

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), (2), (3), (4), (5), (6), (7), and (8).

PURPOSE: This proposed amendment removes outdated language and updates the methodology for calculating the Disproportionate Share Hospital (DSH) payment to align with the federal statute.

(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 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]***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 [and] 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 the cost of providing inpatient (IP) and outpatient (OP) hospital services for all Medicaid eligible individuals including dual eligible and managed care participants less payments the hospital received for claims.]* **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.** 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. *[Depending on the hospital's response to questions 14, 15, and 16 of the state DSH survey, versions 1, 2, and 3, the source of the Medicaid out-of-state net cost, Medicaid organ acquisition net cost, and Medicaid/Medicare crossover net cost will either be—the hospital's estimated data, an amount estimated by MHD based on the most recent annual independent DSH audit trended to the SFY the DSH payments relate to, or was determined by the hospital to be insignificant or zero.*

1. *The estimated Medicaid net cost determined from the state DSH surveys prior to SFY 2017 is the sum of the following estimated data from the "Settlement Calculation" tab:*

- A. *In-state Medicaid inpatient net cost;*
- B. *In-state Medicaid outpatient net cost;*
- C. *Out-of-state Medicaid inpatient net cost;*
- D. *Out-of-state Medicaid outpatient net cost;*
- E. *Medicaid organ acquisition net cost; and*
- F. *Medicaid/Medicare crossover net cost.]*

2. *Beginning with SFY 2017 interim DSH payments, the* **1. The estimated Medicaid net cost is determined from the state DSH survey [using the "Report Summary" tab], 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)(S)](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)(Y)](2)(Z).

(D) Estimated uninsured net cost. Estimated uninsured net 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 *[any reason]* **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.**

[1. The estimated uninsured net cost determined from the state DSH survey prior to SFY 2017 is calculated as the sum of the following:

A. Uninsured inpatient net cost; and

B. Uninsured outpatient net cost.]

[2. Beginning with SFY 2017 interim DSH payments, the] **1. The** estimated uninsured net cost is determined from the state DSH survey *[using the "Report Summary" tab]* 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 from the state DSH survey prior to SFY 2017 is the estimated uninsured net cost less Section 1011 payments.]

[2. Beginning with SFY 2017 interim DSH payments, the] **1. The** estimated uninsured uncompensated care cost is determined from the state DSH survey *[using the "Report Summary" tab]* 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)(Y)](2)(Z)*.

(F) 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) 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 *[during]* for the SFY. *[The source for this calculation is as follows:*

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

2. Estimated hospital DSH liability. The estimated hospital DSH liability 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 payment adjustments for SFY 2011.]

(H) 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) Incorporation by Reference. This rule incorporates by reference the following:

1. 42 CFR 447, which is incorporated by reference and made a part of this rule as published by CMS at its website at <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447?toc=1>, June 9, 2022. This rule does not incorporate any subsequent amendments or additions;

2. 42 CFR 455, which is incorporated by reference and made a part of this rule as published by CMS at its website at <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455?toc=1>, June 9, 2022. 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. This rule does not incorporate any subsequent amendments or additions; and

4. This 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. This rule does not incorporate any subsequent amendments or additions.

[(I)](J) 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 *[can be]* **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** *[can be]* **are** considered uninsured and included in calculating the hospital-specific DSH limit.

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

A. *[Individuals]* **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 *[individual is]* **hospital services are** considered uninsured *[: or]* **costs; and**

B. *[Individuals]* **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 *[; or]* **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

[B.] 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 *[changes that may be incorporated in the final publication of 42 CFR 447.295.]* **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.**

[(J)] **(K)** 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.

[(K)] **(L)** 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.

[(L)] **(M)** 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.

[(M)] **(N)** 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.

