Volume 47, Number 15
Pages 1057–1224
August 1, 2022

SALUS POPULI SUPREMA LEX ESTO

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

JOHN R. ASHCROFT

SECRETARY OF STATE

MISSOURI REGISTER

The *Missouri Register* is published semi-monthly by

SECRETARY OF STATE

JOHN R. ASHCROFT

Administrative Rules Division

James C. Kirkpatrick State Information Center

600 W. Main

Jefferson City, MO 65101

(573) 751-4015

ISSN 0149-2942

The *Missouri Register* and *Code of State Regulations* (CSR) are available on the Internet. The Register address is sos.mo.gov/adrules/moreg/moreg and the CSR is sos.mo.gov/adrules/csr/csr. The Administrative Rules Division may be contacted by email at rules@sos.mo.gov.

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MISSOURI REGISTER

August 1, 2022 Vol. 47 No. 15 **Pages 1057–1224**

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

HOW TO CITE RULES AND RSMO

RULES

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

Title	CSR	Division	Chapter	Rule
3	*Code of*	10-	4	.115
Department	*State*	Agency	General area	Specific area
	Regulations	division	regulated	regulated

and should be cited in this manner: 3 CSR 10-4.115.

Each department of state government is assigned a title. Each agency or division in the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraphs 1., subparagraphs A., parts (I), subparts (a), items I. and subitems a.

The rule is properly cited by using the full citation; for example, 3 CSR 10-4.115, NOT Rule 10-4.115.

Citations of RSMo are to the *Missouri Revised Statutes* as of the date indicated.

Code and *Register* on the Internet

The *Code of State Regulations* and *Missouri Register* are available on the Internet.

The *Code* address is sos.mo.gov/adrules/csr/csr

The *Register* address is sos.mo.gov/adrules/moreg/moreg

These websites contain rulemakings and regulations as they appear in the *Code* and *Registers*.

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

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

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

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

EMERGENCY AMENDMENT

13 CSR 70-15.190 Out-of-State Hospital Services Reimbursement Plan. The division is amending sections (1), (2), (3), (4), (5), and (6), and deletes sections (7), (8), (9), (10), (11), (12), (13), and (14).

PURPOSE: This emergency amendment establishes the method of reimbursing out-of-state hospitals for inpatient or outpatient care provided to any participants of Missouri Medicaid, whether they are under age twenty-one (21) or age twenty-one (21) and over. The division is amending the methodology for both inpatient and outpatient reimbursement for out-of-state hospitals, and updating outdated language and terms.

*EMERGENCY STATEMENT: This emergency amendment amends the methodology for both inpatient and outpatient reimbursement for out-of-state hospitals at a reduced rate, and updates outdated language and terms. The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency rule is necessary to preserve a compelling governmental interest as it allows the State Medicaid Agency to pay out-of-state hospitals and maintain the budget appropriation level due to the new in-state reimbursement methodology under 13 CSR 70-15.010. As a result, the MHD finds it necessary to preserve its compelling governmental interest in reducing the rate of these payments to out of state hospitals on July 1, 2022 to prevent a budget shortfall for State Fiscal Year 2023, which requires an early effective date. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 15, 2022, becomes effective July 1, 2022, and expires February 23, 2023.*

(1) Covered inpatient hospital services include those items and services allowed by the Medicaid State Plan including medically necessary care in a semi-private room. If prior authorized Missouri Medicaid may reimburse for a private room if it is certified medically necessary by a physician to avoid jeopardizing the health of the patient or to protect the health and safety of other patients. No payment will be made for any portion of the room charge when the *[recipient]* **participant** requests and is provided a private room when the private room is not medically necessary.

(2) Payment for authorized inpatient hospital services shall be made on a prospective per diem basis for services provided outside Missouri if the services are covered by the Missouri *[Medical Assistance (]*Medicaid*[)]* Program. To be reimbursed for furnishing services to Missouri Medicaid *[recipients]* **participants**, out-of-state *[providers]* **hospitals** must complete a Missouri *[Medical Assistance]* **Medicaid** Program Provider Participation Application and have the application approved by the Missouri Department of Social Services, *[Division of Medical Services]* **Missouri Medicaid Audit and Compliance (MMAC)**.

(3) Determination of Payment. The payment for inpatient hospital services provided by an out-of-state *[provider]* **hospital** shall be the lowest of:

(A) *[At the out-of-state hospital's election, the prospective inpatient payment may be based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulations for hospitals operating in Missouri with inflationary increases as granted by the Missouri General Assembly or the out-of-state hospital may be exempt from the cost report filing requirements if the hospital accepts the projected statewide average per diem rate for Missouri hospitals as calculated by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average per diem rate for Missouri hospitals shall be the first day of the month following the Division of Medical Services determination of per diem rate based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri;]* **For the out-of-state hospitals whose per diem was set on the hospital's audited Medicaid cost report prior to July 1, 2022, the hospital's per diem will be the rate in effect as of June 30, 2022. For all other out-of-state hospitals, the hospital's per diem will be fifty percent (50%) of the weighted statewide average per diem rate for Missouri hospitals as calculated by the MO HealthNet Division for the SFY in which the service was provided; or**

(B) The amount of total charges billed by the hospital. The *[provider's]* **hospital's** billed charges must be their usual and customary charges for services; or

(C) The Medicare deductible or coinsurance, if applicable, up to the amount allowed by the Missouri Medicaid program.

[(4) Per Diem Reimbursement Rate Computation. The per diem reimbursement rate computation is the same as calculated for Missouri hospitals at 13 CSR 70-15.010(3).

(5) If a provider fails to submit all financial documentation required by Missouri regulations (Medicare cost report, working trial balance, audited financial statements, Medicaid supplemental schedules, and Worksheet C2552-83 for ancillary costs and charges) for hospitals operating in Missouri within thirty (30) days of making the election to receive payment based on information from cost reports, the payment shall be based on the projected statewide average per diem rate in Missouri as developed by the Department of Social Services, Division of Medical Services for the state fiscal year.

(6) Out-of-state hospitals shall present claims to Missouri Medicaid within three hundred sixty-five (365) days from the date of service. In no case shall Missouri be liable for payment of a claim received beyond one (1) year from the date services were rendered. Inpatient and outpatient hospital services must be submitted on the UB-92 claim form.

(7) Out-of-state hospitals are subject to the Department Concurrent Hospital Review process (utilization review) for all non-emergency services.

*[(8)]***(4)** The payment for authorized outpatient hospital services provided by an out-of-state hospital shall be the *[lowest]* **lower** of:

(A) *[At the out-of-state hospital's election, a prospective outpatient payment percentage calculated using the Medicaid over-all outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports and all documentation required by Missouri regulation for hospitals operating in Missouri regressed to the current state fiscal year or the out-of-state hospital may be exempt from the cost report filing requirement if the hospital accepts the projected statewide average outpatient payment percentage as developed by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average outpatient payment percentage shall be the first day of the month following the Division of Medical Services determination of the outpatient payment percentage based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri]* **The outpatient reimbursement as described in 13 CSR 70-15.160**; or

(B) The amount of total charges billed by the hospital.

[(9) Outpatient Reimbursement Rate Computation. The outpatient reimbursement rate computation is the same as calculated for Missouri hospitals at 13 CSR 70-15.160.]

*[(10)]***(5)** Disproportionate Share *[Providers]* **Hospital (DSH) Payments**. Out-of-state hospitals do not qualify for *[disproportionate share ([]*DSH*[])]* payments**.** *[unless they have a low income utilization rate exceeding twenty-five percent (25%) for Missouri residents and the out-of-state hospital can demonstrate that the provision of services to Missouri residents has not been considered in establishing their DSH status in any other state.*

(11) All Medicaid services are subject to program compliance reviews. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made.

(12) Regardless of changes of ownership, management, control, operation, leasehold interests by whatever form for any hospital previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

(13) Participation in the Missouri Medicaid program shall be limited to hospitals who accept as payment in full for covered services rendered to Medicaid recipients the amount paid in accordance with Missouri statute and regulations.]

*[(14)]***(6)** Definitions.

(A) The definitions from regulation 13 CSR 70-15.010 are incorporated as 13 CSR 70-15.190.

[(B) Base year cost report—shall be either a 1995 Medicare cost report and Missouri's supplemental cost report schedules for those hospitals enrolled in the Missouri Medicaid program as of the effective date of this regulation or the most recent submitted cost report to Medicare and Missouri's supplemental cost report schedules for those hospitals that elect to enroll in Missouri Medicaid after the effective date of this regulation.]

