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

PROPOSED AMENDMENT

13 CSR 70-15.220 Disproportionate Share Hospital (DSH) Payments. The division is amending sections (1) – (5), and (7), and deleting section (6).

PURPOSE: This emergency amendment removes outdated language and changes the interim DSH payment calculation for DMH hospitals.

(1) General Reimbursement Principles.

(A) In order to receive federal financial participation (FFP), disproportionate share hospital (DSH) payments are made in compliance with federal statutes and regulations. Section 1923 of the Social Security Act (42 U.S. Code) describes the hospitals that must be paid DSH payments and those that the state may elect to pay DSH payments.

(B) Federally deemed DSH hospitals. The state must pay *[disproportionate share]* **DSH** payments to hospitals that meet the specific obstetric requirements set forth below in paragraph (1)(B)1. and have either a Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state mean or a low-income utilization rate (LIUR) greater than twenty-five percent (25%). The state shall not make DSH payments in excess of each hospital's estimated hospital-specific DSH limit.

1. Obstetrics requirements and exemptions.

A. Hospitals must have two (2) obstetricians, with staff privileges, who agree to provide non-emergency obstetric services to Medicaid eligibles. Rural hospitals, as defined by the federal Executive Office of Management and Budget, may qualify any physician with staff privileges as an obstetrician.

B. Hospitals are exempt from the obstetric requirements if the facility did not offer non-emergency obstetric services as of December 22, 1987.

C. Hospitals are exempt if inpatients are predominantly under eighteen (18) years of age.

(C) State-elected DSH payments. The state may elect to make disproportionate share payments to hospitals that meet the obstetric requirements set forth in paragraph (1)(B)1. and have a MIUR of at least one percent (1%).

(D) Section 1923(g) of the Social Security Act (Act) limits the amount of DSH payments states can pay to each hospital and earn FFP. To be in compliance with the Act, DSH payments shall not exceed one hundred percent (100%) of the uncompensated care costs of providing hospital services to Medicaid and uninsured individuals. Hospital-specific DSH limit calculations must comply with the federal DSH rules (42 CFR 447, Subpart E and 42 CFR 455, Subpart D). If the disproportionate share payments exceed the hospital-specific DSH limit, the difference shall be deducted from disproportionate share payments or recouped from future payments.

(E) All DSH payments in the aggregate shall not exceed the federal DSH allotment within a state fiscal period. The DSH allotment is the maximum amount of DSH payments a state can distribute each year and receive FFP.

(F) The state must submit an annual independent audit of the state's DSH program to the Centers for Medicare & Medicaid Services (CMS). FFP is not available for DSH payments that are found to exceed the hospital-specific eligible uncompensated care cost limit. All hospitals that receive DSH payments are subject to the independent federal DSH audit.

(G) Hospitals qualify for DSH for a period of one (1) state fiscal year and must requalify at the beginning of each state fiscal year to continue to receive disproportionate share payments.

(2) Definitions.

(A) Annual independent DSH audit. The annual independent DSH audit is the annual independent certified audit of the state DSH payments as required by the federal DSH audit rule 42 CFR 455.301 through 42 CFR 455.304. The annual independent DSH audit also includes the reporting requirements of 42 CFR 447.299. The annual independent DSH audit may also be referred to as the federally mandated annual independent DSH audit or independent federal DSH audit.

(B) Division. Unless otherwise specified, division refers to the MO HealthNet Division, the division of the Department of Social Services charged with the administration of Missouri's MO HealthNet Program.

(C) Estimated Medicaid net cost. Estimated Medicaid net cost is defined per *[the annual state DSH survey, as defined in subsection (2)(X), and related training documents and instructions provided to the hospitals by the division or its authorized contractor]***42 CFR 447.299(c)(6), (7), and (10) and 42 CFR 447.295**. The estimated Medicaid net cost is determined by using Medicare cost reporting methodologies described in this rule and is calculated using data reported on the state DSH survey.

1. *[The estimated Medicaid net cost is determined from the state DSH survey, as defined in subsection (2)(X), and is calculated as follows:*

A. Total cost of care for Medicaid IP/OP services;

B. Less regular IP/OP Medicaid FFS rate payments (excluding any other Medicaid payments as defined in subsection (2)(T));

C. Less IP/OP Medicaid MCO payments;

D. Equals the estimated Medicaid net cost; and

E.] The estimated Medicaid net cost shall be trended as set forth in subsection (2)*[(Z)]***(Y)**.

(D) Estimated uninsured *[net]***uncompensated care** cost. Estimated uninsured *[net]***uncompensated care** cost is *[the cost of providing inpatient and outpatient hospital services to individuals without health insurance or other third-party coverage for the hospital services they receive during the year less uninsured payments received on a cash basis for the applicable Medicaid state plan year. The costs are to be calculated using Medicare cost report costing methodologies described in this rule and should not include costs for services that were denied for reasons other than the patient's benefits were exhausted at the time of admittance, or the patient's benefit package did not cover the inpatient or outpatient hospital service(s) received]***defined per 42 CFR 447.295 and 42 CFR 447.299(c)(12) – (15)**.