~~[(N)]~~**(O)** Low Income Utilization Rate (LIUR). The LIUR shall be calculated as follows:

1. As determined from the ~~[fourth]~~**third** prior year ~~[desk-reviewed]~~**audited Medicaid** cost report, 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 patient services attributable to charity care (CC) ~~[(care provided to individuals who have no source of payment, third-party, or personal resources)]~~ less CS directly received from state and local governments in the same period, divided by the total amount of the hospital's charges (THC) for patient services. The total patient charges attributed to CC shall not include any contractual allowances and discounts other than for indigent patients not eligible for MO HealthNet under a state plan.

$$[LIUR = \frac{[TMPR + CS]}{[TNR + CS]} + \frac{[CC - CS]}{THC}]$$

$$LIUR = ((TMPR + CS) / (TNR + CS)) + ((CC - CS) / (THC))$$

~~[(O)]~~**(P)** Medicaid Inpatient Utilization Rate (MIUR). The MIUR shall be calculated as follows:

1. As determined from the ~~[fourth]~~**third** prior year ~~[desk-reviewed]~~**audited Medicaid** cost report, the MIUR will be expressed as the ratio of total Medicaid **eligible hospital** days (TMD) 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.

$$[MIUR = \frac{[TMD]}{[TNID]}]$$

$$MIUR = TMD / TNID$$

~~[(P)]~~**(Q)** 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.

[(Q)](R) Medicare cost reporting methodologies. Medicaid and uninsured costs will be determined utilizing Medicare Cost Report (form CMS 2552) methodologies. *[The Medicare/Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996 and prior to May 1, 2010. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010. If the Medicare CMS 2552-10 is superseded by an alternate Medicare developed cost reporting tool during a Medicaid state plan year, that tool must be used for the Medicaid state plan year.]* The Medicaid Cost Report is completed using the Medicare Cost Report form CMS 2552 using the Medicare cost reporting methodologies. *[The only difference between the Medicare and Medicaid Cost Report is that the Federal Reimbursement Allowance (FRA) (i.e., the Missouri hospital provider tax) is not reflected in the cost in the Medicaid Cost Report.]* 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 *[costs]* **cost** report, applicable instructions, regulations, and governing statutes.

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

[(S)](T) 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 are not limited to:** Direct Medicaid *[Add-On]*, **Acuity Adjustment Payment, Poison Control Payment, Stop Loss Payment**, Graduate Medical Education (GME), *[Enhanced GME,]* Children's Outliers, *[and any]* cost settlements*[,]*, **and** Upper payment limit (UPL) payments, *[Trauma Add-On payments and Trauma Outlier payments,]* if applicable, will be included *[in addition to the above other Medicaid payments]* for purposes of determining the hospital-specific DSH limit 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.

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

[(U)](V) 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.

[(V)](W) 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*[,] and data provided in the most recent independent DSH audit, if applicable].*

[(W)](X) 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. [The following state DSH survey templates 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. This rule does not incorporate any subsequent amendments or additions.]

1. [Version 1 (9/10), also referred to as the 2011 state DSH survey, was used to calculate the SFY 2011 DSH payment adjustments set forth in section (3) and the SFY 2012 interim DSH payments set forth in section (4).

2. Version 2 (9/11) or Version 3 (2/12). The hospital may elect to complete either Version 2 (9/11) or Version 3 (2/12) on which its SFY 2013 interim DSH payments will be calculated. The survey shall be referred to as the SFY to which payments will relate. For example, the survey used to determine interim DSH payments for SFY 2013 will be referred to as the 2013 state DSH survey.

3. Version 3 (2/12) will be used to calculate interim DSH payments beginning with SFY 2014 as set forth in section (4). The survey shall be referred to as the SFY to which payments will relate.

4. Version 4, designated as Myers and Stauffer LC, DSH Version 7.20, will be used to calculate interim DSH payments beginning with SFY 2017 as set forth in section (4).] Beginning with SFY 2017, [The]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 [2013]2019 independent DSH audit will also be used to calculate the interim DSH payment for SFY [2017]2023). The survey shall be referred to as the SFY to which payments will relate.

[(X)](Y) 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.

[(Y)](Z) 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.