*[(C)]***(B)** Out-of-state—not within the physical boundaries of Missouri.

*[(D)]***(C)** Usual and customary charge—the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

AUTHORITY: sections 208.201 and 660.017, RSMo 2016. Original rule filed April 15, 2004, effective Oct. 30, 2004. Emergency amendment filed June 16, 2022, effective July 1, 2022, expires Feb. 23, 2023. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the time the emergency is effective.

PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars ($500) in the time the emergency if effective.

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

EMERGENCY 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 emergency amendment removes outdated language and updates the methodology for calculating the Disproportionate Share Hospital (DSH) payment to align with the federal statute.

EMERGENCY STATEMENT: This emergency amendment deletes language from the definition of uncompensated care as required by federal law when calculating the hospital-specific DSH limit. The Department of Social Services, MO HealthNet Division (MHD) finds that this emergency rule is necessary to preserve a compelling governmental interest as it allows the State Medicaid Agency to impose federal requirements on the DSH payment calculation, which is a requirement to receive federal financial participation. The DSH payments provide

hospitals the ability to provide sufficient medical care to Medicaid participants and the uninsured. As a result, the MHD finds it necessary to preserve its compelling governmental interest in providing these payments to hospitals while complying with federal requirements, which requires an early effective date. A proposed amendment, which covers the same material,is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended by the* ***Missouri*** *and* ***United States Constitutions****. The MHD believes this emergency amendment to be fair to all interested parties under the circumstances. This emergency amendment was filed June 16, 2022, becomes effective July 1, 2022, and expires February 23, 2023.*

(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. *[Obstestrics]* **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.

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

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

*[(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.

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

$$\mathbf{MIUR = TMD / TNID}$$

*[(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 cost*[s]* 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.]***1.** *[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, *[T]***t**he 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)]***(BB)** 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.]***(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 *[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 semi-monthly 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)]***(A)** 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)]***(A)** 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, and 660.017, RSMo 2016, ***and section 208.152, RSMo Supp. 2021****. Emergency rule filed May 20, 2011, effective June 1, 2011, expired Nov. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. For intervening history, please consult the* ***Code of State Regulations****. Emergency amendment filed June 16, 2022, effective July 1, 2022, expires Feb. 23, 2023. A proposed amendment covering this same material is published in this issue of the* ***Missouri Register****.*

PUBLIC COST: This emergency amendment is estimated to cost the state approximately $36.9 million (State Share: $12.7 million FRA and $116 thousand IGT for DMH) in the time the emergency is effective. This emergency amendment is estimated to cost public entities approximately $2.5 million in the time the emergency is effective.

PRIVATE COST: This emergency amendment is estimated to increase payments to in-state private entities by approximately $39.5 million in the time the emergency is effective.

FISCAL NOTE
PUBLIC COST

I. **Department Title:** 13 Social Services
Division Title: 70 MO HealthNet Division
Chapter Title: 15 Hospital Program

Rule Number and Name:	13 CSR 70-15.220 Disproportionate Share Hospital (DSH) Payments
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) & State Hospitals enrolled in MO HealthNet - 38	**Estimated cost for 6 months of SFY 2023: $2.5 million**
Department of Social Services, MO HealthNet Division	**Estimated cost for 6 months of SFY 2023: Total $36.9 million; State Share $12.7 million (FRA) State Share $116 thousand (IGT)**

III. WORKSHEET

Other Government (Public) & State Hospitals Cost:

Estimated Cost for 6 Months of SFY 2023:

	FRA Fund	IGT Fund	Total
Estimated Cost to State Hospitals	$0	$341,402	$341,402
Estimated Cost to Other Government (Public) Hospitals	$2,195,298	$0	$2,195,298
Total Estimated Cost	$2,195,298	$341,402	$2,536,700
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	$747,554	$116,256	$863,810

Department of Social Services, MO HealthNet Division Cost:

Estimated Cost for 6 Months of SFY 2023:

	FRA Fund	IGT Fund	Total
Estimated Cost	$37,290,286	$341,402	$36,948,884
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Cost	$12,698,274	$116,256	$12,582,019

IV. ASSUMPTIONS

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of $3.8 million for 6 months of SFY 2023.

13 CSR 70-15.010
13 CSR 70-15.015
13 CSR 70-15.220
13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

FISCAL NOTE
PRIVATE COST

I. **Department Title:** 13 Social Services
Division Title: 70 MO HealthNet Division
Chapter Title: 15 Hospital Program

Rule Number and Title:	13 CSR 70-15.220 Disproportionate Share Hospital (DSH) Payments
Type of Rulemaking:	Emergency Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
In-State Hospitals – 100	**Private Hospitals enrolled in MO HealthNet**	**Estimated impact for 6 months of SFY 2023: $39.5 million**

III. WORKSHEET

In-State Private Hospitals Impact:

Estimated Impact for 6 Months of SFY 2023:

	FRA Fund	IGT Fund	Total
Estimated Impact to In-State Private Hospitals	$39,485,584	$0	$39,485,584
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	$13,445,828	$0	$13,445,828

IV. ASSUMPTIONS

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of $3.8 million for 6 months of SFY 2023.

13 CSR 70-15.010
13 CSR 70-15.015
13 CSR 70-15.220
13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

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

State of Missouri

Governor's Proclamation

WHEREAS, in 1973 the United States Supreme Court handed down its opinion in the case of *Roe v. Wade*, 410 U.S. 113 (1973), thereby striking down state authority to protect unborn life; and

WHEREAS, the United States Supreme Court identified the Due Process Clause of the 14th Amendment to the United States Constitution as the fount of legal authority for its decision; and

WHEREAS, in 1992 the United States Supreme Court modified the legal analysis underpinning the *Roe* decision in the case of *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), thereby re-affirming its previous decision to limit state's authority to protect unborn life; and

WHEREAS, the State of Missouri began banning abortions in 1825, which was subsequently upheld in 1972 by the Supreme Court of Missouri in the case of *Rogers v. Danforth*, 486 S.W.2d 258, 259 (Mo. banc 1972); and

WHEREAS, the people, through their elected representatives at the state level, have the right and authority to enact policy regarding the protection of unborn life; and

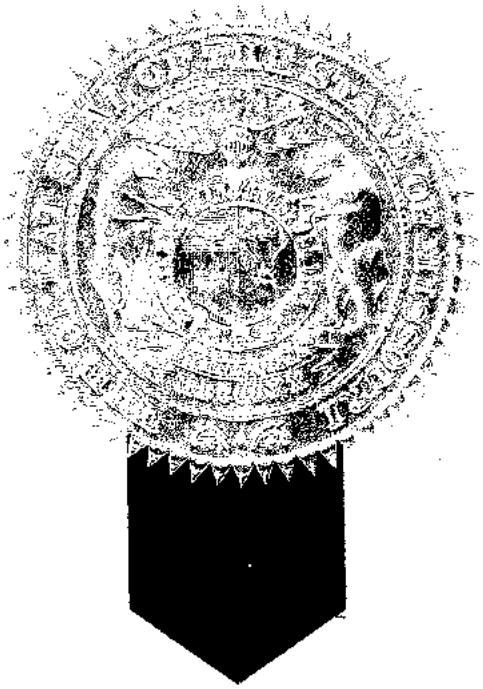
WHEREAS, in 1986 the Missouri General Assembly declared that life begins at conception pursuant to Section 1.205, RSMo; and

WHEREAS, the 10th Amendment to the United States Constitution reserves to the states and the people powers not explicitly delegated to the federal government and no power over protection of unborn life is delegated to the federal government; and

WHEREAS, on June 24, 2022, the United States Supreme Court overturned *Roe* and *Casey* in the case of *Dobbs v. Jackson Women's Health Org.*, 597 U.S. ___ (2022) (slip op.), thereby restoring the people's right, through their elected representatives at the state level, to enact policy regarding the protection of unborn life.

NOW, THEREFORE, I, MICHAEL L. PARSON, GOVERNOR OF THE STATE OF MISSOURI, by virtue of the authority vested in me by the Constitution and the laws of the State of Missouri, specifically Section 188.017, RSMo, do hereby notify the Revisor of Statutes that it is reasonably probable that Section 188.017, RSMo will be upheld by the courts as constitutional. Further, in accordance with *Dobbs*, Section 188.017, RSMo is hereby effective as of the date of this order.

