MHA Management Services

Missouri Hospital Association Updates: Rural Health Transformation Program, State Budget and Disproportionate Share Hospital Payments

July 17, 2026

Learning Objectives

- Understand the current status of RHTP funds and grant opportunities
- Awareness of disproportionate share hospital payments for the SFY 2022 audit, SFY 2023 draft audit and SFY 2027 interim DSH payments
- Realize the current Missouri state budget and upcoming pressures from the federal and state levels

RHTP will stand up a set of five strategic initiatives under the Transformation of Rural Community Health Care (ToRCH Care) program

Regional Coordinating Networks and Hub Activation
Create local and regional groups that help providers coordinate care and focus on critical needs, spanning 104 counties

Alternative Payment Models
Use new payment approaches that reward teamwork and better health outcomes

Rural Health Workforce Programs
Train, recruit, and keep health care workers in rural areas

Digital Backbone
Build shared technology systems so providers can communicate and share information easily

Provider Transformation
Help rural hospitals and clinics modernize how they operate, including strategic renovations

***ToRCH Care will be implemented through RCNs and Hubs** – Hubs are provider-led virtual entities that coordinate patient care, while RCNs oversee regional implementation and performance*

NON-EXHAUSTIVE

RCNs and Hubs will enable:

Care coordination: Deploy in-person, mobile, and virtual services to ensure timely and convenient access to care

Access expansion: Expand access points across all rural counties by integrating providers (e.g., EMS[1], hospitals, FQHCs[2], specialty, pharmacies) into a seamless system of care

Program localization: Launch, expand, and/or enhance community-defined program (e.g., perinatal home visiting, school-based care, nutrition and transportation support) tailored to local health needs

100% of rural Missourians connected to Hubs by 2031

1. Emergency medical services
2. Federally qualified health centers

***Digitization** will create a **foundation for modernized health data** infrastructure to drive seamless exchange of patient health data and **track outcomes** across provider partners*

NON-EXHAUSTIVE

The Digital Backbone will enable:

- **EHR[1] modernization:** Upgrade rural health facility and provider data-sharing tools to enable secure patient data-sharing for smoother care coordination
- **Social-care referral platform:** Connect health and community providers (e.g., food/nutrition) via a shared platform that tracks patient journeys in real-time (e.g., services received, social needs, referrals)
- **Provider training:** Offer ongoing technical assistance in adoption of new data and reporting tools, and technology upgrades to reduce administrative burden
- **Data and AI governance:** Establish statewide standards for privacy, security and responsible AI use

≥ 60% of rural facilities connected via certified interfaces

1. Electronic health records

Deep Dive: Rural Health Workforce Programs

*A statewide initiative will create an **integrated rural health workforce pipeline** that connects education, training, and employment to **grow and retain Missouri's health care talent locally***

NON-EXHAUSTIVE

Rural health workforce programs will enable:

New health care entry points: Expose rural schools to health care careers and certifications early and expand in-state medical school training opportunities

Specialty workforce expansion: Launch programs and pipelines across key behavioral and maternal health roles, like certified nurse midwifes, doulas and perinatal CHWs

Workforce retention: Provide incentives for rural placements (e.g., childcare, housing, awards) to keep providers in rural areas and reduce provider burden

≥ 4,000 rural health care workers trained or retained

Strengthens rural health care infrastructure by ***funding operational innovations and facility modernization*** *to improve* ***access, efficiency and long-term provider sustainability***

NON-EXHAUSTIVE

Provider transformation will enable:

EHR integrated AI: Licensing and implementation support for providers to adopt Ambient AI to automate documentation, streamline workflow and provide real-time recommendations, all to help reduce clinician workload and administrative burden

Remote patient monitoring (RPM): Link ongoing performance data into EHRs to drive proactive patient health management

Strategic renovations: Invest in minor infrastructure improvements to help rural providers stabilize essential services and enable patient safety

Service and access restored and preserved

Deep Dive: Alternative Payment Models (APMs)

***APM will** enable providers to **shift from volume-based care to value-based models** that reward improved health outcomes and reduced avoidable costs, allowing savings to be reinvested*

NON-EXHAUSTIVE

APMs will enable:

Cross-partner engagement: Engage with key players (e.g., MCOs, commercial payers, Medicare Advantage plans) to co-create incentives tied to provider care quality and improved patient outcomes

Long-term sustainability: Reinvest shared savings into community priorities or offsetting provider costs to ensure continued access and quality of care beyond RHTP funding

Flexibility in care provision: Allow rural providers to move beyond fee-for-service or “billing-volume” to less burdensome, outcome-driven service approaches

≥ 50% of rural Missourians covered under value-based contracts, generating shared savings for reinvestment

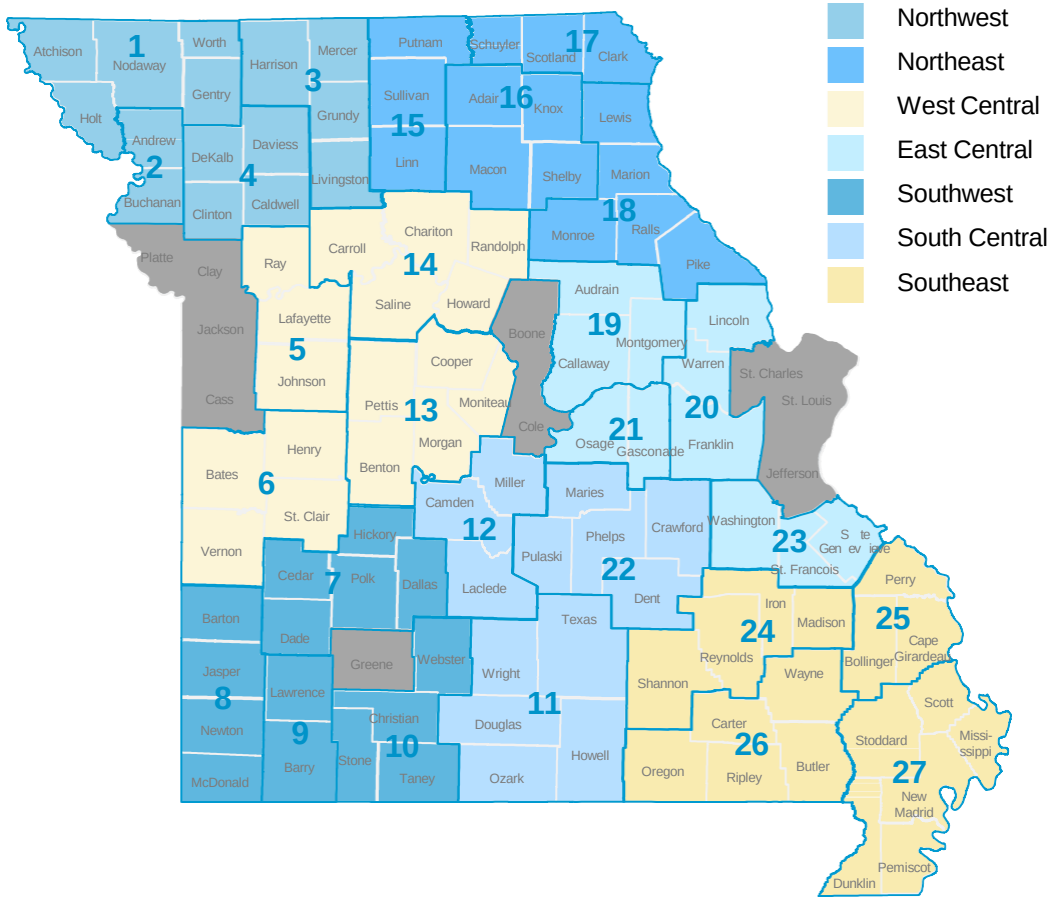
Official Hub & RCN boundaries

27 official Hubs

Convene and coordinate at local level across partner types

7 official RCNs

Drive regional strategy and provide Hubs with implementation support



Source: MO RHTP RCNs/Hubs sessions

Medicaid DSH is a FEDERAL program (Administered by the States)

The state **must pay** DSH payments to hospitals that meet specific obstetric requirements set forth in regulation and have either a Medicaid inpatient utilization rate at least one (1) standard deviation above the state mean or a low-income utilization rate greater than twenty-five percent (25%).

The state **may elect** to make DSH payments to hospitals that meet the OB requirements and have a Medicaid inpatient utilization rate of at least one percent (1%).

The state **cannot** make DSH payments in excess of each hospital's estimated hospital-specific DSH limit.