[(Z)](AA) Uncompensated care costs (UCC). [The uncompensated care costs eligible for consideration in determining the hospital-specific DSH limit are calculated by reducing costs incurred in furnishing inpatient and outpatient hospital services to the Medicaid and uninsured populations by revenues received from Medicaid (not including DSH payments), Medicare, private pay, managed care, self-pay, other third parties, and Section 1011 payments. 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 any reason. For purposes of this calculation, the Medicaid and uninsured populations include:

1. The Medicaid population includes all Medicaid eligible individuals including dual eligible and managed care participants; and

2. *The uninsured population includes individuals without health insurance or other third-party coverage as defined in this rule, consistent with 42 CFR 447.]* **The uncompensated care costs are those set forth in subsection (2)(H).**

[(AA)](AB) 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) DSH Payment Adjustments.

(A) *Beginning in Medicaid state plan year 2011, DSH payments made to hospitals will be revised based on the results of a 2011 state DSH survey. The revisions based on the 2011 state DSH survey will ensure state fiscal year (SFY) 2011 DSH payments are eligible for FFP through compliance with the federal DSH rules. These revisions are to serve as interim adjustments until the federally-mandated annual independent DSH audits are complete. Annual independent DSH audits are finalized three (3) years following the SFY year-end reflected in the audit. For example, the SFY 2011 DSH audit will be finalized in 2014. The interim adjustments shall be determined as follows:*

1. *2011 estimated hospital-specific DSH limits were determined based upon the state's calculations using data provided in the 2011 state DSH survey, SFY 2011 other Medicaid payments maintained by MHD, and data provided in the final 2007 independent DSH audit, if applicable. DSH payments will be limited to the hospital's estimated hospital-specific DSH limit. The state's calculations will be based on 2011 state DSH surveys received by MO HealthNet as of May 31, 2011. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a material impact on the survey results. The state's calculations are set forth below—*

A. *The 2011 estimated hospital-specific DSH limit is calculated as follows:*

(I) *2011 estimated Medicaid net cost from the 2011 state DSH survey;*

(II) *Less actual SFY 2011 other Medicaid payments;*

(III) *Equals 2011 estimated Medicaid uncompensated care cost;*

(IV) *Plus 2011 estimated uninsured uncompensated care cost from the 2011 state DSH survey;*

(V) *Equals 2011 estimated hospital-specific DSH limit;*

B. *The total 2011 estimated longfall/shortfall for each hospital is calculated as follows:*

(I) *2011 estimated hospital-specific DSH limit;*

(II) *Less DSH payments paid by MHD during SFY 2011;*

(III) *Less out-of-state DSH payments received by the hospital during SFY 2011;*

(IV) *Equals total 2011 estimated longfall/shortfall;*

C. *The total 2011 estimated hospital DSH liability is an overpayment subject to recoupment which will be the SFY 2011 interim DSH payment adjustment for hospitals with an estimated longfall. The total 2011 estimated hospital DSH liability is the lessor of the—*

(I) *The 2011 estimated longfall; or*

(II) *DSH payments paid during SFY 2011;*

D. *Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their SFY 2011 DSH payments adjusted based on combining the results of the 2011 state DSH surveys prorated monthly for the time period the merger was effective. If a 2011 estimated DSH liability is identified, the surviving hospital assumes the responsibility for the overpayment. The calculation for combining and prorating the 2011 state DSH surveys is set forth below—*

(I) The estimated hospital DSH liability prior to the merger shall be calculated as follows:

(a) The calculations set forth in subparagraphs (3)(A)1.A., (3)(A)1.B., and (3)(A)1.C. will be calculated based on each separate hospital's 2011 state DSH survey, prorated monthly for the time period prior to the merger;

(II) The estimated hospital DSH liability beginning with the month the merger is effective shall be calculated as follows:

(a) The 2011 state DSH surveys for each hospital shall be added together to yield a combined 2011 state DSH survey and prorated monthly for the time period the merger was effective. The calculations set forth in subparagraphs (3)(A)1.A., (3)(A)1.B., and (3)(A)1.C. will be calculated for the combined 2011 state DSH survey;

(III) The total estimated hospital DSH liability for the merged entity will be the sum of the amounts determined in part (3)(A)1.D.(I) for each hospital plus the combined amount determined in part (3)(A)1.D.(II); and

E. Facilities not providing a 2011 state DSH survey shall have their SFY 2011 DSH payments revised using the most recent hospital-specific information provided to the state by the independent DSH auditor trended to the applicable SFY using the trend factor published in Health Care Costs by DRI/McGraw-Hill and listed in 13 CSR 70-15.010. A facility that was not included in the most recent hospital-specific information provided to the state by the independent DSH auditor shall have their entire SFY 2011 DSH payment recouped.