IN WITNESS WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of the State of Missouri, in the City of Jefferson, on this 24th day of June, 2022.



ATTEST:

Michael L. Parson
GOVERNOR

ATTEST:

SECRETARY OF STATE

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbology under the heading of proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register.* If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety- (90-) day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

Proposed Amendment Text Reminder:
Boldface text indicates new matter.
[Bracketed text indicates matter being deleted.]

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 20—Division of Learning Services
Chapter 400—Office of Educator Quality

PROPOSED AMENDMENT

5 CSR 20-400.610 Certification Requirements for Initial Administrator Certificate *[(School Leader Kindergarten-Grade 12)]*. The State Board of Education is amending the administrative rule title, deleting subparagraphs (4)(A)5.A. and (4)(A)5.B., adding new subparagraphs (4)(A)5.A. and (4)(A)5.B., and amending section (5).

PURPOSE: *This amendment updates the requirements for an Initial Administrator Certificate (Superintendent, Kindergarten-Grade 12).*

(4) An applicant for a Missouri Initial Administrator Certificate (Superintendent, Kindergarten-Grade 12) who possesses good moral character may be granted an Initial Administrator Certificate (Superintendent, Kindergarten-Grade 12) subject to the certification requirements found in 5 CSR 20-400.500 and the following additional certification requirements specific to Superintendents:

(A) Professional Requirements. An Initial Administrator certificate, valid for a period of four (4) years from the date of issuance, will be issued to applicants meeting the following requirements:

1. A permanent or professional Missouri certificate of license to teach;

2. A minimum of three (3) years of experience as a building- or district-level administrator at a public or accredited nonpublic school;

3. The applicant must achieve a score equal to or in excess of the qualifying score on the required exit assessment(s) as defined in 5 CSR 20-400.310 and 5 CSR 20-400.440. The official score shall be submitted to the department;

4. Completion of a course in Psychology/Education of the Exceptional Child;

5. Completion of an educational specialist or advanced degree program in educational leadership and recommendation from the designated official of a regionally accredited college or university or other education leadership program approved by the department which shall include:

[A. Specific courses (must be separate graduate courses of at least two (2) semester hours

(I) Foundations of Educational Administration, including components of Career and Special Education;

(II) School Supervision; and

(III) School Law;

B. Knowledge and/or competency in each of the following areas:

(I) Vision, Mission, and Goals—

(a) Developing and articulating a vision; and

(b) Implementing and stewarding a vision;

(II) Teaching and Learning—

(a) Promoting positive school culture;

(b) Promoting effective instructional programs;

(c) Ensuring comprehensive professional growth plans; and

(d) Data and assessment;

(III) Management of Organizational Systems—

(a) Managing the organizational structure;

(b) Leading personnel;

(c) Managing resources; and

(d) Processes of effective evaluation of educators;

(IV) Collaboration with Families and Stakeholders—

(a) Collaborating with families and other community members;

(b) Responding to community interests and needs; and

(c) Mobilizing community resources;

(V) Ethics and Integrity—

(a) Personal and professional responsibilities;

(VI) The Education System—

(a) Understanding the larger context;

(b) Responding to the larger context; and

(c) Influencing the larger context;

(VII) Professional Development—

(a)Increasing knowledge and skills based on best practices; and]

A. Coursework must be at the graduate level and fall within the following five (5) domains of district-level leadership —

(I) Visionary Leadership;

(II) Instructional Leadership;

(III) Managerial Leadership;

(IV) Relational Leadership; and

(V) Innovative Leadership;

B. Knowledge and/or competency in each of the following areas:

(I) Visionary Leadership—

(a) Knows the importance of a vision and how it relates to the core values and culture of the district;

(b) Understands the importance of all stakeholders knowing the collective mission, vision, and core values;

(c) Understands how multiple sources of data are connected to a mission, vision, and core values;

(II) Instructional Leadership—

(a) Understands how standards apply to horizontal and vertical alignment of local curricula and content areas;

(b) Understands a variety of research-based instructional practices and how to appropriately match them to learning content;

(c) Understands legal implications impacting instruction and ensures meaningful feedback related to effective teacher and leader practice;

(d) Understands the importance of assessing student learning using a variety of formal and informal assessments;

(e) Understands the importance of multiple strategies for analyzing data to inform the instructional process; and

(f) Understands the principles of adult learning and how these help develop principal and teacher capacity;

(III) Managerial Leadership—

(a) Knows how safe and functional district facilities and grounds support student learning;

(b) Understands how routines, protocols, procedures, policies, and technology support the district environment;

(c) Understands tools used to determine key attributes of effective personnel;

(d) Understands the necessity of establishing and communicating clear expectations, guidelines, policies, and procedures respecting the rights of all staff and students;

(e) Understands the role of observation, feedback, documentation, and intervention for improving or removing personnel and the legal and ethical decisions in creating an effective educator evaluation process;

(f) Is knowledgeable of requirements regarding personnel records, laws, and reports;

(g) Understands the statutory requirements that affect how a district budget works and the major sources of revenue to support district goals and priorities; and

(h) Understands the statutory requirements that affect how non-fiscal resources support district goals and priorities;

(IV) Relational Leadership—

(a) Knows how and why analysis of student demographics is used to determine the overall diversity of a district and its impact on the teaching and learning process;

(b) Understands the legal implications of in-district and out-of-district strategies and resources available in supporting the well-being of each student;

(c) Understands how to build positive and ethical relationships in support of student learning and well-being;

(d) Understands the importance of building effective, ethical relationships with all staff;

(e) Understands how to develop a culture of support and respect among staff and in the community;

(f) Serves as a district leader and understands the importance of building leadership capacity in a district;

(g) Understands a variety of strategies for building relationships and working cooperatively with board members; and

(h) Recognizes the impact the larger political, social, economic, legal, and cultural issues can have on educational issues in the school district;

(V) Innovative Leadership—

(a) Recognizes knowledge, skills, and best practices support continuous professional growth;

(b) Understands the need for professional networks as a key element of professional growth;

(c) Understands the importance of reflection and a commitment to ongoing learning;

(d) Understands the importance of feedback for improving performance;

(e) Understands how time management is a key factor for maintaining a focus on district priorities;

(f) Recognizes that beliefs based on new knowledge, understandings, and technology are used as a catalyst for change;

(g) Understands the need to be flexible and willing to vary an approach when circumstances change; and

C. Directed field experiences in superintendency of at least three (3) semester hours.

(5) The requirements of this rule shall become effective *[August 1, 2020]* **August 31, 2023.**

*AUTHORITY: sections 161.092, 168.011, 168.071, 168.081, 168.400, 168.405, and 168.409, RSMo 2016, and section 168.021, RSMo Supp. [2019] **2021**. Original rule filed Oct. 29, 2013, effective May 30, 2014. Amended: Filed June 13, 2019, effective Jan. 30, 2020. Amended: Filed June 24, 2022.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Elementary and Secondary Education, ATTN: Dr. Paul Katnik, Assistant Commissioner, Office of Educator Quality, PO Box 480, Jefferson City, MO 65102-0480 or by email to educatorquality@dese.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.*

Title 5—DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Division 25—Office of Childhood
Chapter 100—Early Childhood Development

PROPOSED AMENDMENT

5 CSR 25-100.330 General Provisions Governing Programs Authorized Under the Early Childhood Development Act. The state board of education is amending sections (1) and (2), and adding paragraph (1)(A)9.

PURPOSE: The amendment updates the requirements for programs and projects carried out by school districts under the Early Childhood Development Act; this amendment also updates the Office of Early and Extended Learning to the Office of Childhood, pursuant to Executive Order 21-02.