1. *[The estimated uninsured net cost is determined from the state DSH survey and is calculated as follows:*

A. Total IP/OP uninsured cost of care;

B. Less total IP/OP indigent care/self-pay revenues;

C. Equals the estimated uninsured net cost.

(E) Estimated uninsured uncompensated care cost (UCC).

1. The estimated uninsured uncompensated care cost is determined from the state DSH survey and is calculated as follows:

A. Estimated uninsured net cost, as defined in subsection (2)(D);

B. Less total applicable section 1011 payments;

C. Equals the estimated uninsured uncompensated care cost; and

D.] The estimated uninsured uncompensated care cost shall be trended as set forth in subsection (2)*[(Z)]***(Y)**.

*[(F)]***(E)** Federal DSH allotment. The maximum amount of DSH a state can distribute each year and receive federal financial participation (FFP) in the payments in accordance with 42 CFR 447.297 and 42 CFR 447.298.

*[(G)]***(F)** Hospital DSH liability. The hospital DSH liability is the amount of DSH overpayments subject to recoupment as determined from the final annual independent DSH audit. It is the lesser of the total longfall or the DSH payments paid for the SFY.

*[(H)]***(G)** Hospital-specific DSH limit. The hospital-specific DSH limit is the sum of the Medicaid uncompensated care cost plus the uninsured uncompensated care cost and is calculated each year. The source for this calculation is as follows:

1. Actual hospital-specific DSH limit. The actual hospital-specific DSH limit is determined from the final annual independent DSH audit; and

2. Estimated hospital-specific DSH limit. The estimated hospital-specific DSH limit is calculated by the state using data from the state DSH survey, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable, which is used in determining the interim DSH payments.

*[(I)]***(H)** Incorporation by reference. This rule incorporates by reference the following:

1. 42 CFR **Chapter IV, Part** 447, which is incorporated by reference and made a part of this rule as published by the *[U.S. Government Publishing Office, and available at its website at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447?toc=1, June 9, 2022.]***Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, October 1, 2024.** This rule does not incorporate any subsequent amendments or additions;

2. 42 CFR **Chapter IV, Part** 455, which is incorporated by reference and made a part of this rule as published by the *[U.S. Government Publishing Office, and available at its website at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455?toc=1, June 9, 2022.]***Office of the Federal Register, 800 North Capitol St. NW, Suite 700, Washington, DC 20408, October 1, 2024**. This rule does not incorporate any subsequent amendments or additions;

3. The state DSH survey template and instructions are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[at its website at https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm, June 16, 2022]***April 22, 2025**. This rule does not incorporate any subsequent amendments or additions; and

4. *[This]***The** alternate state DSH survey supplemental template and instructions are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, *[at its website at https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm, June 16, 2022]***May 21, 2025**. This rule does not incorporate any subsequent amendments or additions.

*[(J)]***(I)** Individuals without health insurance or other third-party coverage for the services received.

1. Individuals who have no health insurance or other source of third-party coverage for the specific inpatient or outpatient hospital services they received during the year are considered uninsured. As set forth in CMS' final rule published in the *Federal Register*, December 3, 2014, for 42 CFR 447.295, a service-specific approach must be used to determine whether an individual is uninsured. The service-specific coverage determination can occur only once per individual per service provided and applies to the entire service, including all elements as that service, or similar services, would be defined by MO HealthNet. Determination of an individual's third-party coverage status is not dependent on receipt of payment by the hospital from the third party.

2. The costs for inpatient and outpatient hospital services provided to individuals without health insurance or other third-party coverage for the inpatient or outpatient hospital services they received during the year are considered uninsured and included in calculating the hospital-specific DSH limit.

3. The following costs shall be considered uninsured and included in calculating the hospital-specific DSH limit:

A. Costs for services provided to individuals whose benefit package does not cover the hospital service received. If the service is not included in an individual's health benefits coverage through a group health plan or health insurer, and there is no other legally liable third party, the hospital services are considered uninsured costs; and

B. Costs for services provided to individuals who have reached lifetime insurance limits for certain services or with exhausted insurance benefits at the time of service. When a lifetime or annual coverage limit is imposed by a third-party payer, specific services beyond the limit would not be within the individual's health benefit package from that third-party payer and would be considered uninsured costs, as long as the benefits were exhausted when the patient was admitted; and

C. For American Indians/Alaska Natives, Indian Health Services (IHS) and tribal coverage is only considered third-party coverage when services are received directly from IHS or tribal health programs or when IHS or a tribal health program has authorized coverage through the contract health service program.

