/MR to the department. The remittance shall be made payable to the director of the Department of Revenue. If the remittance is not received before the next MO HealthNet payment cycle, the MO HealthNet Division shall offset the balance due from that check.

(B) If no offset has been authorized by the ICF/MR, the MO HealthNet Division will begin collecting the ICF/MRFRA on the first day of each month. The ICF/MRFRA shall be remitted by the ICF/MR facility to the MO HealthNet Division. The remittance shall be made payable to the director of the Department of Revenue and deposited in the state treasury to the credit of the ICF/MRFRA Fund.

(C) If the ICF/MR is delinquent in the payment of its ICF/MRFRA assessment, the director of the Department of Social Services shall withhold and remit to the Department of Revenue an amount equal to the assessment from any payment made by the MO HealthNet Division to the ICF/MR provider.

*AUTHORITY: sections 630.050 and 633.401, RSMo Supp. 2011. * Emergency rule filed July*



1, 2008, effective July 11, 2008, expired Dec. 28, 2008. Original rule filed July 1, 2008, effective Feb. 28, 2009. Emergency amendment filed Sept. 1, 2011, effective Oct. 1, 2011, expired March 28, 2012. Amended: Filed Sept. 1, 2011, effective March 30, 2012.

Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008 and 633.401, RSMo 2008, amended 2009, 2011.

9 CSR 10-31.040 Community Mental Health Center Clinic UPL

PURPOSE: This rule establishes the formula to determine supplemental payments under Medicaid subject to the clinic upper payment limit to Community Mental Health Center Clinics (CMHC).

(1) Definitions. The terms used in this rule shall mean—

(A) Medicare rate is the rate established in the 2010 Resource Based Relative Value Scale (RVRVS) table plus the Health Professional Shortage Area (HPSA) add-on payment; and

(B) Current Medicaid rate is the rate on file with the MO HealthNet Division at the beginning of the state fiscal year.

(2) Supplemental Payment to Community Mental Health Centers. The Department of Mental Health (DMH) contracts with privately owned and operated Community Mental Health Centers (CMHCs), which act as administrative entities of DMH. The CMHCs are designated as entry and exit points for DMH services and are required to provide a comprehensive array of services to any DMH patients in their designated service areas who seek care.

(3) To recognize the CMHCs' higher costs of doing business and their role as safety net providers, each Missouri CMHC will be paid an annual supplement, calculated at the beginning of each state fiscal year, and payable in quarterly installments. The supplemental payment will increase reimbursement for CMHC-provided clinics to 1.36 times the Medicare rate for such services, an amount that the state reasonably estimates to be comparable to that paid by private commercial payers. The payment will be subject to the clinic upper payment limit established at 42 CFR 447.321.

(4) Amount of Annual Supplemental Payment. Each CMHC's annual payment will be

determined using the following methodology.

(A) For each service procedure where there is a corresponding Medicare fee for a CMHC-provided clinic procedure, DMH will subtract the current Medicaid rate from the market proxy of 1.36 times the Medicare rate, then multiply the result by the number of units of service.

(B) For each service procedure where there is no corresponding Medicare fee for a CMHC-provided clinic procedure, DMH will calculate the difference between what the CMHC received under the current Medicaid rate and what the CMHC would have received if paid the cost-based fee used to approximate the commercial rate for such procedures, then multiply the result by the number of units of service.

(C) The amounts calculated in subsections (4)(A) and (4)(B) will be added together to determine each CMHC's total supplemental payment.

(D) In all years subsequent to state fiscal year 2012, the results of these calculations will be multiplied by a trend factor equal to the Consumer Price Index in the expenditure category Medical Care Services/Professional Services.

AUTHORITY: section 630.050, RSMo Supp. 2011, and sections 630.655 and 632.050, RSMo 2000. Original rule filed Feb. 1, 2012, effective Aug. 30, 2012.*

**Original authority: 630.050, RSMo 1980, amended 1993, 1995, 2008; 630.655, RSMo 1980; and 632.050, RSMo 1980.*