(1) All programs and projects carried out by school districts under the Early Childhood Development Act (ECDA) shall be conducted in conformity with—

(A) The school district's annual application for district program

approval under the ECDA, pursuant to applicable state laws and regulations and the following:

1. The school district *[must]* **shall** designate a supervisor who will be responsible for the oversight**,** *[and]* delivery**, and evaluation** of the *[Parents as Teachers (PAT)]* **parent education** program **including presenting the goals, objectives, and effectiveness of the program regularly to the local school board**;

2. The school district *[must]* **shall** establish a Community Advisory Committee **or utilize an existing committee that includes key stakeholders such as families, early childhood providers, school administration, school board members, and other community leaders. The purpose of the Community Advisory Committee is to promote, plan, and evaluate the parent education program. The Community Advisory Committee shall meet, at a minimum, twice during the program year**;

3. The school district *[must use parent educators that meet the minimum requirements established by the Department of Elementary and Secondary Education (department) and renew curriculum subscription(s) annually through Parents as Teachers National Center]* **shall provide families with access to qualified parent educator(s) who provide parent education services. The parent educator(s) shall be trained in an approved curriculum and complete the required hours of annual professional development**;

4. The school district *[must]* **shall** provide *[a PAT]* **an approved parent education** program that *[promotes early learning, knowledge and understanding of child development, partnerships between families and schools, and access to community resources for a]* **supports families expecting a child or who have a child under the age of kindergarten entry. These services shall be provided for, at a** minimum, *[of]* nine (9) months during the program year;

5. *[The PAT program must be implemented to provide family]* **The school district shall offer families access to** personal visits *[using the department approved curriculum]*, developmental screenings *[for age eligible children using a department approved screening instrument]*, group connections, and *[access to a resource]* **a** network **of resources within the community to support their child's education and development**;

6. The school district *[must]* **shall,** annually**,** gather and summarize feedback from families regarding the services received and use the results for program improvement;

7. The school district *[must maintain documentation to verify services that maintains confidentiality of participating families; and]* **shall utilize a systematic method for collecting, reporting, and securely storing data;**

8. *[The]* **If a** school district *[must collect and report all data requested by the department.]* **fails to offer or is unable to offer an approved parent education program, the district shall enter into a contract with another district, public agency, or state-approved not-for-profit agency to offer an approved program that meets these requirements; and**

9. Funds received from the department, subject to appropriation by the General Assembly, for this parent education program cannot be used to support other programs and services provided in the school district. Prior to payment for programs and projects carried out by school districts under the ECDA, the school district shall agree to follow all procurement assurances, including monitoring, for the use of state and/or federal funds by written agreement with the department.

(2) Any rule or interpretation of a rule promulgated by the State Board of Education in exercising its responsibilities under the statute may be waived by the assistant commissioner, Office of *[Early and Extended Learning]* **Childhood**, upon *[his/her]* determination that a situation exists in which the application of the rule or interpretation would *[work]* **cause** an extreme hardship upon the affected party, or would work to the detriment of the intended beneficiaries of the program.

AUTHORITY: sections 161.092, and 178.691–178.699, RSMo 2016. This rule previously filed as 5 CSR 50-270.010 and 5 CSR 20-600.110. Original rule filed April 4, 1985, effective Sept. 3, 1985. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 24, 2022.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with Lisa Ivy, Department of Elementary and Secondary Education, Office of Childhood, PO Box 480, Jefferson City, MO 65102-0480, by faxing (573) 526-8000, or via email at childhoodrules@dese.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.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 20—Clean Water Commission
Chapter 6—Permits

PROPOSED AMENDMENT

10 CSR 20-6.010 Construction and Operating Permits The Clean Water Commission is amending subsections (1)(B), (2)(A) and (C), (4)(A), (5)(B), and (5)(G).

PURPOSE: The amendment requires that applicants submit electronic versions of applications and makes the submittal of paper copies optional unless required upon department request. This amendment will also clarify the construction permit application exemption in 10 CSR 20-6.010(5)(B)3. to be consistent with the statutory requirement that industrial facilities get a permit. The third component of the amendment establishes an exemption from higher level continuing authorities for industrial stormwater permittees and industrial no-discharge permittees.

(1) Permits – General.

(B) The following are exempt from permit regulations:

1. Nonpoint source discharges;

2. Service connections to wastewater collection systems;

3. Internal plumbing, piping, water diversion, or retention structures that are an integral part of an industrial process, plant or operation, except to the point wastewater is conveyed to receiving water;

4. Routine maintenance or repairs of any existing collection system, wastewater treatment facility, or other water contaminant or point source;

5. Onsite systems for single family residences;

6. The discharge of water from an environmental emergency cleanup site under the direction of, or the direct control of, the department or the Environmental Protection Agency (EPA), provided the discharge does not violate any condition of 10 CSR 20-7.031 Water Quality Standards;

7. Water used in constructing and maintaining a drinking water well and distribution system for public and private use, geologic test holes, exploration drill holes, groundwater monitoring wells, and heat pump wells;

8. Projects for beneficial use, that do not exceed a period of one

year, may be exempted by written project approval from the department. The department may extend the permit exemption for up to one additional year.

9. The application of pesticides in order to control pests (e.g., any insect, rodent, nematode, fungus, weed, etc.) in a manner that is consistent with the requirements of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) and the Missouri Pesticide Use Act unless such application is made directly into or onto waters of the state, in which case the applicator shall obtain a permit;

10. Hydrostatic *[T]***t**esting. Persons discharging water used for the hydrostatic testing of new pipelines and storage tanks in the state of Missouri may discharge to waters of the state without first obtaining a permit if the discharge is *de minimis* (less than one thousand (< 1,000 gallons) or meeting the requirements in section (14) of this rule;

11. Nondischarging *[earthen basins]* **facilities** for domestic wastewater flows of three thousand gallons per day (3,000 gpd) or less; and

12. Agrichemical rinsates and any spilled or recovered fertilizers and pesticides that are field applied at rates compatible with product labeling.

(2) Continuing Authorities.

(A) Each application for a construction permit or operating permit shall identify the person, as that term is defined in section 644.016(15), RSMo, that is the owner of, operator of, or area-wide management authority for a water contaminant source, point source, wastewater treatment facility, or sewer collection system. This person shall be designated as the continuing authority and shall sign the application. By doing so, the person designated as the continuing authority acknowledges responsibility for compliance with all permit conditions. **Industrial stormwater permits, industrial no-discharge permits, and construction stormwater permits are exempt from the higher level continuing authority requirements in this rule.**

(C) Applicants **for permits other than industrial stormwater permits, industrial no-discharge permits, and construction stormwater permits** proposing use of a lower preference continuing authority*[,]* when the higher level authority is available*[,]* must submit one (1) of the following for the department's review, provided it does not conflict with any area-wide management plan approved under section 208 of the Federal Clean Water Act or by the Missouri Clean Water Commission:

1. A waiver from the existing higher authority;

2. A written statement or a demonstration of non-response from the higher authority declining the offer to accept management of the additional wastewater;

3. A to-scale map showing that all parts of the legal boundary of the property to be connected are beyond two thousand feet (2000') from the collection system operated by a higher preference authority;

4. A proposed connection or adoption charge by the higher authority that would equal or exceed what is economically feasible for the applicant, which may be in the range of one hundred twenty percent (120 percent) of the applicant's cost for constructing or operating a wastewater treatment system;

5. A proposed service fee on the users of the system by the higher authority that is above what is affordable for existing home owners in that area;

6. Terms for connection or adoption by the higher authority that would require more than two **(2)** years to achieve full sewer service; or

7. A demonstration that the terms for connection or adoption by the higher authority are not viable or feasible to homeowners in the area.

(4) Facility Plans and Engineering Reports. Applicants seeking a construction permit shall submit a facility plan or engineering report unless otherwise designated by the department.

(A) Submit the engineering report and/or facility plan prior to submittal of the *[C]***c**onstruction *[P]***p**ermit *[A]***a**pplication, including the following, as applicable:

1. A signed *[F]***f**acility *[P]***p**lan or *[E]***e**ngineering *[R]***r**eport. All facility plans and engineering reports are to be signed and sealed by a Missouri registered professional engineer, and contain the information in accordance with 10 CSR 20-8*[.]***;**

2. Identify the alternative technical manuals and design criteria utilized that are different from the design standards provided in 10 CSR 20-8.110 through 10 CSR 20-8.220*[.]***;**

3. Submit *[one (1) hard copy and]* an electronic version (in *[P]***p**ortable *[D]***d**ocument *[F]***f**ormat (PDF) searchable format or department approved equivalent) for review. **To aid in review efficiency, the applicant may also submit paper copies of the documents, particularly those in large format. The department may request paper copies in addition to the electronic version;**

4. For *[E]***e**ngineering *[R]***r**eports*[,]***.**

A. Submit a plan of the existing and proposed sewers for projects involving new sewer systems and substantial additions to existing systems.