4. The costs associated with the following shall not be included as uninsured costs:

A. Bad debts or unpaid coinsurance/deductibles for individuals with third-party coverage. Administrative denials of payment or requirements for satisfaction of deductible, copayment, or coinsurance liability do not affect the determination that a specific service is included in the health benefits coverage; and

B. Unpaid balances due for claims denied by the third-party payer for billing discrepancies, which include but are not limited to denials due to lack of pre-authorization, denials due to timely filing, denials due to lack of medical necessity, etc.; and

C. Prisoners. Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third-party coverage. However, an individual can be included as uninsured if a person has been released from secure custody and is referred to the hospital by law enforcement or corrections authorities and is admitted as a patient rather than an inmate to the hospital.

5. These definitions, and the resulting uninsured costs includable in calculating the hospital-specific DSH limit, are subject to change based on any federal DSH audit regulation changes. The division reserves the right to determine whether changes in federal DSH audit regulation will be applied to the interim DSH payment calculations.

*[(K)]***(J)** Institution for Mental Diseases (IMD) DSH allotment. The IMD DSH allotment is a portion of the state-wide DSH allotment and is the maximum amount set by the federal government that may be paid to IMD hospitals. Any unused IMD DSH allotment not paid to IMD hospitals for any plan year may be paid to hospitals that are under their projected hospital-specific DSH limit.

*[(L)]***(K)** Inpatient and outpatient hospital services. For purposes of determining the estimated hospital-specific DSH limit and the actual hospital-specific DSH limit, the inpatient and outpatient hospital services are limited to inpatient and outpatient hospital services included in the approved Missouri Medicaid State Plan.

*[(M)]***(L)** Lifetime or annual health insurance coverage limit. An annual or lifetime limit, imposed by a third-party payer, that establishes a maximum dollar value, or maximum number of specific services on a lifetime or annual basis, for benefits received by an individual.

*[(N)]***(M)** Longfall. The longfall is the total amount a hospital has been paid for inpatient and outpatient hospital services (including all DSH payments) in excess of their hospital-specific DSH limit. The source for this calculation is as follows:

1. Actual longfall. The actual longfall is based on the annual independent DSH audit; and

2. Estimated longfall. The estimated longfall is calculated by the state using data from the state DSH survey, other Medicaid payments, and data provided in the most recent independent DSH audit, if applicable.

*[(O)]***(N)** Low income utilization rate (LIUR). The LIUR shall be calculated as follows:

1. As determined from the *[third prior year audited Medicaid cost report]***state DSH survey**, the LIUR shall be the sum (expressed as a percentage) of the fractions, calculated as follows:

A. Total MO HealthNet 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

B. The total amount of the hospital's charges for **in**patient services attributable to charity care (CC) less **inpatient cash subsidies (I**CS) directly received from state and local governments in the same period, divided by the total amount of the hospital's **inpatient** 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 MO HealthNet under a state plan.

$$LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC - \mathbf{I}CS) / (THC))$$

*[(P)]***(O)** Medicaid inpatient utilization rate (MIUR). The MIUR shall be calculated as follows:

1. As determined from the *[third prior year audited Medicaid cost report]***state DSH survey**, the MIUR will be expressed as the ratio of total Medicaid eligible **inpatient** hospital days (TM**I**D) provided under a state plan divided by the provider's total number of inpatient hospital days (TNID); and

2. 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.

$$MIUR = TM\mathbf{I}D / TNID$$

*[(Q)]***(P)** Medicaid state plan year. Medicaid state plan year coincides with the twelve- (12-) month period for which a state calculates DSH payments. For Missouri, the Medicaid state plan year coincides with its state fiscal year (SFY) and is July 1 through June 30.

*[(R)]***(Q)** Medicare cost reporting methodologies. Medicaid and uninsured costs will be determined utilizing Medicare Cost Report (form CMS 2552) methodologies. The Medicaid Cost Report is completed using the Medicare Cost Report form CMS 2552, using the Medicare cost reporting methodologies. Based on these methodologies, the costs included in the DSH payment calculation will reflect the -Medicaid and uninsured portion of total allowable hospital costs from the Medicare Cost Report or the Medicaid Cost Report, as applicable. Costs such as the Missouri Medicaid hospital provider tax FRA are recognized as allowable costs for Medicaid and DSH program purposes and apportioned to Medicaid, uninsured, Medicare, and other payers following the cost finding principles included in the *cost* report, applicable instructions, regulations, and governing statutes.

*[(S)]***(R)** New facility. A new hospital determined in accordance with 13 CSR 70-15.010 without a base year cost report.