2. DSH payments paid during SFY 2011 that exceed the 2011 estimated hospital-specific DSH limits will be recouped from the hospitals to reduce their payments to their 2011 estimated hospital-specific DSH limit.

3. The amount of SFY 2011 DSH payments to be recouped from a hospital by the MO HealthNet Division will be limited in each state fiscal year to two percent (2%) of the hospital's taxable revenue set forth as follows. For recoupments made during SFY 2012 the recoupment amount will be limited to two percent (2%) of the hospital's SFY 2011 taxable revenue. Any balance remaining to be recouped during SFY 2013 will be limited to two percent (2%) of the hospital's SFY 2012 taxable revenue. Any balance remaining to be recouped will be incorporated in the final DSH adjustment, if applicable. The limitation on recoupment of DSH payments shall only apply to recoupments determined in accordance with section (3). No limitation on the recoupment of DSH payments shall apply if the hospital DSH liability is determined as a result of the final annual independent DSH audit set forth in section (6).

(B) Any payments that are recouped from hospitals as a result of the state's calculation in subsection (3)(A) will be redistributed to hospitals that are shown to have been paid less than their 2011 estimated hospital-specific DSH limits (i.e., estimated shortfall). These redistributions will occur proportionally based on each hospital's 2011 estimated shortfall to the total 2011 estimated shortfall, not to exceed each hospital's 2011 estimated hospital-specific DSH limit.

1. Redistribution payments to hospitals that have been paid less than their 2011 estimated hospital-specific DSH limit must occur after the recoupment of payments made to hospitals that have been paid in excess of their 2011 estimated hospital-specific DSH limits. The state may establish a hospital-specific recoupment plan. However, total industry redistribution payments may not exceed total industry recoupments collected to date.

2. If the Medicaid program's original 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 estimated 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.

(4)(3) Interim DSH Payments.

(A) [Beginning with SFY 2012, interim DSH payments shall be calculated on an annual basis as set forth below.

1. SFY 2012 interim DSH payments will be based on the state's calculations using data provided in the 2011 state DSH survey after applying the trend factor published in Health Care Costs by DRI/McGraw-Hill for the current fiscal year, estimated SFY 2012 other Medicaid payments calculated by MHD in accordance with 13 CSR 70-15.010, and data provided in the final 2007 independent DSH audit, if applicable.

2. 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 [MHD]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[, and data provided in the most recent final independent DSH audit, if applicable].

(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 [MHD]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 cost 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) Disproportionate share payments will coincide with the semimonthly claim payment schedule.

(F) 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 [(4)(B)](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) 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 [(4)(B)](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) *[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 estimated 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.]***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.

[(5)](4) Department of Mental Health (DMH) Hospitals *[Hospital (DMH)]* DSH Adjustments and Payments.

(A) *[Effective June 1, 2011, interim DSH payments made to DMH hospitals will be revised based on the results of a DMH state DSH survey which uses federally-mandated DSH audit standards. These revisions are to serve as interim adjustments until the federally-mandated DSH audits are complete in 2014.*

(B) Beginning in SFY 2012, 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. Additional adjustments may be done based on the results of the federally-mandated DSH audits as set forth below in subsection [(6)(A)](5)(A).

(C) *[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 hospitals that are under their projected hospital-specific DSH limit.]*

[(6)](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 [2011]2022 DSH payments will be made following the completion of the annual independent DSH audit in [2014]2025 (SFY [2015]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 *[March]***October** 31 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; and

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.

*[(7)]***(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 *[2011]***2022** state DSH survey will use *[2009]***2018** cost data which must be maintained until the *[2014]***2022** DSH audits are completed in SFY *[2015]***2026**.