B. Submit a plan for projects involving construction or revision of pumping stations.

C. Provide the design basis and operating life*[.]***; and**

5. For *[F]***f**acility *[P]***p**lans*[,]***.**

A. Submit an approved *[W]***w**ater *[Q]***q**uality *[R]***r**eview and *[A]***a**ntidegradation evaluation or determination for all new and expanding facilities, in accordance with 10 CSR 20-7.031(3). For non-funded projects, information submitted as part of the *[A]***a**ntidegradation *[R]***r**eport does not have to be resubmitted with the facility plan.

B. Evaluate the feasibility of constructing and operating a facility with no discharge to waters of the state if the report is for a new or modified wastewater treatment facility.

C. Evaluate the economics of the project including alternatives to constructing a discharging system, including an evaluation of alternatives of wastewater irrigation or subsurface dispersal and connection to a regional wastewater treatment facility.

D. A geohydrological evaluation conducted by the department's Missouri Geological Survey, for all proposed new construction, new or major modification of earthen basins, new outfall locations, wastewater irrigation fields, and subsurface dispersal sites. Include any recommendations provided in the geohydrological evaluation.

(5) Construction Permits.

(B) The following activities are exempt from construction permitting when the activities meet the applicable standards in 10 CSR 20-2 through 10 CSR 20-9. Projects exempt from construction permitting may require professional engineering, as defined in section 327.181, RSMo:

1. Construction of a separate storm sewer;

2. Sewer extensions of one thousand feet (1,000') or less, including gravity sewers and/or force mains, with no more than one pump station;

3. Construction of *[less than three thousand gallons per day (3,000 gpd) non-discharging lagoon systems]* **nondischarging facilities for domestic wastewater flows of three thousand gallons per day (3,000 gpd) or less**;

4. Class II and smaller *[A]***a**nimal *[F]***f**eeding *[O]***o**perations (AFO), as designated in 10 CSR 20-6.300;

5. Nondomestic discharges of process wastewater except discharges utilizing an earthen basin;

6. Stormwater best management practices, as defined in 10 CSR 20-6.200;

7. Industrial facilities connecting to a publicly owned wastewater treatment facility;

8. Treatment facilities evaluated and constructed under other

department programs;

9. Systems adding common metal salts for phosphorus removal prior to existing liquid-solids separation and tertiary filtration;

10. Adding pre-engineered dechlorination equipment;

11. Solids processing equipment;

12. Like-for-like replacement (e.g., replacing eight-inch (8") pipe with eight-inch (8") pipe at the same location and grade, but material type may be different);

13. Outfall relocation within the same receiving stream, close proximity to the existing outfall, and upon review by the department;

14. Projects which the department has determined a construction permit is not required through written determination; and

15. Minor projects that change equipment or operations, but do not affect the overall capacity of the treatment or treatment type, including, but not limited to:

A. Internal piping changes;

B. pH adjustment;

C. Addition of solids storage tanks;

D. Screening equipment;

E. Grit removal equipment;

F. Administrative buildings;

G. Fences and access roads;

H. Flow measuring devices;

I. Mixing equipment;

J. Addition and/or improvement of sampling equipment;

K. Replacement of aeration equipment; and

L. Polymer additives.

(G) An application for a construction permit shall be made on forms provided by the department and include the following items:

1. A *[C]***c**onstruction *[P]***p**ermit *[A]***a**pplication *[F]***f**orm signed—

A. For a corporation, by an individual having responsibility for the overall operation of the regulated facility or activity, such as the plant manager, or by a delegated individual having overall responsibility for environmental matters at the facility;

B. For a partnership or sole proprietorship, by a general partner or the proprietor respectively; or

C. For a municipal, state, federal, or other public facility, by either a principal executive officer or by a delegated individual having overall responsibility for environmental matters at the facility;

2. Appropriate permit fee according to 10 CSR 20-6.011;

3. An electronic copy of the construction permit application and the information listed below in *[P]***p**ortable *[D]***d**ocument *[F]***f**ormat (PDF) searchable format or department approved equivalent*[, along with one paper copy for projects not seeking department funding or two paper copies for projects seeking department funding under 10 CSR 20-4;]*. **To aid in review efficiency, the applicant may also submit paper copies of the documents, particularly those in large format. The department may request paper copies in addition to the electronic version;**

4. An approved *[W]***w**ater *[Q]***q**uality *[R]***r**eview and antidegradation evaluation or determination for all new and expanding facilities, in accordance with 10 CSR 20-7.031(3);

5. A summary of design;

6. Detailed engineering plans and technical specifications signed, sealed, and dated by a Missouri registered professional engineer, which contain the information in accordance with 10 CSR 20-8, or other regulations as applicable;

7. A map showing the location of all outfalls, with scale, as well as a flowchart indicating each process which contributes to an outfall; and

8. Other information necessary to determine compliance with the Missouri Clean Water Law and these regulations as required by the department.

AUTHORITY: sections 640.710 and 644.026, RSMo 2016. Original rule filed June 6, 1974, effective June 16, 1974. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 30, 2022.*

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Natural Resources, Division of Environmental Quality, Water Protection Program, Attn: Steven Hamm, PO Box 176, Jefferson City, MO 65102. Comments may also be sent with name and address through e-mail to Steven Hamm@dnr.mo.gov, or online https://apps5.mo.gov/proposed-rules/welcome.action#OPEN. To be considered, comments must be received no later than September 8, 2022. The public hearing is scheduled to be held at 10 a.m. on September 1, 2022, at the Lewis and Clark State Office Building, LaCharrette/Nightingale Conference Rooms, 1101 Riverside Drive, Jefferson City, MO 65101. Virtual attendance is also available via Webex, meeting number (access code): 2454 853 6339; meeting password: DNR. Call-in number toll number (US/Canada): 1-650-479-3207. To join from a video system or application: Dial 24548536339@stateofmo.webex.com.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 20—Clean Water Commission
Chapter 6—Permits

PROPOSED AMENDMENT

10 CSR 20-6.200 Storm Water Regulations. The department is amending this rule by adding section (7) Qualifying Local Program and section (8) Silvicultural Activities.

PURPOSE: This amendment adds language related to the qualifying local program process and silvicultural activities.

(7) Qualifying Local Programs.

(A) Regulated municipal separate storm sewer systems (MS4s) may request department approval to implement a qualifying local program. A qualifying local program is formal recognition that a regulated MS4 has a department-approved local sediment and erosion control program that meets or exceeds the requirements listed in 10 CSR 20-6.200(7)(B) for construction and land disturbance activities occurring within the regulated MS4's jurisdiction. While a regulated MS4 has an approved qualifying local program, construction and land disturbance activities in its jurisdiction for which the regulated MS4 has issued a land disturbance or equivalent permit do not require a Missouri state operating permit for land disturbance.

(B) Qualifying local programs are for storm water discharges associated with land disturbance activities only, which includes clearing, grubbing, excavating, grading, and other activities that result in the destruction of the root zone and have potential to cause negative impacts to receiving waterbodies. Each approved qualifying local program shall include reviewing site plans, inspecting construction sites, and taking enforcement action against owners or operators of sites that are polluting the waters of the state within its jurisdiction.

1. Qualifying local programs are only applicable to regulated MS4s, as defined in paragraph (1)(D)24. of this rule, including large, medium, or small MS4s, as defined in paragraphs (1)(D)10., 15., and 29., respectively, of this rule.

2. At a minimum, a qualifying local program shall include:

A. Requirements for construction site operators to implement appropriate erosion and sediment control best management practices that meet or exceed applicable state requirements;

B. Requirements for construction site operators to control waste such as discarded building materials, concrete truck washout, chemicals, litter, and sanitary waste at the construction site that may cause negative impacts to water quality;

C. Requirements for construction site operators to develop and implement a storm water pollution prevention plan. A storm water pollution prevention plan includes site descriptions, descriptions of appropriate control measures to protect water quality, copies of approved state, tribal, or local requirements, maintenance procedures, inspection procedures, and identification of non-storm water discharges; and

D. Requirements to submit a site plan for review that incorporates considerations of potential water quality impacts.

3. Regulated MS4s seeking to become recognized as having a qualifying local program may apply by sending a letter to the department requesting formal recognition pursuant to this subsection.

4. The department will review each request to become recognized as having a qualifying local program submitted by a regulated MS4.

A. The department will review the regulated MS4's land disturbance program and compliance history to determine eligibility and to ensure that the program meets or exceeds state requirements established in the Missouri land disturbance permit and the MS4 permit.