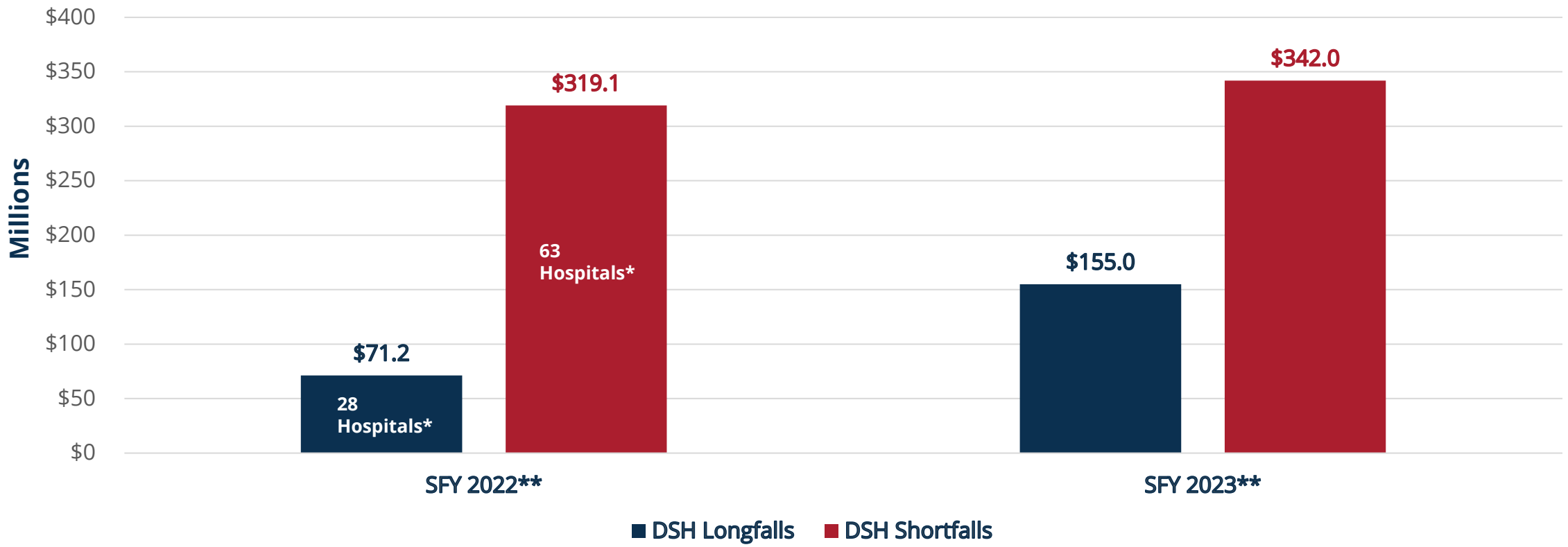
Disproportionate Share Hospital Payments

Medicaid DSH Program

- Purpose
  - Helps hospitals that serve a “disproportionate share” of Medicaid/uninsured patients by offsetting uncompensated care costs.
- DSH Payment Limit
  - A hospital’s DSH payments **cannot exceed its total uncompensated care costs (UCC)** for Medicaid shortfall + uninsured care.
- Missouri Participation
  - MO HealthNet distributes DSH payments to qualifying hospitals. Any federal DSH cuts or state funding changes directly impact these payments.

State Fiscal Year 2022 and 2023 Final DSH Audits

DSH Longfalls and Shortfalls SFY 2022 and SFY 2023



*Two bankruptcy hospitals with DSH longfalls (totaling $1,773,163) have been excluded. One closed hospital with a DSH shortfall (totaling $5,703,235) has been excluded as well.
**Note: The State Institutions of Mental Disease (IMDs) have been excluded from the above figures.

SFY 2022 DSH Audit

Settlement Update

- MHD issued recoupment notices to the hospitals with SFY 2022 DSH audit liabilities. These liabilities must be paid by September 30, 2026.
- MHD plans to redistribute the funds to hospitals that have SFY 2022 DSH shortfalls on one of the December 2026 payrolls.

Unspent DSH Allotment

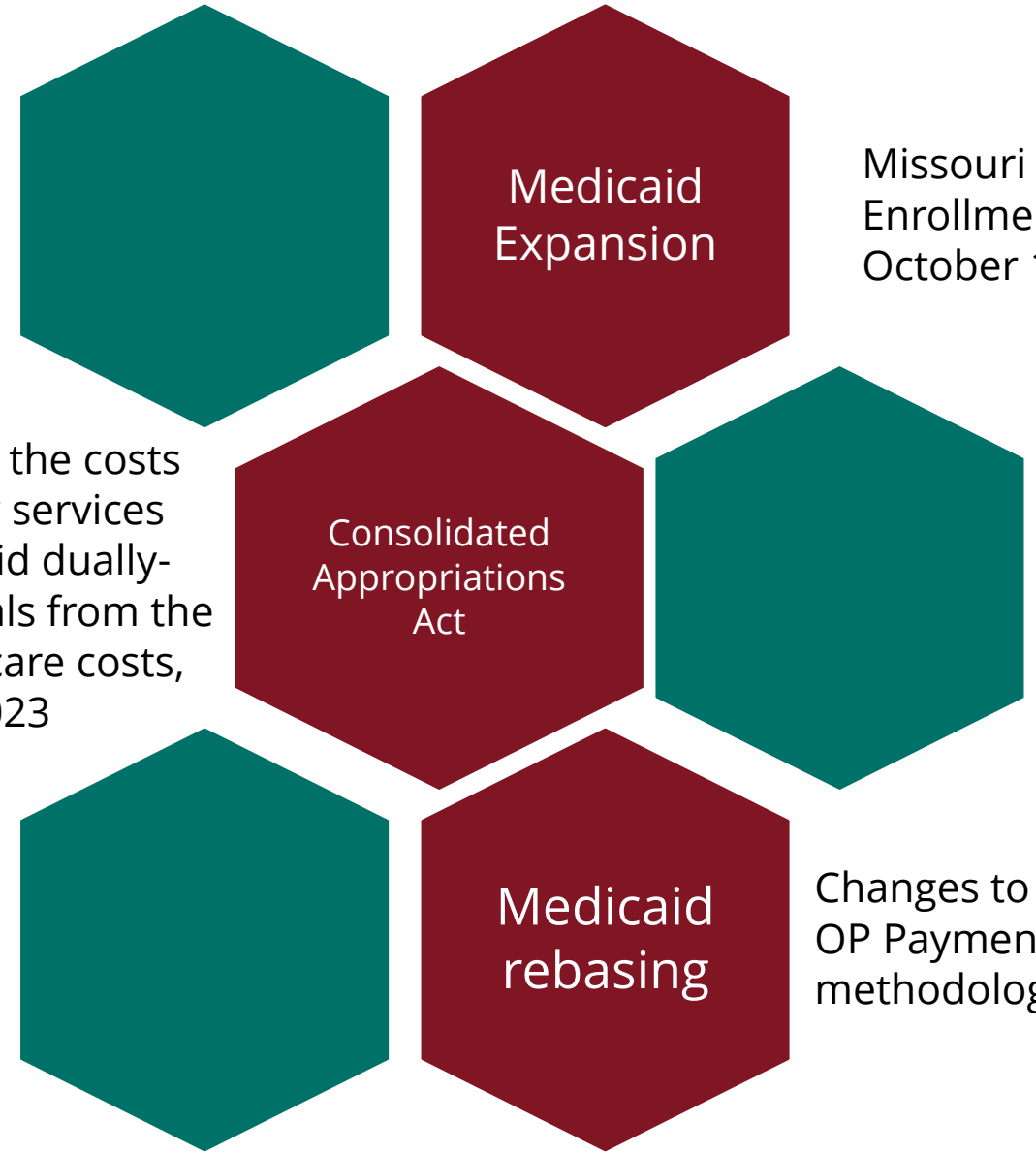
- The current SFY 2027 FRA assessment rate of 5.0% will generate sufficient funds to process approximately $182.8 million in unspent DSH allotment payments for SFY 2022.
- These payments will be processed in June 2027.

SFY 2023 DSH Audit Settlement Update

- Meyers and Stauffer shared the SFY 2023 draft independent DSH audit with the MO HealthNet Division.
- The final audit is not due to the Centers for Medicare & Medicaid Services until December 31, 2026.