*[(T)]***(S)** Other Medicaid payments. For purposes of determining estimated hospital-specific DSH limits, the other Medicaid payments include any non-claim specific Medicaid payment made to a hospital for inpatient or outpatient hospital services including but not limited to Direct Medicaid, acuity adjustment payment, poison control payment, stop loss payment, graduate medical education (GME), children's outliers, cost settlements, and upper payment limit (UPL) payments, if applicable, will be included in the annual independent DSH audit. Any other payments made with state only funds are not required to be offset in determining the hospital-specific DSH limit.

*[(U)]***(T)** Out-of-state DSH payments. DSH payments received by a Missouri hospital from a state other than Missouri.

*[(V)]***(U)** Section 1011 payments. Section 1011 payments are made to a hospital for costs incurred for the provision of specific services to specific aliens to the extent that the provider was not otherwise reimbursed for such services. Because a portion of the Section 1011 payments are made for uncompensated care costs that are also eligible under the hospital-specific DSH limit, a defined portion of the Section 1011 payments must be recognized as an amount paid on behalf of those uninsured.

*[(W)]***(V)** Shortfall. The shortfall is the hospital-specific DSH limit in excess of the total amount a hospital has been paid for inpatient and outpatient hospital services (including all DSH payments). The source for this calculation is as follows:

1. Actual shortfall. The actual shortfall is based on the annual independent DSH audit; and
2. Estimated shortfall. The estimated shortfall is calculated by the state using data from the state DSH survey, and other Medicaid payments.

*[(X)]***(W)** State DSH survey. *[The state DSH survey was designed to reflect the standards of calculating uncompensated care cost established by the federal DSH rules in determining hospital-specific DSH limits. The DSH survey is also similar to, or the same as, the DSH survey that is utilized by the independent auditor during the annual independent DSH audit performed in accordance with the federally mandated DSH audit rules. The blank state DSH survey is referred to as the state DSH survey template.*

*1.]*Beginning with SFY 2017, the state DSH survey shall be the most recent DSH survey collected during the independent DSH audit of the fourth prior SFY (i.e., the most recent survey collected by the independent DSH auditor for the SFY 2019 independent DSH audit will also be used to calculate the interim DSH payment for SFY 2023). The survey shall be referred to as the SFY to which payments will relate.

*[(Y)]***(X)** Taxable revenue. Taxable revenue is the hospital's total inpatient adjusted net revenues plus outpatient adjusted net revenues determined in accordance with 13 CSR 70-15.110, paragraph (1)(A)13.

*[(Z)]***(Y)** Trends. A trend of one and a half percent (1.5%) will be applied to the hospital's estimated Medicaid net cost and the estimated uninsured uncompensated care cost (UCC) from the year subsequent to the state DSH survey period to the current SFY (i.e., the SFY for which the interim DSH payment is being determined). The first year's trend shall be adjusted to bring the facility's cost to a common fiscal year end of June 30 and the full trends shall be applied for the remaining years. The trends shall be compounded each year to determine the total cumulative trend.

[(AA) Uncompensated care costs (UCC). The uncompensated care costs are those set forth in subsection (2)(H).

*(BB)]***(Z)** Uninsured revenues. Payments received on a cash basis that are required per 42 CFR 455.301 through 42 CFR 455.304 and 42 CFR 447.299 to be offset against the uninsured cost to determine the uninsured net cost include any amounts received by the hospital, by or on behalf of either self-pay or uninsured individuals during the SFY under audit.

(3) Interim DSH Payments.

(A) Beginning with SFY 2013, interim DSH payments shall be calculated on an annual basis and will be based on the state's calculations using data provided in the state DSH survey for the applicable SFY, and estimated other Medicaid payments calculated by the division in accordance with 13 CSR 70-15.010, 13 CSR 70-15.015, and 13 CSR 70-15.230 for the applicable SFY.

(B) The interim DSH payments will be calculated as follows:

1. The estimated hospital-specific DSH limit is calculated as follows:

A. Estimated Medicaid net cost from the state DSH survey calculated in accordance with subsection (2)(C);

B. Less estimated other Medicaid payments calculated by the division in accordance with 13 CSR 70-15.010, 13 CSR 70-15.015, and 13 CSR 70-15.230;

C. Equals estimated Medicaid uncompensated care cost;

D. Plus estimated uninsured uncompensated care cost from the state DSH survey calculated in accordance with subsection (2)(E);

E. Equals estimated hospital-specific DSH limit;

2. The estimated uncompensated care costs potentially eligible for MHD interim DSH payments excludes out-of-state DSH payments and is calculated as follows:

A. Estimated hospital-specific DSH limit;

B. Less estimated out-of-state (OOS) DSH payments;

C. Equals estimated uncompensated care cost (UCC) net of OOS DSH payments;

3. Hospitals determined to have a negative estimated UCC net of OOS DSH payments (payments exceed costs) will not receive interim DSH payments because their estimated payments for the SFY are expected to exceed their estimated hospital-specific DSH limit; and

4. Qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments (costs exceed payments) will receive interim DSH payments. The interim DSH payments are subject to the federal DSH allotment, the availability of state funds, and the estimated hospital-specific DSH limits less estimated OOS DSH payments. The interim DSH payments will be calculated as follows:

A. Interim DSH payments to qualified DSH hospitals determined to have a positive estimated UCC net of OOS DSH payments will be calculated as follows:

(I) Up to one hundred percent (100%) of the available federal DSH allotment will be allocated to each hospital with a positive estimated UCC net of OOS DSH payments, and the allocation shall result in each hospital receiving the same percentage of their estimated UCC net of OOS DSH payments. The allocation percentage will be calculated at the beginning of the SFY by dividing the available federal DSH allotment to be distributed by the total hospital industry's positive estimated UCC net of OOS DSH payments; and

(II) The allocated amount will then be reduced by one percent (1%) for hospitals that do not contribute through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative.

(C) Hospitals may elect not to receive an interim DSH payment for a SFY by completing a DSH waiver form. This includes federally deemed hospitals that do not have uncompensated care costs to justify the receipt of an interim DSH payment. Hospitals that elect not to receive an interim DSH payment for a SFY must notify the division, or its authorized agent, that it elects not to receive an interim DSH payment for the upcoming SFY. If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the division to be included in the independent DSH audit. If the request is approved by the division, the hospital must submit all necessary data elements to the independent DSH auditor in order to be included in the audit and eligible for final DSH payment adjustments.

[(D) Hospitals, including federally deemed hospitals, may elect to receive an upper payment limit payment as defined in 13 CSR 70-15.230 in lieu of DSH payments. Hospitals that elect to receive an upper payment limit payment rather than a DSH payment must submit a request to the MO HealthNet Division on an annual basis. If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY, and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the division to be included in the independent DSH audit. If the request is approved by the division, the hospital must submit all necessary data elements to the independent DSH auditor in order to be included in the audit and eligible for final DSH payment adjustments.]

*[(E)]***(D)** Disproportionate share payments will coincide with the semimonthly claim payment schedule.

*[(F)]***(E)** New facilities that do not have a Medicare/Medicaid cost report on which to base the state DSH survey will be paid the *[lesser of the]* estimated hospital-specific DSH limit less OOS DSH payments based on the estimated state DSH survey *[or the industry average estimated interim DSH payment. The industry average estimated interim DSH payment is calculated as follows:*

1. Hospitals receiving interim DSH payments, as determined from subsection (3)(B), shall be divided into quartiles based on total beds;

2. DSH payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average interim DSH payment per bed; and

3. The number of beds for the new facility shall be multiplied by the average interim DSH payment per bed.]

*[(G)]***(F)** Interim DSH payments for hospital mergers.

1. Hospitals that merge prior to the beginning of the SFY. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their interim DSH payment determined based on adding each hospital's state DSH survey to yield a combined state DSH survey and applying the same calculations in subsection (3)(B).

2. Hospitals that merge after the beginning of the SFY. The interim DSH payments that have been determined separately for the hospitals will be added together and paid to the surviving hospital effective with the approval date of the merger.

*[(H)]***(G)** Interim DSH payment adjustments.

1. To minimize hospital longfalls, interim DSH payments made to hospitals will be revised if changes to federally mandated DSH audit standards are enacted during a SFY, updated for Medicaid expansion until it is captured in the required state DSH survey, or any changes in Medicaid reimbursement until it is captured in the required state DSH survey. These revisions are to serve as interim adjustments until the federally mandated DSH audits are complete. DSH audits are finalized three (3) years following the SFY year-end reflected in the audit. For example, the SFY 2019 DSH audit will be finalized in calendar year (CY) 2022.

(4) Department of Mental Health (DMH) Hospitals DSH Adjustments and Payments.

(A) Beginning in SFY *[2012]***2026**, *[due to structural changes occurring at the DMH facilities, interim DSH payments will be based on the third prior base year cost report trended to the current SFY adjusted for the federal reimbursement allowance (FRA) assessment paid by DMH hospitals. The interim DSH payments calculated using the third prior base year cost report may be revised based on the results of a DMH state DSH survey.]***the DMH hospitals interim DSH payments will be calculated in accordance with subsection (3)(B).** Additional adjustments may be done based on the results of the federally mandated DSH audits as set forth below in subsection (5)(A).

(5) Final DSH Adjustments.

(A) Final DSH adjustments will be made after actual cost data is available and the annual independent DSH audit is completed. Annual independent DSH audits are completed three (3) years following the state fiscal year-end reflected in the audit. For example, final DSH adjustments for SFY 2022 DSH payments will be made following the completion of the annual independent DSH audit in 2025 (SFY 2026).