B. If the department concurs that the regulated MS4 is eligible to have a qualifying local program and that its land disturbance program meets or exceeds applicable state requirements, then the department will incorporate the local requirements specific to that regulated MS4's qualifying local program. If covered by a site-specific permit, the department will modify its MS4 permit if necessary. If covered by a general two-step permit, the MS4 shall modify and notify the public of their storm water management plan for thirty (30) days to incorporate the local requirements specific to that regulated MS4's qualifying local program.

C. For site-specific MS4 permits, the regulated MS4 must submit a modified storm water management plan within thirty (30) days of the MS4 permit modification. For general two-step permits, the regulated MS4 must submit the modified storm water management plan after the public notice is complete.

D. After the department receives and approves the modified storm water management plan, the department will send official correspondence to the regulated MS4 indicating that the department has approved its qualifying local program.

5. A regulated MS4 may end its qualifying local program at its discretion upon written notice to the department. The qualifying local program shall remain effective for at least ninety (90) days after the date the written notice is sent to the department, ending on a date determined by the regulated MS4. This provides time for the regulated MS4 to notify all affected construction site permit holders of the need to obtain a Missouri state operating permit for land disturbance.

6. The department may revoke any qualifying local program designation if the regulated MS4 does not comply with this rule or the program requirements as established. The department's revocation may be appealed to the Missouri Clean Water Commission by the regulated MS4 or by any adversely affected party within thirty (30) days of the date of revocation. The appeal shall be filed with the Administrative Hearing Commission, 131 W High St., PO Box 1557, Jefferson City, MO 65101 and shall be a contested case and be conducted pursuant to section 644.066, RSMo. The filing of an appeal shall stay the department's revocation. If the revocation is not appealed, or upon the final disposition of an appeal in which the revocation is sustained, the qualifying local program shall remain effective for ninety (90) days after the department's revocation or final disposition of the appeal, whichever occurs later. This provides time for the regulated MS4 to notify all affected construction site permit holders of the need to obtain a Missouri state operating permit for land disturbance.

(8) Silvicultural Activities.

(A) The department does not require storm water permitting for silviculture activities conducted in accordance with 33 U.S. Code 1342(l)(3), January 2014, as published by the U.S. Government Publishing Office available at https://bookstore.gpo.gov/ or for mail orders print and fill out order form online and mail to U.S. Government Publishing Office, PO Box 979050, St. Louis, MO 63197-9000.

AUTHORITY: sections 644.026 and 644.036, RSMo 2016. Original rule filed July 15, 1991, effective Oct. 1, 1992. For intervening history, please consult the ***Code of State Regulations****. Amended: Filed June 30, 2022.*

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

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

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Natural Resources, Division of Environmental Quality, Water Protection Program, Attn: Sarah Wright, PO Box 176, Jefferson City, MO 65102. Comments may also be sent with name and address through email to sarah.wright@dnr.mo.gov, or online https://apps5.mo.gov/proposed-rules/welcome.action#OPEN. To be considered, comments must be received no later than September 8, 2022. The public hearing is scheduled to be held at 10 a.m. on September 1, 2022, at the Lewis and Clark State Office Building, LaCharrette/Nightingale Conference Rooms, 1101 Riverside Drive, Jefferson City, MO 65101. Virtual attendance is also available via Webex, meeting number (access code): 2454 853 6339; meeting password: DNR. Call-in number toll number (US/Canada): 1-650-479-3207. To join from a video system or application: Dial 24548536339@stateofmo.webex.com.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 140—Division of Energy
Chapter 8—Certification of Renewable Energy and Renewable Energy Standard Compliance Account

PROPOSED AMENDMENT

10 CSR 140-8.010 Certification of Renewable Energy and Renewable Energy Standard Compliance Account. The Missouri Department of Natural Resources is amending parts (2)(A)6.B.(II) and (III) and adding a new part (2)(A)6.B.(IV).

PURPOSE: This amendment clarifies that black liquor is not an eligible renewable energy resource under Missouri's Renewable Energy Standard (section 393.1025, RSMo et seq.) unless used as an input for the thermal depolymerization or pyrolysis of waste material.

(2) Eligible Renewable Energy Resources.

(A) *[Eligible Renewable Energy Resources.]* The electricity must be derived from one (1) of the following types of renewable energy resources or technologies, as defined in section 393.1025(5),

RSMo:

1. Wind;

2. Solar thermal sources or solar photovoltaic cells and panels;

3. Dedicated crops grown for energy production—herbaceous and woody crops that are harvested specifically for energy production in a sustainable manner;

4. Cellulosic agricultural residues—organic matter remaining after the harvesting and processing of agricultural crops. They include—

A. Field residues*[, which are]*—organic materials left on agricultural lands after the crops have been harvested, such as stalks, stubble, leaves, and seed pods; and

B. Process residues*[, which are]*—organic materials left after the crops have been processed into a usable resource, such as husks, seeds, and roots;

5. Plant residues—the residues of plants that would be converted into energy, that otherwise would be waste material;

6. Clean and untreated wood—non-hazardous wood 1) that has not been chemically treated with chemical preservatives such as creosote, pentachlorophenol, or chromated copper arsenate; and 2) that does not contain resins, glues, laminates, paints, preservatives, or other treatments that would combust or off-gas, or mixed with any other material that would burn, melt, or create other residue aside from wood ash.

A. Eligible clean and untreated wood may include, but is not necessarily limited to, the following sources:

(I) Forest-related resources, such as pre-commercial thinnings waste, slash (tree tops, branches, bark, or other residue left on the ground after logging or other forestry operations), brush, shrubs, stumps, lumber ends, trimmings, yard waste, dead and downed forest products, and small diameter forest thinnings (twelve inches (12") in diameter or less);

(II) Non-chemically treated wood and paper manufacturing waste, such as bark, trim slabs, scrap, shavings, sawdust, sander dust, and pulverized scraps;

(III) Vegetation waste, such as landscape waste or right-of-way trimmings;

(IV) Wood chips, pellets, or briquettes derived from non-toxic and unadulterated wood wastes or woody energy crops;

(V) Municipal solid waste, construction and demolition waste, urban wood waste, and other similar sources only if wood wastes are segregated from other solid wastes or inorganic wastes; and

(VI) Other miscellaneous waste, such as waste pellets, pallets, crates, dunnage, scrap wood, tree debris left after a natural catastrophe, and recycled paper fibers that are no longer suitable for recycled paper production.

B. Ineligible clean and untreated wood may include, but is not necessarily limited to, the following sources:

(I) Post-consumer wastepaper;

(II) Wood from old growth forests (one hundred fifty (150) years old or older); *[and]*

(III) Unsegregated solid waste; **and**

(IV) Black liquor, unless used as an input consistent with paragraph (2)(A)10. of this rule;

7. Methane from landfills, wastewater treatment, or agricultural operations. Agricultural operations are defined as 1) the growing or harvesting of aquatic plants or agricultural crops grown in soil; or 2) the raising of animals for the purpose of making a profit, providing a livelihood, or conducting agricultural research or instruction. Wastewater treatment is defined as physical, chemical, biological, and mechanical procedures applied to an industrial or municipal discharge or to any other sources of contaminated water to remove, reduce, or neutralize contaminants;

8. Hydropower, not including pumped storage, that does not require a new diversion or impoundment of water and that each generator has a nameplate rating of ten megawatts (10 MW) or less. If an improvement to an existing hydropower facility does not require a new diversion or impoundment of water and incrementally increases the nameplate rating of each generator, up to ten megawatts (10 MW) per generator, the improvement qualifies as an eligible renewable energy resource;

9. Fuel cells using hydrogen produced by one (1) of the above-named renewable energy resources. RECs based on generating electricity in fuel cells from hydrogen derived from an eligible energy resource are eligible for compliance purposes only to the extent that the energy used to generate the hydrogen did not create RECs;

10. Products from thermal depolymerization or pyrolysis of waste material. Waste materials are specifically segregated materials from a waste stream for the purpose of producing energy or that are capable of producing energy. Pyrolysis is a thermochemical process through which organic matters are decomposed at elevated temperatures in an oxygen-deficient atmosphere into useful energy forms. Thermal depolymerization is the thermal decomposition (hydrous pyrolysis process) of organic compounds heated to high temperatures in the presence of water resulting in liquid oil; or

11. Other sources of energy, not including nuclear, that may become available after November 4, 2008, and are certified as eligible renewable energy resources as provided in section (3) of this rule.