State Fiscal Year 2023

Why hospitals may experience DSH liability for the first time



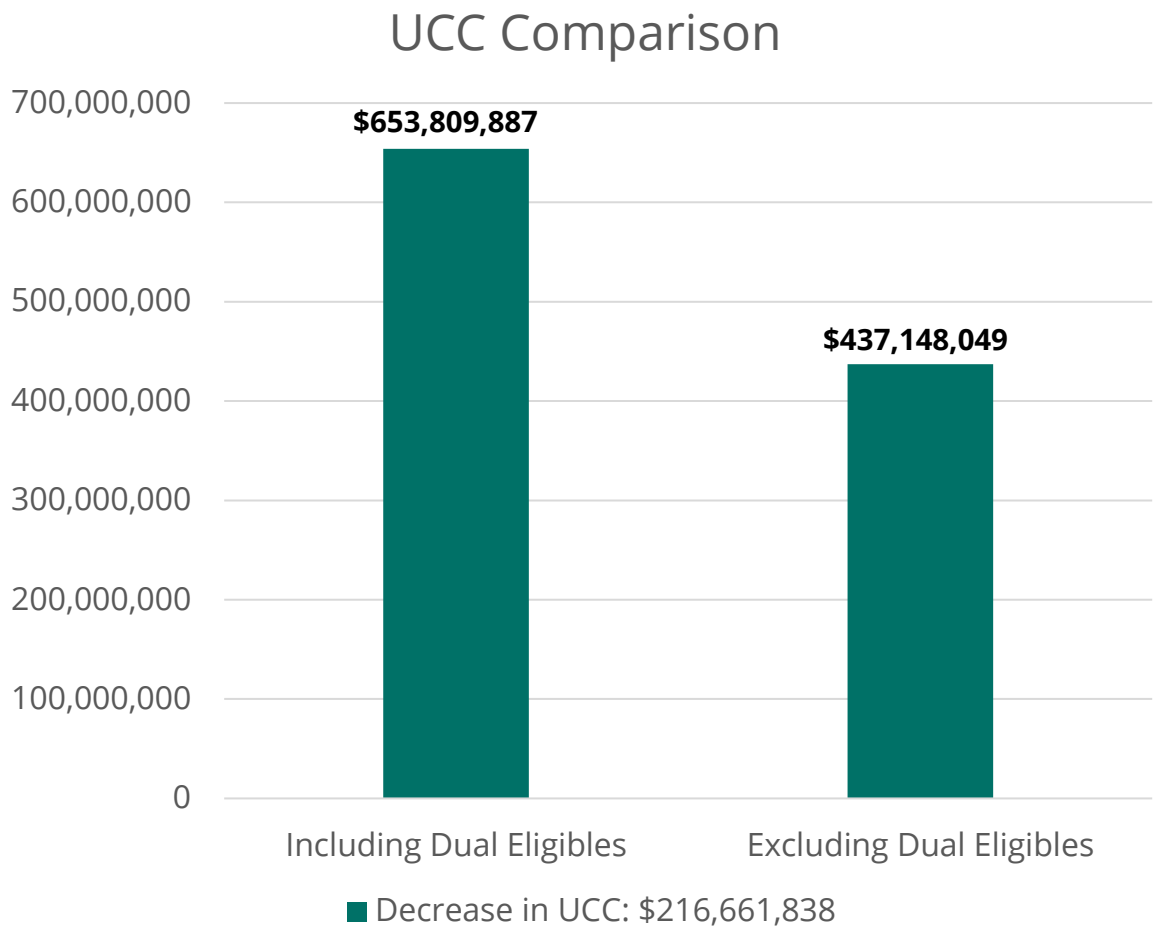
Missouri – Enrollment began October 1, 2021

Act excludes both the costs and payments for services related to Medicaid dually-enrolled individuals from the uncompensated care costs, effective July 1, 2023

Changes to both IP and OP Payment methodologies

Consolidated Appropriations Act

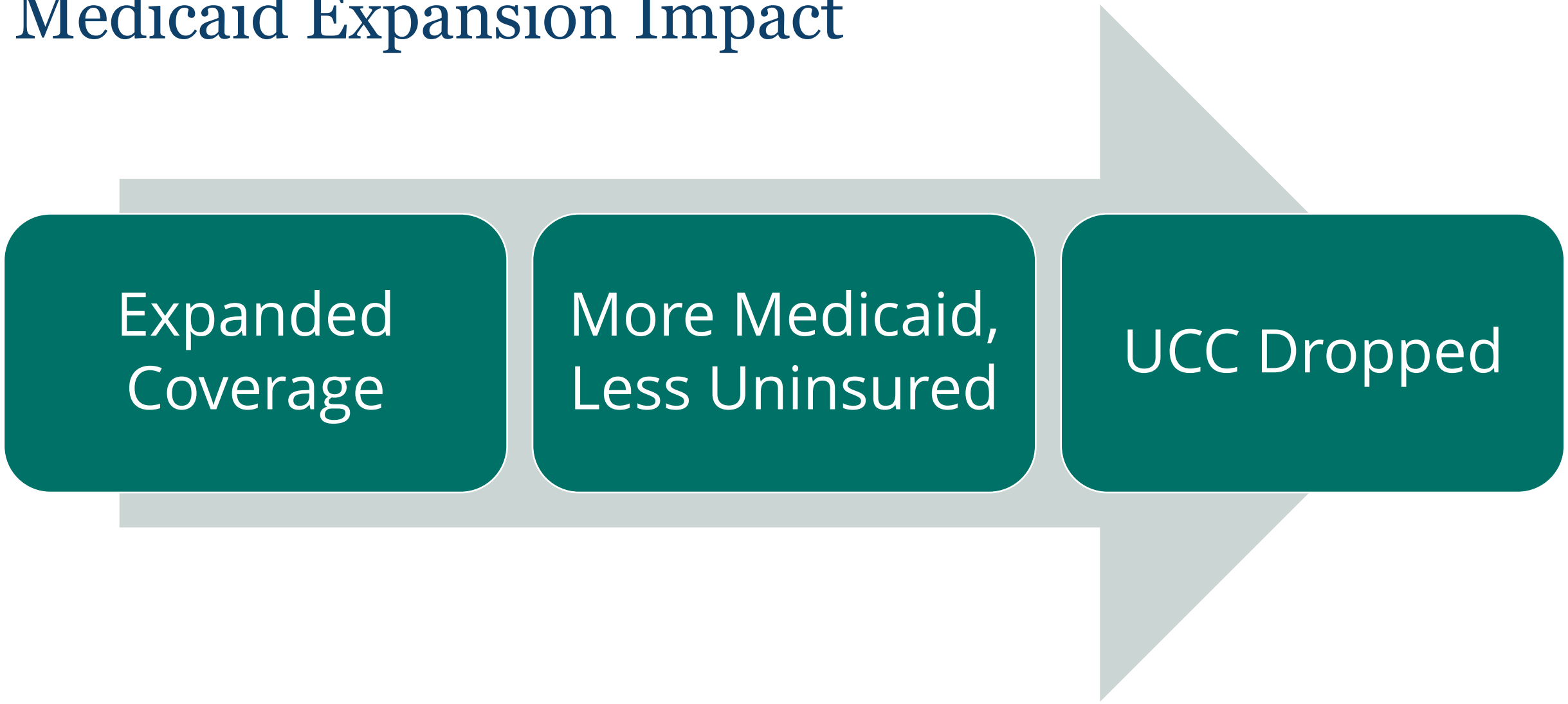
- Patients with Third-Party Liability (Medicare or commercial coverage) are excluded from Medicaid DSH
  - Effective for SFY 2023
  - Removes crossover and other Medicaid-eligible populations from DSH limit
- Supplemental Payment Provisions
  - States were "encouraged" to consider moving from supplemental payment, or add-on payment methodologies, to incorporate into rates
  - For this reason, and others, Missouri rebased inpatient rates effective SFY 2023



MHD Guidance on CAA (2026) UCC and DSH Implications

- Consolidated Appropriations Act of 2026 was enacted on February 3
- Required state interpretation of DSH calculations
- MHD guidance was released to MHA on July 9
  - Beginning with state fiscal year 2024, uncompensated care costs will be calculated based on the most favorable option of:
    - Medicaid primary and uninsured **or**
    - Medicaid primary, Medicaid duals (Title 18 and applicable plans primary) and uninsured
  - For those hospitals who qualify for the 97th percentile exception, the calculation for SFY 2024 can consider the best outcome among:
    - Medicaid primary and uninsured
    - Medicaid primary, Medicaid duals (Title 18 and applicable plans primary) and uninsured **or**
    - All Medicaid eligibles and uninsured
  - No hospital will face a penalty under the new UCC methodology as overpayments cannot increase. However, some overpaid hospitals may benefit by seeing a reduction in their overpayment amounts.
  - This change may reduce potential Disproportionate Share Hospital liabilities and allow hospitals to release reserves as part of SFY 2026 year-end calculations.