(B) Final DSH adjustments may result in a recoupment for some hospitals and additional DSH payments for other hospitals based on the results of the annual independent DSH audit as set forth below—

1. Hospital DSH liabilities are overpayments which will be recouped. If the annual independent DSH audit reflects that a facility has a hospital DSH liability, it is an overpayment to the hospital and is subject to recoupment. The hospital's DSH liability shown on the final independent DSH audit report, that is required to be submitted to CMS by December 31 will be due to the division by *[October 31]***September 30** of the following year;

2. Any overpayments that are recouped from hospitals as the result of the final DSH adjustment will be redistributed to hospitals that are shown to have a total shortfall. These redistributions will occur proportionally based on each hospital's total shortfall to the total shortfall, not to exceed each hospital-specific DSH limit less OOS DSH payments;

3. Redistribution payments to hospitals that have a total shortfall must occur after the recoupment of hospital DSH liabilities. However, total industry redistribution payments may not exceed total industry recoupments collected to date;

4. If the amount of DSH payments to be recouped as a result of the final DSH adjustment is more than can be redistributed, the entire amount in excess of the amount able to be redistributed will be recouped and the federal share will be returned to the federal government. The state share of the final DSH recoupments that has not been redistributed to hospitals with DSH shortfalls may be used to make a hospital upper payment limit payment and/or a state-only quality improvement payment to all non-DMH hospitals. The state-only quality improvement payment will be paid proportionally to non-DMH hospitals based on the number of hospital staffed beds to total staffed beds for the same state fiscal year the final DSH adjustment relates to. Staffed beds are reported on the Missouri Annual Licensing Survey which is mandated by the Department of Health and Senior Services in accordance with 19 CSR 10-33.030;

5. If the Medicaid program's original interim DSH payments did not fully expend the federal DSH allotment for any plan year, the remaining DSH allotment may be paid to hospitals that are under their hospital-specific DSH limit as determined from the annual independent DSH audit. These payments will occur proportionally based on each hospital's shortfall to the total shortfall, not to exceed each hospital's hospital-specific DSH limit less OOS DSH payments;

6. If the Medicaid program's original DSH payments did not fully expend the federal Institute for Mental Disease (IMD) DSH allotment for any plan year, the remaining IMD DSH allotment may be paid to IMD hospitals that are under their projected hospital-specific DSH limit. These payments will occur proportionally based on each hospital's estimated shortfall to the total

estimated shortfall, not to exceed each hospital's estimated hospital-specific DSH limit less OOS DSH payments; and

7. Bankrupt-liquidation or closed hospitals are not eligible for final DSH redistributions or unspent allotment payments.

[(6) Record Retention.

(A) Records used to complete the state's DSH survey shall be kept until the final audit is completed. For example, the SFY 2022 state DSH survey will use 2018 cost data, which must be maintained until the 2022 DSH audits are completed in SFY 2026.

(B) Records provided by hospitals to the state's independent auditor shall also be maintained until the federal independent DSH audit is complete.]

*[(7)]***(6)** State DSH Survey Reporting Requirements.

(A) Beginning in SFY 2016, each hospital must complete and submit the state DSH survey set forth in paragraph (2)*[(X)1.]***(W)** (i.e., required state DSH survey) to the independent DSH auditor, the MO HealthNet Division's authorized agent, in order to be considered for an interim DSH payment for the subsequent SFY (i.e., DSH surveys collected during SFY 2016 will be used to calculate SFY 2017 interim DSH payments). The independent DSH auditor will distribute the state DSH survey template to the hospitals to complete and will notify them of the due date, which shall be a minimum of thirty (30) days from the date it is distributed. However, the state DSH survey is due to the independent DSH auditor no later than March 1 preceding the beginning of each state fiscal year for which the interim DSH payment is being calculated (i.e., the state DSH survey used for SFY 2017 interim DSH payments will be due to the independent DSH auditor no later than March 1, 2016). Hospitals that do not submit the state DSH survey by March 1 will not be eligible to receive an interim DSH payment for that SFY. The division may grant an industry-wide extension on the March 1 deadline due to unanticipated circumstances that affect the industry as a whole. The independent DSH auditor may perform an initial review of the required state DSH survey submitted by the hospital and make preliminary adjustments for use in calculating the interim DSH payment. The independent DSH auditor shall provide the hospital with any preliminary adjustments that are made for review and comment prior to the data being provided to MHD for use in calculating the interim DSH payment for the SFY. Additional or revised audit adjustments may be made to the DSH survey for purposes of the independent DSH audit.

1. A new facility that does not have cost report data for the fourth prior year may complete the state DSH survey using actual, untrended cost and payment data from the most recent twelve- (12-) month cost report filed with the division.