*AUTHORITY: section 393.1030, RSMo Supp. [2011] **2021**. This rule originally filed as 10 CSR 140-8.010 and 4 CSR 340-8.010. Original rule filed June 14, 2010, effective Jan. 30, 2011. Amended: Filed Feb. 29, 2012, effective Aug. 30, 2012. Moved to 4 CSR 340-8.010, effective Aug. 28, 2013. Moved to 10 CSR 140-8.010, effective Jan. 15, 2020. Amended: Filed June 22, 2022.*

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

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

*NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Department of Natural Resources' Division of Energy, Craig Redmon, Director, PO Box 176, Jefferson City, MO 65102, by fax at (573) 751-6860, or via email at energy@dnr.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.*

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

PROPOSED AMENDMENT

13 CSR 70-15.190 Out-of-State Hospital Services Reimbursement Plan. The division is amending sections (1) and (2), deleting sections (3)–(14), and adding new sections (3)–(6).

PURPOSE: This amendment establishes the method of reimbursing out-of-state hospitals for inpatient or outpatient care provided to any participants of Missouri Medicaid, whether they are under age twenty-one (21) or age twenty-one (21) and over. The division is amending the methodology for both inpatient and outpatient reimbursement for out-of-state hospitals, and updating outdated language and terms.

(1) Covered inpatient hospital services include those items and services allowed by the Medicaid State Plan including medically necessary care in a semi-private room. If prior authorized**,** Missouri Medicaid may reimburse for a private room if it is certified medically necessary by a physician to avoid jeopardizing the health of the

patient or to protect the health and safety of other patients. No payment will be made for any portion of the room charge when the *[recipient]* **participant** requests and is provided a private room when the private room is not medically necessary.

(2) Payment for authorized inpatient hospital services shall be made on a prospective per diem basis for services provided outside Missouri if the services are covered by the Missouri *[Medical Assistance (]*Medicaid*[)]* Program. To be reimbursed for furnishing services to Missouri Medicaid *[recipients]* **participants**, out-of-state *[providers]* **hospitals** must complete a Missouri *[Medical Assistance]* **Medicaid** Program Provider Participation Application and have the application approved by the Missouri Department of Social Services, *[Division of Medical Services]* **Missouri Medicaid Audit and Compliance (MMAC)**.

[(3) Determination of Payment. The payment for inpatient hospital services provided by an out-of-state provider shall be the lowest of:

(A) At the out-of-state hospital's election, the prospective inpatient payment may be based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulations for hospitals operating in Missouri with inflationary increases as granted by the Missouri General Assembly or the out-of-state hospital may be exempt from the cost report filing requirements if the hospital accepts the projected statewide average per diem rate for Missouri hospitals as calculated by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average per diem rate for Missouri hospitals shall be the first day of the month following the Division of Medical Services determination of per diem rate based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri;

(B) The amount of total charges billed by the hospital. The provider's billed charges must be their usual and customary charges for services; or

(C) The Medicare deductible or coinsurance, if applicable, up to the amount allowed by the Missouri Medicaid program.

(4) Per Diem Reimbursement Rate Computation. The per diem reimbursement rate computation is the same as calculated for Missouri hospitals at 13 CSR 70-15.010(3).

(5) If a provider fails to submit all financial documentation required by Missouri regulations (Medicare cost report, working trial balance, audited financial statements, Medicaid supplemental schedules, and Worksheet C2552-83 for ancillary costs and charges) for hospitals operating in Missouri within thirty (30) days of making the election to receive payment based on information from cost reports, the payment shall be based on the projected statewide average per diem rate in Missouri as developed by the Department of Social Services, Division of Medical Services for the state fiscal year.

(6) Out-of-state hospitals shall present claims to Missouri Medicaid within three hundred sixty-five (365) days from the date of service. In no case shall Missouri be liable for payment of a claim received beyond one (1) year from the date services were rendered. Inpatient and outpatient hospital services must be submitted on the UB-92 claim form.

(7) Out-of-state hospitals are subject to the Department Concurrent Hospital Review process (utilization review) for all non-emergency services.

(8) The payment for authorized outpatient hospital services provided by an out-of-state hospital shall be the lowest of:

(A) At the out-of-state hospital's election, a prospective outpatient payment percentage calculated using the Medicaid over-all outpatient cost-to-charge ratio from the fourth, fifth, and sixth prior base year cost reports and all documentation required by Missouri regulation for hospitals operating in Missouri regressed to the current state fiscal year or the out-of-state hospital may be exempt from the cost report filing requirement if the hospital accepts the projected statewide average outpatient payment percentage as developed by the Department of Social Services, Division of Medical Services for the state fiscal year in which the service was provided. The effective date for any increase above the statewide average outpatient payment percentage shall be the first day of the month following the Division of Medical Services determination of the outpatient payment percentage based on information from the hospital's Medicare base year cost report and all financial documentation required by Missouri regulation for hospitals operating in Missouri; or

(B) The amount of total charges billed by the hospital.

(9) Outpatient Reimbursement Rate Computation. The outpatient reimbursement rate computation is the same as calculated for Missouri hospitals at 13 CSR 70-15.160.

(10) Disproportionate Share Providers. Out-of-state hospitals do not qualify for disproportionate share (DSH) payments. unless they have a low income utilization rate exceeding twenty-five percent (25%) for Missouri residents and the out-of-state hospital can demonstrate that the provision of services to Missouri residents has not been considered in establishing their DSH status in any other state.

(11) All Medicaid services are subject to program compliance reviews. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made.

(12) Regardless of changes of ownership, management, control, operation, leasehold interests by whatever form for any hospital previously certified for participation in the Medicaid program, the department will continue to make all the Title XIX payments directly to the entity with the hospital's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

(13) Participation in the Missouri Medicaid program shall be limited to hospitals who accept as payment in full for covered services rendered to Medicaid recipients the amount paid in accordance with Missouri statute and regulations.

(14) Definitions.

(A) The definitions from regulation 13 CSR 70-15.010 are incorporated as 13 CSR 70-15.190.

(B) Base year cost report—shall be either a 1995 Medicare cost report and Missouri's supplemental cost report schedules for those hospitals enrolled in the Missouri Medicaid program as of the effective date of this regulation or the most recent submitted cost report to Medicare and Missouri's supplemental cost report schedules for those hospitals that elect to enroll in Missouri Medicaid after the effective date of this regulation.

(C) Out-of-state—not within the physical boundaries of

Missouri.

(D) Usual and customary charge—the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.]

(3) Determination of Payment. The payment for inpatient hospital services provided by an out-of-state hospital shall be the lowest of—

(A) For the out-of-state hospitals whose per diem was set on the hospital's audited Medicaid cost report prior to July 1, 2022, the hospital's per diem will be the rate in effect as of June 30, 2022. For all other out-of-state hospitals, the hospital's per diem will be fifty percent (50%) of the weighted statewide average per diem rate for Missouri hospitals as calculated by the MO HealthNet Division for the State Fiscal Year (SFY) in which the service was provided; or

(B) The amount of total charges billed by the hospital. The hospital's billed charges must be their usual and customary charges for services; or

(C) The Medicare deductible or coinsurance, if applicable, up to the amount allowed by the Missouri Medicaid program.

(4) The payment for authorized outpatient hospital services provided by an out-of-state hospital shall be the lower of—

(A) The outpatient reimbursement as described in 13 CSR 70-15.160; or

(B) The amount of total charges billed by the hospital.

(5) Disproportionate Share Hospital (DSH) Payments. Out-of-state hospitals do not qualify for DSH payments.

(6) Definitions.

(A) The definitions from regulation 13 CSR 70-15.010 are incorporated as 13 CSR 70-15.190.

(B) Out-of-state—not within the physical boundaries of Missouri.

(C) Usual and customary charge—the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.

AUTHORITY: sections 208.201 ***and 660.017****, RSMo [2000]* ***2016****. Original rule filed April 15, 2004, effective Oct. 30, 2004. Emergency amendment filed June 16, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 16, 2022.*

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

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

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, Legal Services Division-Rulemaking, PO 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.*

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)–(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-*[D]***d**eemed DSH *[H]***h**ospitals. 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 *[I]***i**npatient *[U]***u**tilization *[R]***r**ate (MIUR) at least one (1) standard deviation above the state mean or a *[L]***l**ow-*[I]***i**ncome *[U]***u**tilization *[R]***r**ate (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. *[Obstestrics]* **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.

(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.

(2) Definitions.