Medicaid Expansion Impact



Medicaid Rate Change Impacts

Outpatient - Simplified Fee Schedule started July 20, 2021.

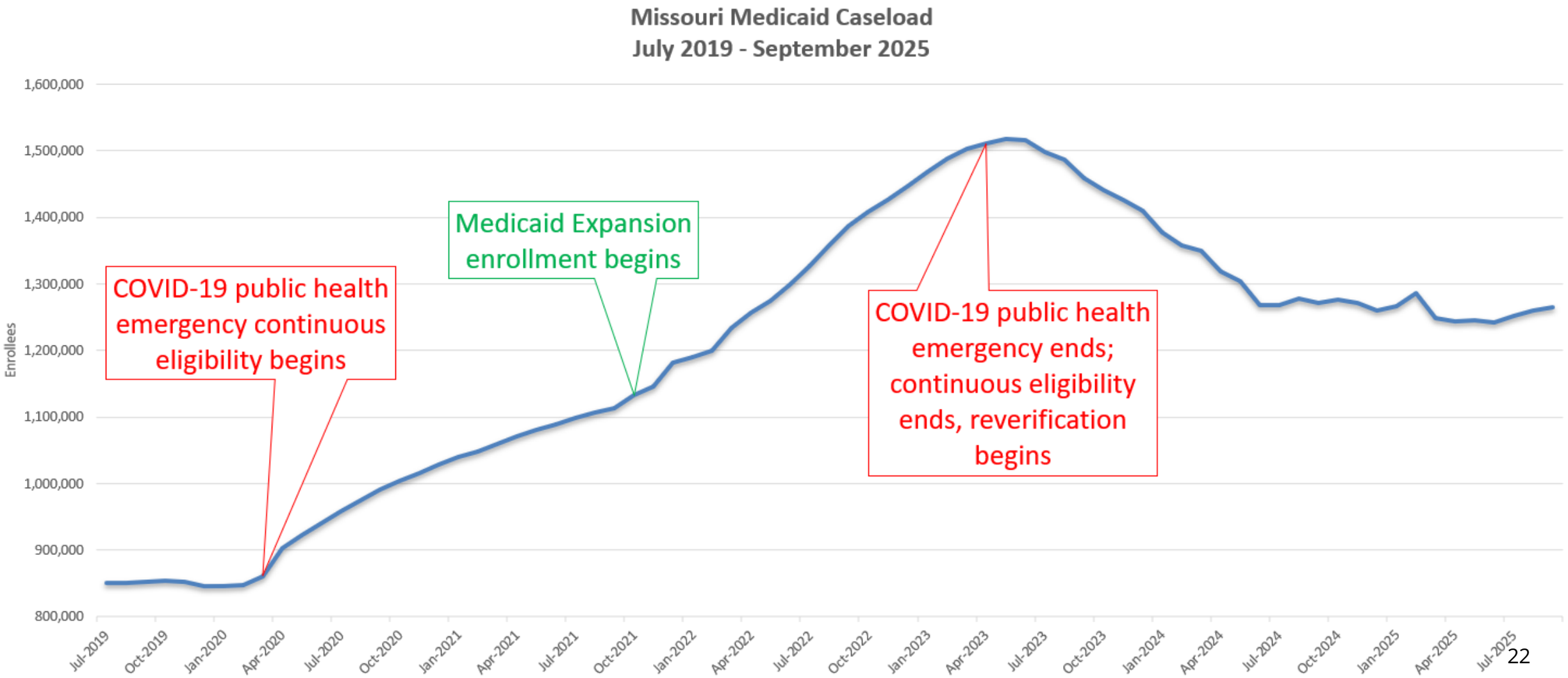
Previously paid on a percent of charge

Inpatient – Per diem rates are updated to third prior-year cost report, starting July 1, 2022, to be cost-based.

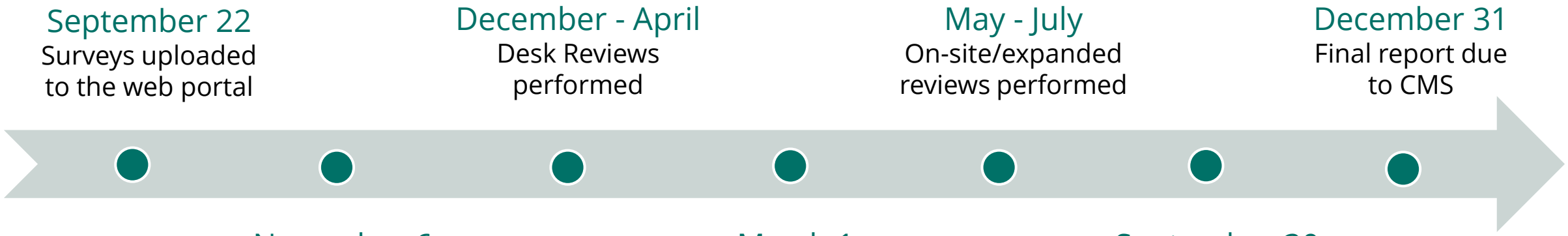
Previously paid on a 1995 per-diem rate

Inpatient – Moved to DRG effective July 1, 2025.

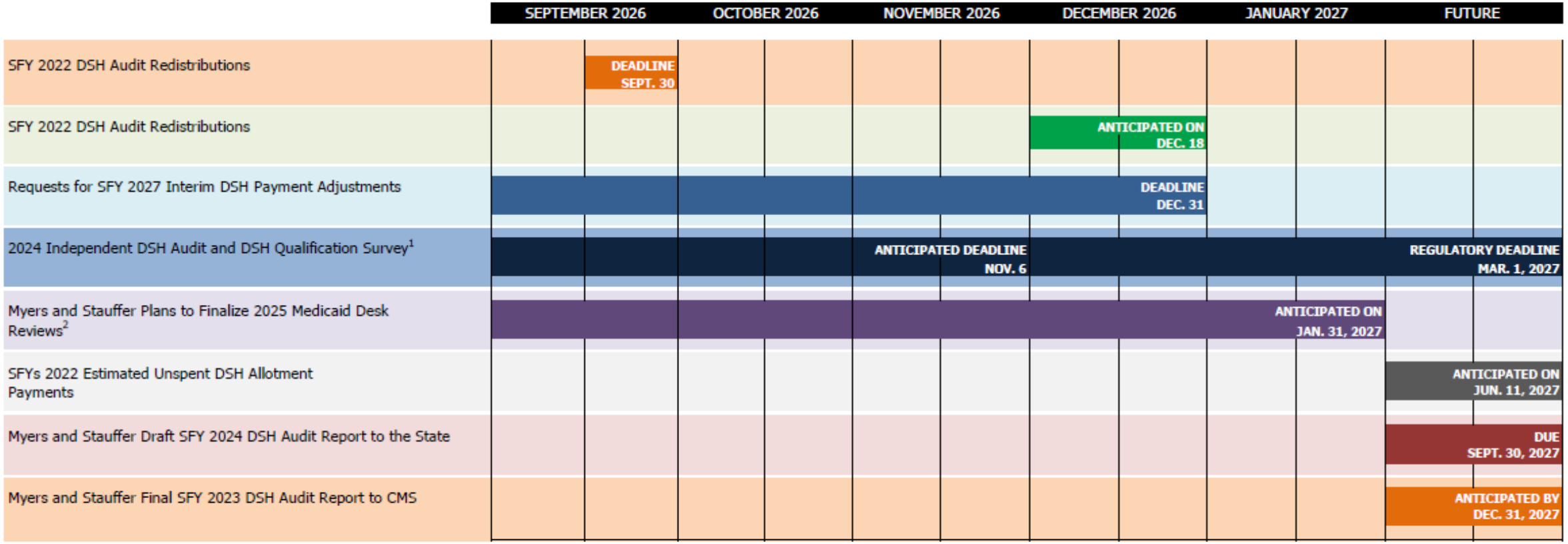
Medicaid Caseload Over Time



DSH Timeline



MO HealthNet Division and MHA Management Services Corporation Timeline



Notes:

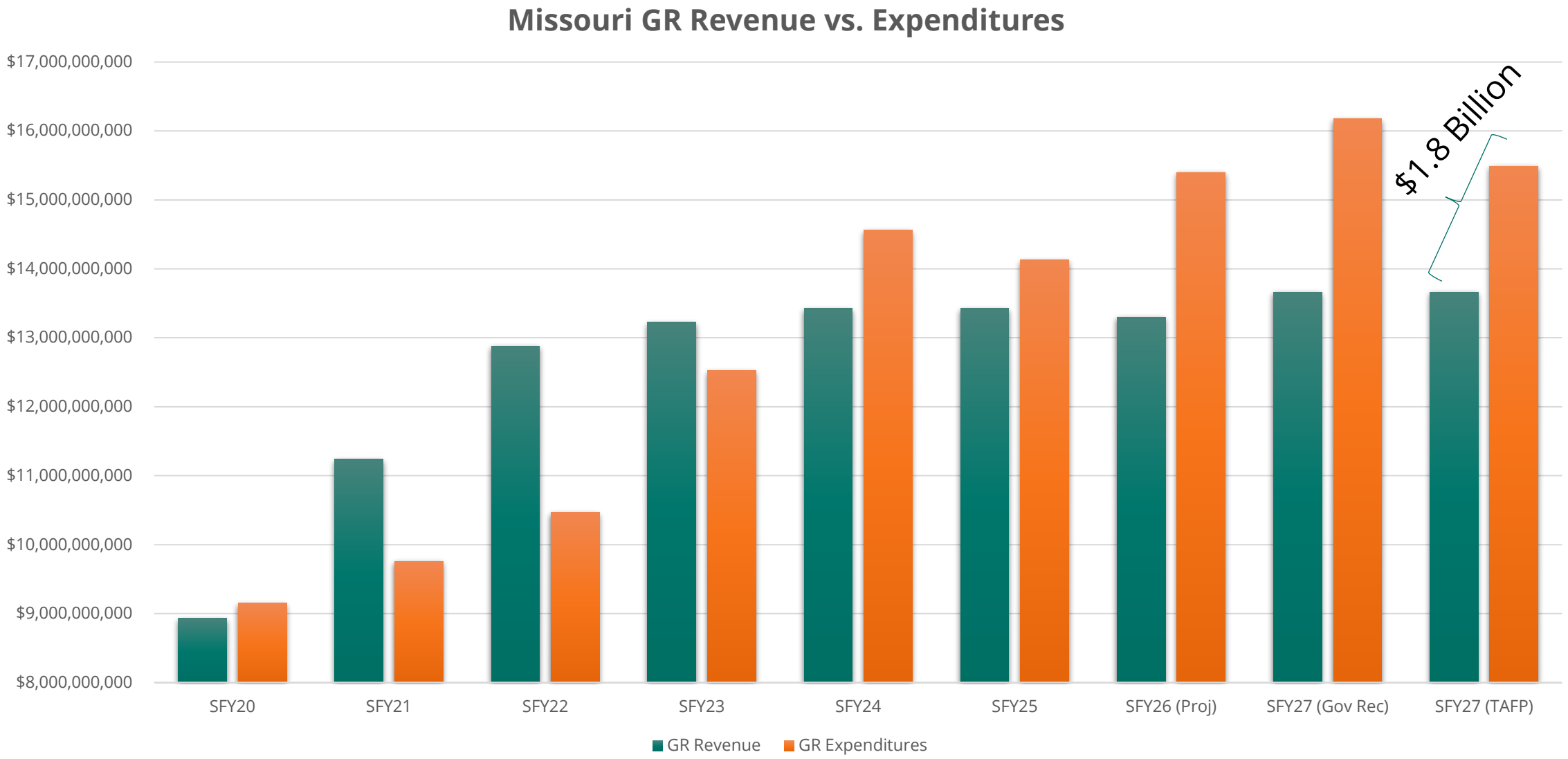
1. In accordance with state regulation 13 CSR 70-15.220, Disproportionate Share Hospital Payments, hospitals that do not submit a DSH survey by March 1, 2026, will not be eligible to receive an interim SFY 2028 DSH payment. Hospitals that are not included in the SFY 2023 independent DSH audit will be contacted to complete a survey or submit a waiver.
2. For state fiscal year 2028, the taxable revenue calculation will again be completed as part of the desk review performed by Myers and Stauffer.

Access to the FRA Website

- You can access your hospital-specific forms, explanation of SFY 2027 terms and the FRA tutorial by visiting the following website: www.mhanet.com/docshare

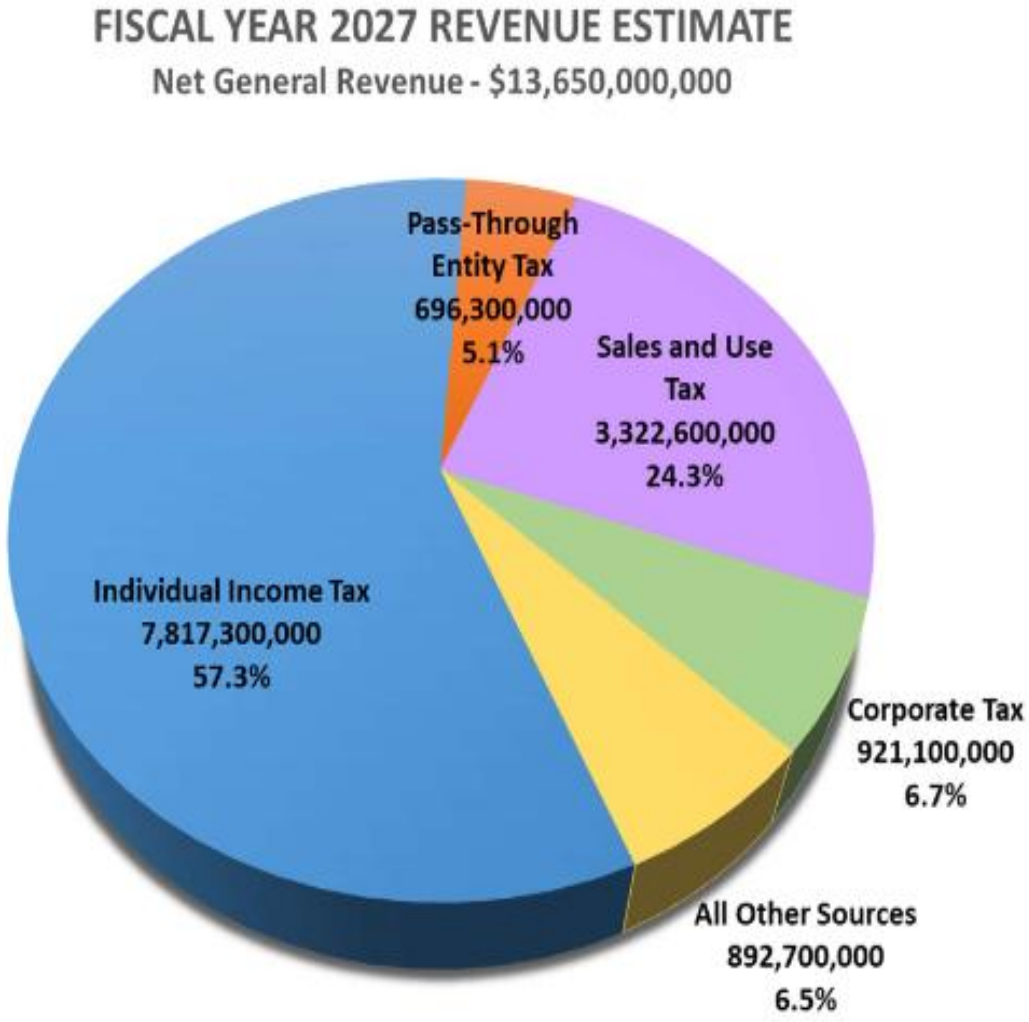
  - Request Username and Password
  - Enter Username and Password
  - Click on Download
  - Click on FRA for Hospital-Specific Forms
  - Click on Info for explanation of SFY 2027 terms and the FRA Tutorial
  - For assistance, contact botto@mohospitals.org

State of Missouri Budget


Missouri GR Revenue vs. Expenditures
$17,000,000,000
$16,000,000,000
$15,000,000,000
$14,000,000,000
$13,000,000,000
$12,000,000,000
$11,000,000,000
$10,000,000,000
$9,000,000,000
$8,000,000,000
$1.8 Billion
SFY20
SFY21
SFY22
SFY23
SFY24
SFY25
SFY26 (Proj)
SFY27 (Gov Rec)
SFY27 (TAFP)
GR Revenue
GR Expenditures

SFY 2027 Revenue Projections and Sources

- Projected SFY 2027 net general revenue collections — $13.650 billion
  - Individual Income Tax $7.82 billion
  - Sales and Use Tax $3.32 billion
  - Corporate Income Tax $0.92 billion
  - All Other Sources $0.89 billion