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

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

(A) *[Prior to SFY 2017, each hospital participating in the MO HealthNet program shall submit a state DSH survey prescribed by the state MO HealthNet agency and must be submitted by December 31 of each year. However, a corrected survey may be accepted if it is supported by documentation and the state determines the correction is appropriate and has a material impact on the survey results. The state DSH survey for each interim DSH payment period shall be completed based on the third prior year Medicare cost report adjusted to reflect anticipated operations for the interim DSH payment period. The historical Medicare cost report data may be adjusted for inflationary trends, volume adjustments, changes in reimbursement methodology, and/or other business decisions (i.e., expanded or terminated services, etc.) For example, the state DSH survey that will be used to determine SFY 2013 interim DSH payments will be based on the state DSH survey completed using the 2010 Medicare cost report data adjusted by the hospital to 2013.*

1. If a new facility does not have a third prior year Medicare cost report, the state DSH survey shall be completed using the second prior year Medicare cost report, if available, adjusted to reflect anticipated operations for the interim DSH payment period.

2. If a new facility does not have a second prior year Medicare cost report, the state DSH survey shall be completed using the prior year Medicare cost report, if available, adjusted to reflect anticipated operations for the interim DSH payment period.

3. If a new facility does not have a prior year Medicare cost report, the state DSH survey shall be completed using facility projections to reflect anticipated operations for the interim DSH payment period. Interim DSH payments determined from this state DSH survey are limited to the industry average estimated interim DSH payment as set forth in subsection (4)(F).

(B) Beginning in SFY 2016, each hospital must complete and submit the state DSH survey set forth in paragraph [(2)(W)4.](2)(X)1. (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 [(4)(F)](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 [(8)(B)5.D.](7)(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. *[This 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 dss.mo.gov/mhd, February 1, 2017. This rule does not incorporate any subsequent amendments or additions.]*

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 [(8)(B)5.D.](7)(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 [(8)(B)5.C.(I) and (II)](7)(A)5.C.(I) and (II). The allocation percentage calculated at the beginning of the SFY year as set forth in part [(4)(B)4.A.(I)](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 *[on the "Report Summary" tab, Column J,]* from the alternate state DSH survey is at least twenty percent (20.00%) higher than the Trended Total Estimated Net Cost *[on the "Report Summary" tab, Column L,]* 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 [(8)(B)5.D.(II)(a)I.-III.](7)(A)5.D.(II)(a)I.-III. 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 *[nature]***God** (i.e., tornado, hurricane, flooding, earthquake, lightening, 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)(W)4.]***(2)(X)1.** 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 *[(8)(B)5.D.(II)(a)IV.,]***(7)(A)5.D.(II)(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 *[(8)(B)5.D.(III)(b)-(d).]***(7)(A)5.D.(III)(b)-(d).** The requests relating to extraordinary circumstances received after the March 1 deadline will be included with the Interim DSH Payment Adjustments requests in part *[(8)(B)5.D.(III)]***(7)(A)5.D.(III)** in distributing the unobligated DSH allotment and available state funds remaining for the SFY; or

(III) 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 *[on the "Report Summary" tab, Column J,]* from the alternate data is at least twenty percent (20.00%) higher than the Trended Total Estimated Net Cost *[on the "Report Summary" tab, Column L,]* 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) 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) 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;

[(IV) If a provider met the criteria to use alternate data for an Interim DSH Payment Adjustment ((8)(B)5.D.(III)) in the prior SFY, it may continue to use alternate data for its interim DSH payment until the required state DSH survey reflects the impact of the change. The hospital must submit the request and the alternate data to the division for review and approval no later than March 1.]

AUTHORITY: sections 208.152, 208.153, 208.158, 208.201, 660.017, and RSMo. 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 December 15, 2022.*

**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; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.158, RSMo 1967; and 208.201, RSMo 1987, amended 2007.*

PUBLIC COST: This proposed amendment is estimated to cost the state approximately \$73.9 million (State Share: \$25.4 million FRA and \$232 thousand IGT for DMH) for SFY 2023. This proposed amendment is estimated to cost public entities approximately \$5.1 million for SFY 2023.

PRIVATE COST: This proposed amendment is estimated to increase payments to in-state private entities by approximately \$79 million for SFY 2023.

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. No public hearing is scheduled.