(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,]

1. *[t]***T**he 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 *[C]***c**ost of *[C]***c**are for Medicaid IP/OP *[S]***s**ervices;

B. Less *[R]***r**egular IP/OP Medicaid FFS *[R]***r**ate *[P]***p**ayments (excluding any other Medicaid payments as defined in subsection *[(2)(S)]***(2)(T)**);

C. Less IP/OP Medicaid MCO *[P]***p**ayments;

D. Equals the *[E]***e**stimated Medicaid *[N]***n**et *[C]***c**ost; and

E. The *[E]***e**stimated Medicaid *[N]***n**et *[C]***c**ost 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,]

1. *[t]***T**he 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 *[U]***u**ninsured *[C]***c**ost of *[C]***c**are;

B. Less *[T]***t**otal IP/OP *[I]***i**ndigent *[C]***c**are/*[S]***s**elf-*[P]***p**ay *[R]***r**evenues;

C. Equals the *[E]***e**stimated *[U]***u**ninsured *[N]***n**et *[C]***c**ost.

(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,]

1. *[t]***T**he estimated uninsured uncompensated care cost is determined from the state DSH survey *[using the "Report Summary" tab]* and is calculated as follows:

A. Estimated *[U]***u**ninsured *[N]***n**et *[C]***c**ost, as defined in subsection (2)(D);

B. Less *[T]***t**otal *[A]***a**pplicable *[S]***s**ection 1011 *[P]***p**ayments;

C. Equals the *[E]***e**stimated *[U]***u**ninsured *[U]***u**ncompensated *[C]***c**are *[C]***c**ost; and

D. The *[E]***e**stimated *[U]***u**ninsured *[U]***u**ncompensated *[C]***c**are *[C]***c**ost shall be trended as set forth in subsection *[(2)(Y)]* **(2)(Z)**.

(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.]

(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 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. 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 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. 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 *[W]***w**ithout *[H]***h**ealth *[I]***i**nsurance or *[O]***o**ther *[T]***t**hird-*[P]***p**arty *[C]***c**overage **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 *[can be]* **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 *[individuals]* **costs** shall be considered uninsured **and included in 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 *[I]***i**ncome *[U]***u**tilization *[R]***r**ate (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.

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

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

*[(O)]***(P)** Medicaid *[I]***i**npatient *[U]***u**tilization *[R]***r**ate (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.

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

$$\mathbf{MIUR = TMD / TNID}$$

*[(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 cost*[s]* 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 not limited to**: Direct Medicaid *[Add-On]*, **acuity adjustment payment, poison control payment, stop loss payment,** *[G]***g**raduate *[M]***m**edical *[E]***e**ducation (GME), *[Enhanced GME, C]***c**hildren's *[O]***o**utliers, *[and any]* cost settlements*[.]***, and** *[U]***u**pper 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.]***1.** *[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,** *[T]***t**he 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 *[E]***e**stimated Medicaid *[N]***n**et *[C]***c**ost and the *[E]***e**stimated *[U]***u**ninsured *[U]***u**ncompensated *[C]***c**are *[C]***c**ost (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)]***(BB)** 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.]***(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 *[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 *[W]***w**aiver 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) Disproportionate share payments will coincide with the semi-monthly 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 *[P]***p**ayments for *[H]***h**ospital *[M]***m**ergers.

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 *[Hospital]* (DMH) **Hospitals** 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)]***(A)** 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 *[Q]***q**uality *[I]***i**mprovement payment to all non-DMH hospitals. The state-only *[Q]***q**uality *[I]***i**mprovement 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*[.]*; **and**

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)]***(A)** 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 *[W]***w**aiver 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 *[P]***p**rocess to *[U]***u**se *[A]***a**lternate *[D]***d**ata for *[I]***i**nterim DSH *[P]***p**ayment.

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 (III)]* **(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 *[P]***p**ercent (20.00%) DSH *[O]***o**utlier. 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 *[U]***u**ntrended *[T]***t**otal *[E]***e**stimated *[N]***n**et *[C]***c**ost *[on the "Report Summary" tab, Column J,]* from the alternate state DSH survey is at least twenty percent (20.00%) higher than the *[T]***t**rended *[T]***t**otal *[E]***e**stimated *[N]***n**et *[C]***c**ost *[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 *[C]***c**ircumstances. 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, light*[e]*ning, 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 *[I]***i**nterim DSH *[P]***p**ayment *[a]***a**djustments 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 *[I]***i**nterim DSH *[P]***p**ayment *[A]***a**djustments 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 *[P]***p**ayment *[A]***a**djustment.

(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 *[U]***u**ntrended *[T]***t**otal *[E]***e**stimated *[N]***n**et *[C]***c**ost *[on the "Report Summary" tab, Column J,]* from the alternate data is at least twenty percent (20.00%) higher than the *[T]***t**rended *[T]***t**otal *[E]***e**stimated *[N]***n**et *[C]***c**ost *[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, [and] 208.201, **and 660.017,** RSMo 2016**, and section 208.152, RSMo Supp. 2021**. Emergency rule filed May 20, 2011, effective June 1, 2011, expired Nov. 28, 2011. Original rule filed May 20, 2011, effective Jan. 30, 2012. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 16, 2022, effective July 1, 2022, expires Feb. 23, 2023. Amended: Filed June 16, 2022.*

PUBLIC COST: This proposed amendment is estimated to cost state agencies 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 political subdivisions 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, PO 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.*

FISCAL NOTE
PUBLIC COST

I. **Department Title:** 13 Social Services
Division Title: 70 MO HealthNet Division
Chapter Title: 15 Hospital Program

Rule Number and Name:	13 CSR 70-15.220 Disproportionate Share Hospital (DSH) Payments
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Affected Agency or Political Subdivision	Estimated Cost of Compliance in the Aggregate
Other Government (Public) & State Hospitals enrolled in MO HealthNet - 38	**Estimated cost for SFY 2023: $5.1 million**
Department of Social Services, MO HealthNet Division	**Estimated cost for SFY 2023: Total $73.9 million; State Share $25.4 million (FRA) State Share $232 thousand (IGT)**

III. WORKSHEET

Other Government (Public) & State Hospitals Cost:

Estimated Cost for SFY 2023:

	FRA Fund	IGT Fund	Total
Estimated Cost to State Hospitals	$0	$682,803	$682,803
Estimated Cost to Other Government (Public) Hospitals	$4,390,596	$0	$4,390,596
Total Estimated Cost	$4,390,596	$682,803	$5,073,399
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	$1,495,108	$232,511	$1,727,619

Department of Social Services, MO HealthNet Division Cost:

Estimated Cost for SFY 2023:

	FRA Fund	IGT Fund	Total
Estimated Cost	$74,580,571	$682,803	$73,897,768
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share Cost	$25,396,549	$232,511	$25,164,037

IV. ASSUMPTIONS

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of $7.6 million for SFY 2023.

13 CSR 70-15.010
13 CSR 70-15.015
13 CSR 70-15.220
13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.

FISCAL NOTE
PRIVATE COST

I. Department Title: 13 Social Services
Division Title: 70 MO HealthNet Division
Chapter Title: 15 Hospital Program

Rule Number and Title:	13 CSR 70-15.220 Disproportionate Share Hospital (DSH) Payments
Type of Rulemaking:	Proposed Amendment

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
In-State Hospitals – 100	**Private Hospitals enrolled in MO HealthNet**	**Estimated impact for SFY 2023: $79 million**

III. WORKSHEET

In-State Private Hospitals Impact:

Estimated Impact for SFY 2023:

	FRA Fund	IGT Fund	Total
Estimated Impact to In-State Private Hospitals	$78,971,167	$0	$78,971,167
State Share Percentage	34.0525%	34.0525%	34.0525%
Estimated State Share	$26,891,657	$0	$26,891,657

IV. ASSUMPTIONS

The following regulations are impacted by the change to the hospital reimbursement methodology and the impact of all the regulations should be netted to arrive at the total impact. The net impact is a cost to the state of $7.6 million for SFY 2023.

13 CSR 70-15.010
13 CSR 70-15.015
13 CSR 70-15.220
13 CSR 70-15.230

The fiscal impact is estimated based on historical utilization and enrollment. Other variables such as the length of the Federal Public Health Emergency and Medicaid Expansion enrollment may indirectly affect the hospital utilization both positively and negatively. Due to the uncertainty of these variables, the state will continue to monitor the impacts to the Managed Care Organizations and hospitals.