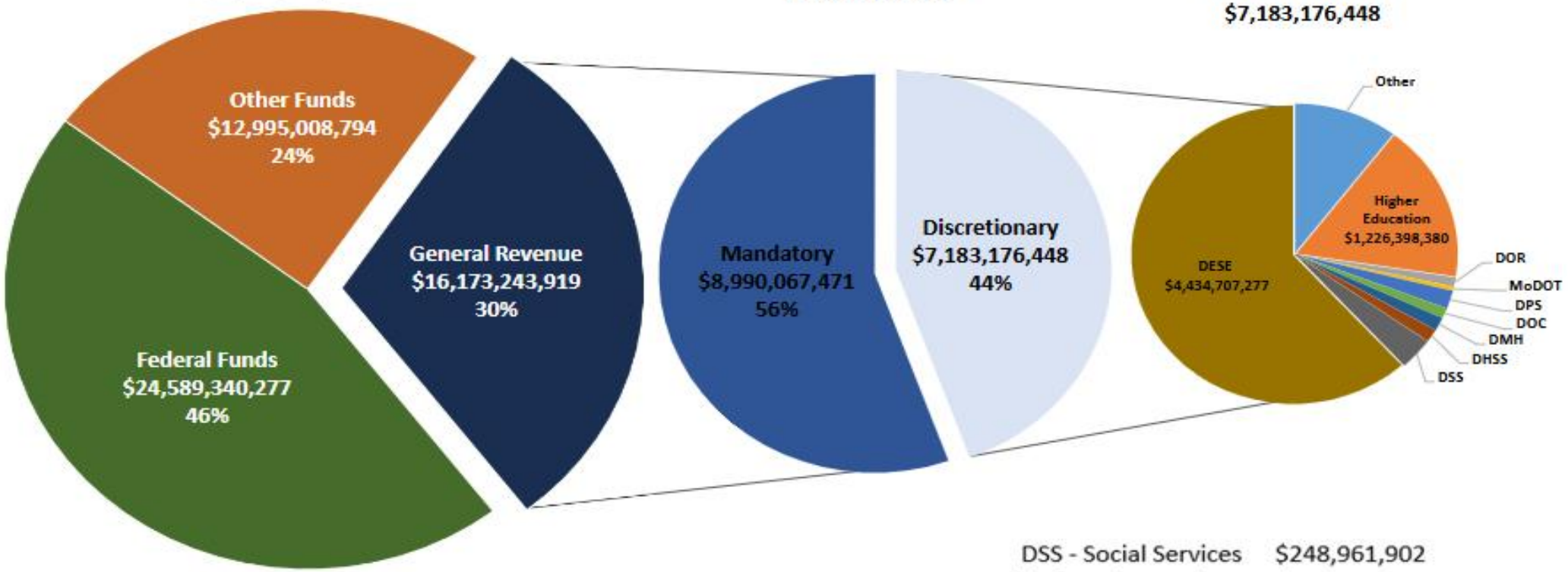


FISCAL YEAR 2027 GOVERNOR'S RECOMMENDED OPERATING BUDGET

TOTAL BUDGET (ALL FUNDS)
***$53,757,592,990**

TOTAL GENERAL REVENUE
$16,173,243,919

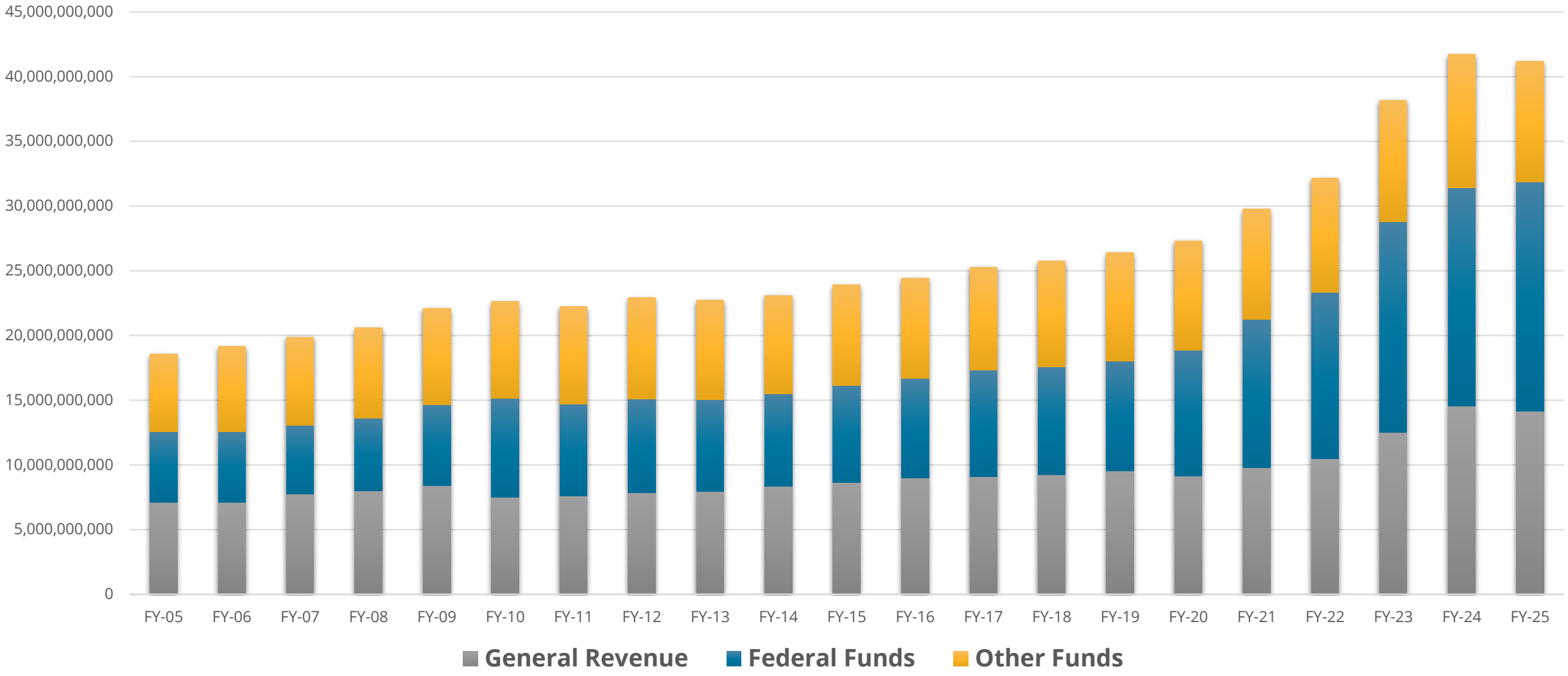
DISCRETIONARY GENERAL REVENUE
$7,183,176,448



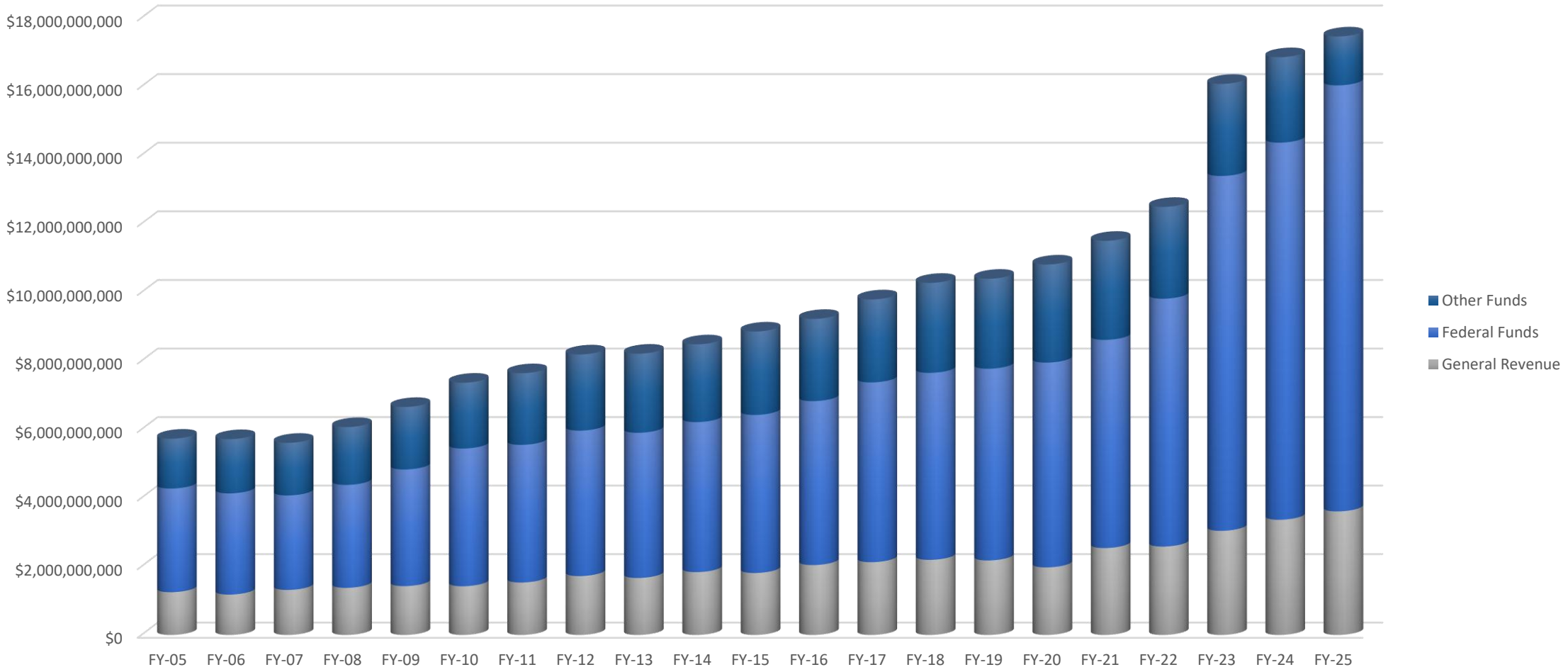
DSS - Social Services	$248,961,902
DHSS - Health & Senior Services	$100,554,055
DMH - Mental Health	$102,337,855
DOC - Corrections	$80,480,063
DPS- Public Safety	$138,942,250
MoDOT - Transportation	$32,264,777
DOR - Revenue	$72,633,561