2. A new facility that has not yet filed a twelve- (12-) month Medicaid cost report with the division may complete the state DSH survey using facility projections to reflect anticipated operations for the interim DSH payment period. Trends shall not be applied to the data used to complete the state DSH survey. Interim DSH payments determined from this state DSH survey are limited to the industry average estimated interim DSH payment as set forth in subsection (3)(F).

3. Hospitals may elect not to receive an interim DSH payment for a SFY by completing a DSH waiver form. Hospitals that elect not to receive an interim DSH payment for a SFY must notify the division, or its authorized agent, that it elects not to receive an interim DSH payment for the upcoming SFY. If a hospital does not receive an interim DSH payment for a SFY, it will not be included in the independent DSH audit related to that SFY, and will not be eligible for final DSH audit payment adjustments related to that SFY unless it submits a request to the division to be included in the independent DSH audit. If the request is approved by the division, the hospital must submit all necessary data elements to the independent DSH auditor in order to be included in the audit and eligible for final DSH payment adjustments.

4. If a hospital received an interim DSH payment and later determined that it did not have uncompensated care costs for Medicaid and the uninsured to support part or all the interim DSH payment that it received or is receiving, the hospital may request that the interim DSH payments be stopped or it may return the entire interim DSH payment it received.

5. Exceptions process to use alternate data for interim DSH payment.

A. A hospital may submit a request to the division to have its interim DSH payment based on alternate data as set forth below rather than the state DSH survey required to be submitted for the year (i.e., required state DSH survey) if it meets the criteria for any of the circumstances detailed below in subparagraph *[(7)(A)5.D.]***(6)(A)5.D.** The request must include an explanation of the circumstance, the impact it has on the required state DSH survey period, and how it causes the data to be materially misstated or unrepresentative. The division shall review the facility's request and may, at its discretion and for good cause shown, use the alternate data in determining the interim DSH payment for the SFY. The division shall notify the facility of its decision regarding the request.

(I) Alternate state DSH survey. A state DSH survey completed using the actual, untrended cost and payment data from the most recent twelve- (12-) month cost report filed with the division. Any hospital requesting an exception must complete an alternate state DSH survey. If the most recent full-year cost report filed with the division does not reflect the impact of any material changes, a supplemental schedule, as defined below, may be completed and submitted in addition to the alternate state DSH survey. If the impact of any changes is reflected in the most recent full-year cost report filed with the division, the facility may only use the alternate state DSH survey.

(II) Alternate state DSH survey supplemental schedule. A supplemental schedule developed by the division to recognize material changes that have occurred at a hospital that are not yet reflected in the hospital's alternate state DSH survey. The supplemental schedule uses the data from the alternate state DSH survey as the basis and includes additional fields to reflect changes that occurred subsequent to the alternate state DSH survey period through the SFY for which the interim DSH payment is being calculated. The blank alternate state DSH survey supplemental schedule is referred to as the alternate state DSH survey supplemental template.

B. The provider must submit both the required state DSH survey and the alternate data for review to determine if the facility meets the criteria set forth below in subparagraph *[(7)(A)5.D.]***(6)(A)5.D.**

C. The interim DSH payment based on the applicable alternate data shall be calculated in the same manner as the interim DSH payment based on the required state DSH survey, except for the trends applied to the alternate data as noted below in parts *[(7)(A)5.C.(I) and (II).]***(6)(A)5.C.(I) and (II).** The allocation percentage calculated at the beginning of the SFY year as set forth in part (3)(B)4.A.(I) shall be applied to the estimated UCC net of OOS DSH payments based on the alternate data to determine the preliminary interim DSH payment.

(I) Alternate state DSH survey. The trends applied to the alternate state DSH survey shall be from the year subsequent to the alternate state DSH survey period to the current SFY for which the interim DSH payment is being determined.

(II) Alternate state DSH survey supplemental schedule. Trends shall not be applied to an alternate state DSH survey supplemental schedule since it incorporates changes from the full-year cost report period through the SFY for which the interim DSH payment is being calculated.

D. Following are the circumstances for which a provider may request that its interim DSH payment be based on alternate data rather than the required state DSH survey, including the criteria and other requirements:

(I) *[Twenty percent (20.00%) DSH outlier. A provider may request that the alternate state DSH survey be used prior to the interim DSH payment being determined for the SFY if the untrended total estimated net cost from the alternate state DSH survey is at least twenty percent (20.00%) higher than the trended total estimated net cost from the required state DSH survey (i.e., the increase is at least twenty percent (20.00%) rounded to two (2) decimal places).*

(a) Both the required state DSH survey and the alternate state DSH survey must be submitted to the independent DSH auditor and the division, respectively, no later than March 1 preceding the beginning of each SFY for which interim DSH payments are being made;

(II)] Extraordinary circumstances. A provider may request that alternate data be used if the facility experienced an extraordinary circumstance during or after the required state DSH survey report period up to the SFY for which the interim DSH payment is being calculated that caused the required DSH survey report period to be materially misstated and unrepresentative. If circumstances found in items *[(7)(A)5.D.(II)(a)I.-IV.]***(6)(A)5.D.(I)(a)I.-IV.** below are applicable, the facility may complete and submit the applicable alternate data.