*Excludes Refunds

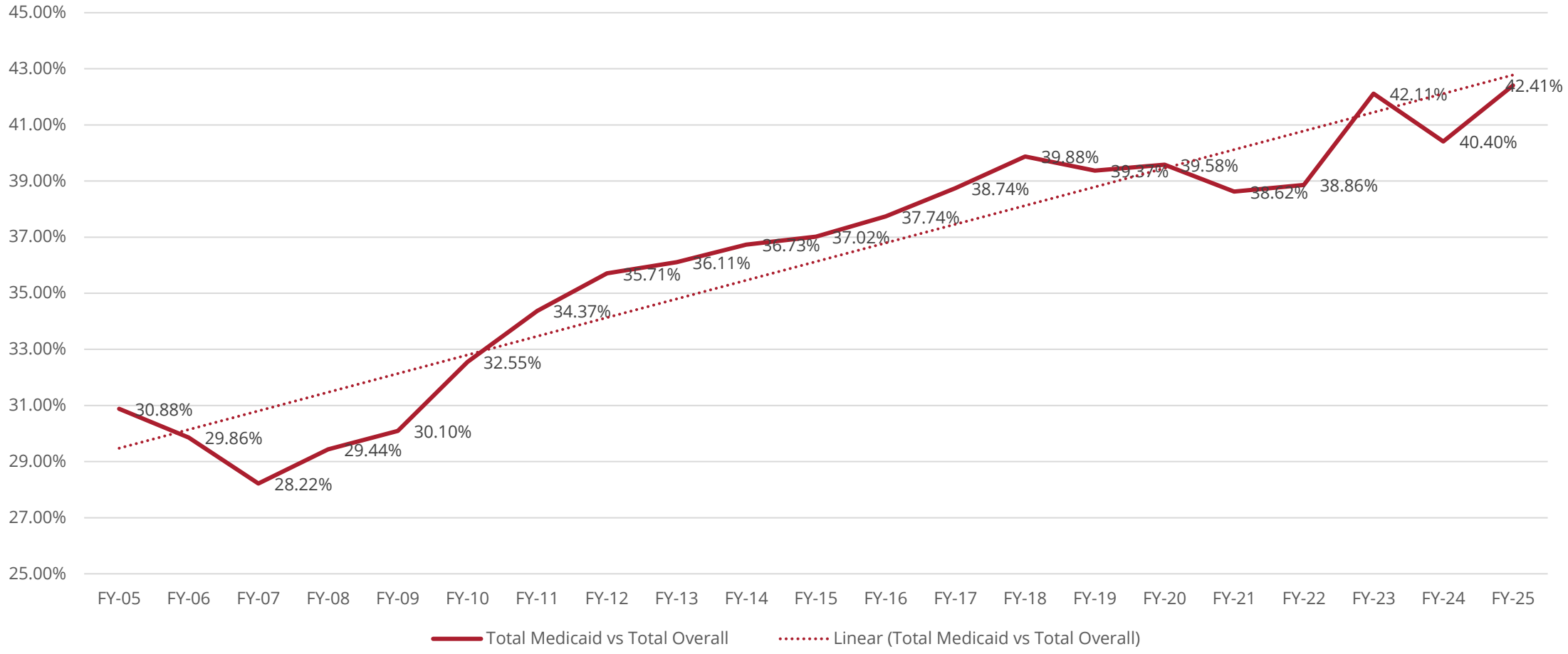
Missouri's Total Budget



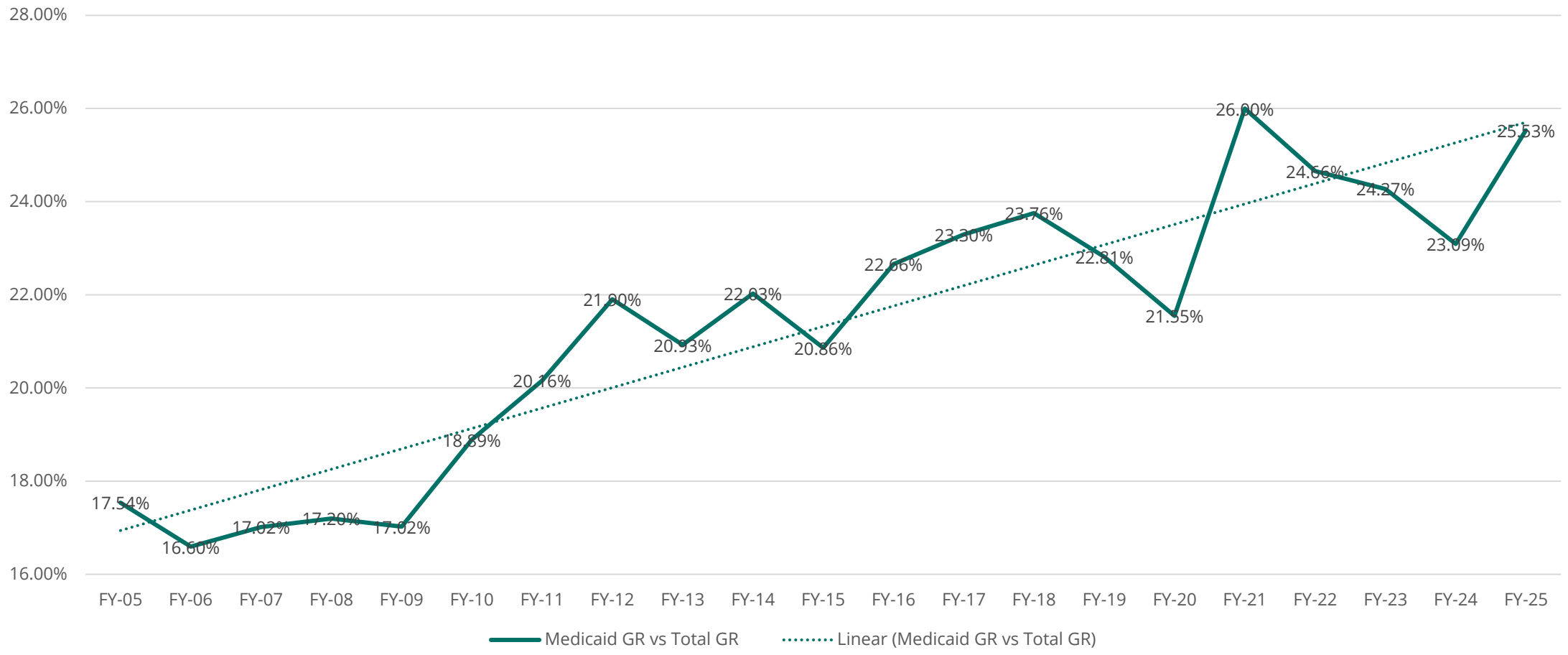
Medicaid Expenditures FY 05 – FY 25



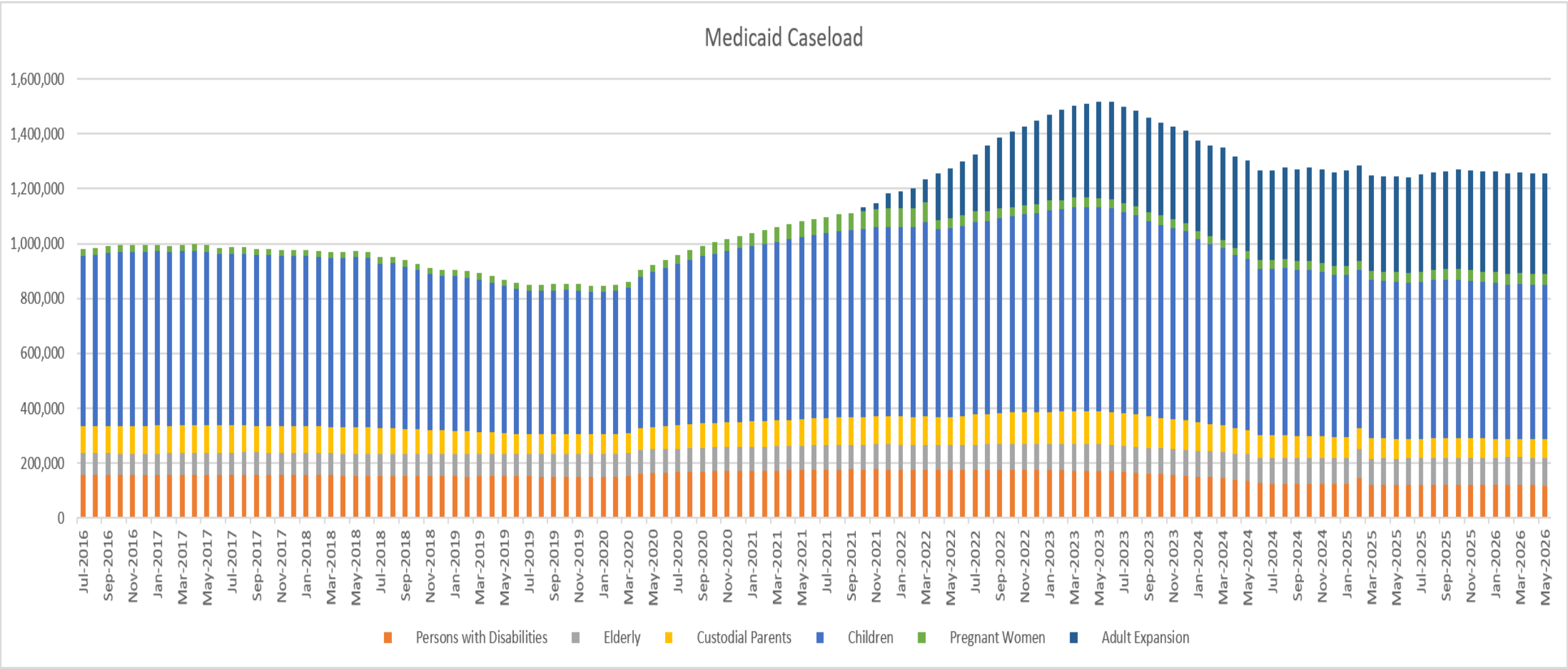
Medicaid as a Percent of Missouri's Total Budget FY 05 – FY 25



Medicaid as a Percent of Missouri's Total General Revenue FY 05 – FY 25



Medicaid Caseload

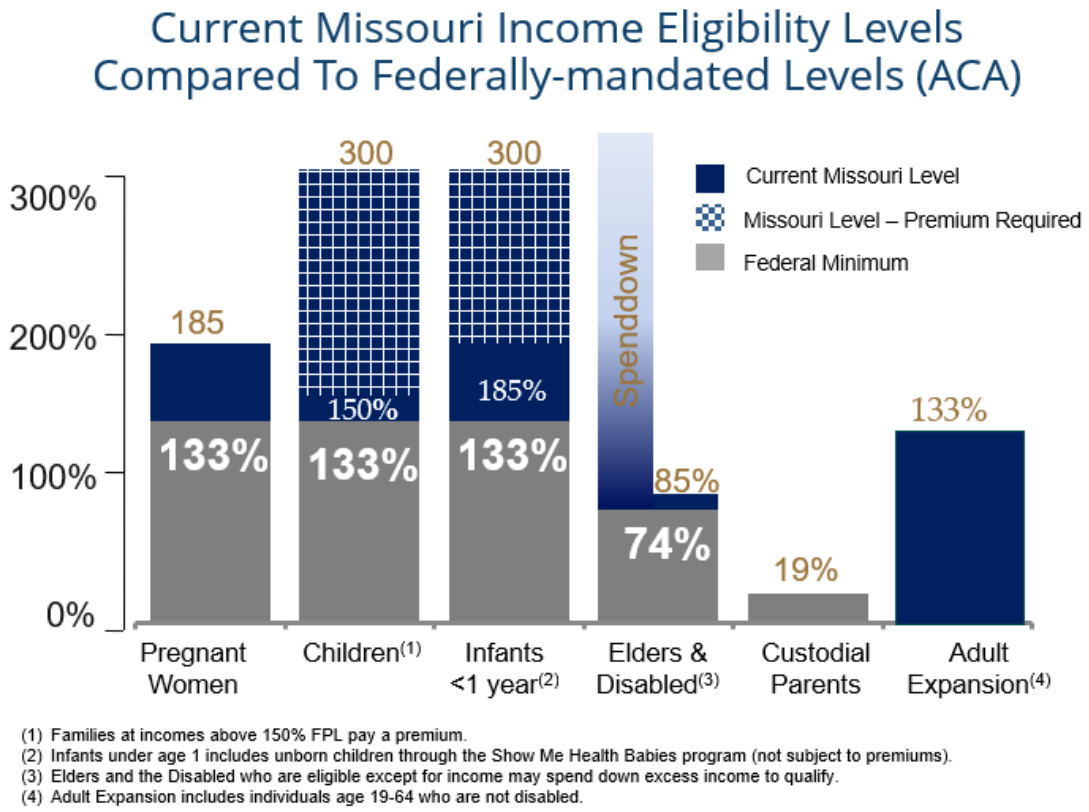


Medicaid Cuts

- Who is covered?
- What is covered?
- How much the state pays for it?

If we can't produce scalpel-like reductions, we are going to get hit with a blunt ax!

Who is Covered



(1) Families at incomes above 150% FPL pay a premium.
(2) Infants under age 1 includes unborn children through the Show Me Health Babies program (not subject to premiums).
(3) Elders and the Disabled who are eligible except for income may spend down excess income to qualify.
(4) Adult Expansion includes individuals age 19-64 who are not disabled.

- Lower pregnant women from 185% to 133% FPL
- Lower who is eligible with a premium payment
- Lower children from 150% to 133% FPL
- Lower infants from 185% to 133% FPL
- Lower disabled and elderly from 85% to 74% FPL

What is Covered

- Mandatory Services
  - Hospital (IP/OP)
  - Nursing Facility
  - Physician Related
  - Home Health
  - Non-Emergency Medical Transportation
  - Nurse Midwife
  - Medication Assisted Treatment
  - FQHCs / RHCs
- Optional Services
  - Pharmacy
  - Dental
  - Dentures
  - Mental Health Services
  - Hospice
  - CCBHCs
  - Home and Community-Based Services