(a) Extraordinary circumstances include unavoidable circumstances that are beyond the control of the facility and include the following:

I. Act of God (i.e., tornado, hurricane, flooding, earthquake, lightning, natural wildfire, etc.);

II. War;

III. Civil disturbance; or

IV. If the data to complete the required state DSH survey set forth in paragraph (2)*[(X)1.]***(W)** is not available due to a change in ownership because the prior owner is out of business and is uncooperative and unwilling to provide the necessary data.

(b) A change in hospital operations or services (i.e., terminating or adding a service or a hospital wing; or, a change of owner, except as noted in item *[(7)(A)5.D.(II)(a)IV.]***(6)(A)5.D.(I)(a)IV.**, manager, control, operation, leaseholder or leasehold interest, or Medicare provider number by whatever form for any hospital previously certified at any time for participation in the MO HealthNet program, etc.) does not constitute an extraordinary circumstance.

(c) Both the required state DSH survey and the alternate data must be submitted to the independent DSH auditor and the division, respectively, no later than March 1 if the alternate data is to be used to determine the interim DSH payment at the beginning of the SFY.

(d) A hospital may submit a request to use alternate data due to extraordinary circumstances after March 1, but the alternate data and the resulting interim DSH payment will be subject to the same requirements as the interim DSH payment adjustments noted below in subparts *[(7)(A)5.D.(III)(b)-(d)]***(6)(A)5.D.(II)(a)-(c)**. The requests relating to extraordinary circumstances received after the March 1 deadline will be included with the interim DSH payment adjustments requests in part *[(7)(A)5.D.(III)]***(6)(A)5.D.(II)** in distributing the unobligated DSH allotment and available state funds remaining for the SFY; **and**

*[(III)]***(II)** Interim DSH payment adjustment.

(a) *[After the interim DSH payment has been calculated for the current SFY based on the required state DSH survey, a provider may request that alternate data be used if the untrended total estimated net cost from the alternate data is at least twenty percent (20.00%) higher than the trended total estimated net cost from the required state DSH survey (i.e., the increase is at least twenty percent (20.00%) rounded to two (2) decimal places).*

(b)] The division will process interim DSH payment adjustments once a year. After all requests are received, the division will determine whether revisions to the interim DSH payments are appropriate. Any revisions to the interim DSH payments are subject to the unobligated DSH allotment remaining for the SFY and availability of state funds.

*[(c)]***(b)** The request, including the alternate data, must be submitted to the division by December 31 of the current SFY for which interim DSH payments are being made.

*[(d)]***(c)** To the extent that state funds are available, the DSH allotment for the SFY that has not otherwise been obligated will be distributed proportionally to the hospitals determined to meet the above criteria, based on the difference between the preliminary interim DSH payment based on the alternate data and the original interim DSH payment*[; and]***.**

(IV) If a provider received an exception that allows it to use alternate data for interim DSH payment purposes under paragraph *[(7)(A)5.]***(6)(A)5.** in the prior SFY, it may continue to use alternate data for its interim DSH payment until the required state DSH survey reflects the annual impact of the change. The alternate state DSH survey supplemental schedule should be used until the most recent cost report on file with the division reflects the annual impact of the change. Both the required state DSH survey and the applicable alternate data must be submitted to the independent DSH auditor and the division no later than March 1 preceeding the beginning of each SFY for which the interim DSH payment is being made.

AUTHORITY: sections 208.153, 208.158, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2023. Emergency rule filed May 20, 2011, effective June 1, 2011, expired Nov. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. Emergency amendment filed June 20, 2012, effective July 1, 2012, expired Dec. 28, 2012. Amended: Filed April 2, 2012, effective Oct. 30, 2012. Amended: Filed Jan. 13, 2015, effective Sept. 30, 2015. Amended: Filed Feb. 1, 2016, effective July 30, 2016. Amended: Filed Dec. 30, 2016, effective Aug. 30, 2017. Emergency amendment filed June 16, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 16, 2022, effective Jan. 30, 2023. Amended: Filed Jan. 18, 2024, effective Aug. 30, 2024. Emergency amendment filed June 20, 2025, effective July 7, 2025, expired Feb. 26, 2026. Amended filed June 23, 2025.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021, 2023; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.158, RSMo 1967; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate for SFY 2026.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate for SFY 2026.

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, Legal Services Division-Rulemaking, P.O. Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing will not be scheduled.*