  - Physical/Occupational/Speech Therapy

What the State Pays - Inpatient

- Could lower APR-DRG base payments
  - Could lower just out-of-state hospital rates
- Could not update the wage index to FFY 2026
- Could move policy adjustors down
- Could increase the coding impact from 1% that would result in decreased payment amounts

What the State Pays – Outpatient

- Could lower percent of Medicare rate down from 90% (attempted this year)
- Could not grant Medicare adjustment (2.4% increase last year)
- Could lower percentage down for certain procedures
- Could implement a site-neutral type policy for payments

Upcoming Federal Changes

- Work / Community Engagement Requirements – January 1, 2027
- State Directed Payment Reductions – 10-year period begins January 1, 2027
- Provider Tax Rate Reductions
- Pressures on 340B

APR-DRG SFY 27 Recap

- APR-DRG Changes from SFY 2026 to SFY 2027
  - Updated from APR-DRG Version 42 to 43
  - Updated wage index from FFY 2025 to FFY 2026
  - Added a 1% coding impact to reflect anticipated aggregate increases in coding intensity
  - In-state hospital base rate: $7,685 → $7,745
  - Out-of-state hospital base rate: $3,672 → $3,998
  - Policy Adjusters
    - Pediatrics 1.70 → 1.51
    - Obstetrics 1.27 → 1.14
    - General Medicine 1.31 → 1.31
    - Mental Health and Substance Abuse 1.92 → 2.00

Questions

MHA Management Services

Thank You

We would like to thank Emily Reese and Forvis Mazars for DSH-related data and resources used in this presentation.