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

PROPOSED AMENDMENT

13 CSR 70-15.015 *[Direct Medicaid]*Supplemental Payments. The division is amending section (1) and adding sections (2) – (14)

PURPOSE: This proposed amendment updates the title of the regulation and adds supplemental payments.

(1) **Definitions**

(A) Base year cost report. Audited Medicaid cost report from the third prior calendar year. If a facility has more than one (1) cost report with periods ending in the third prior calendar year, the cost report covering a full twelve- (12-) month period will be used. If none of the cost reports covers a full twelve- (12-) months, the cost report with the latest period will be used. If a hospital's base year cost report is less than or greater than a twelve- (12-) month period, the data shall be adjusted, based on the number of days reflected in the base year cost report to a twelve- (12-) month period. Any changes to the base year cost report after the division issues a final decision on assessment or payments will not be included in the calculations.

(B) Case mix index (CMI). The hospital CMI is determined based on the hospital's MO HealthNet inpatient claims and Solventum All-Patient Refined Diagnosis Related Groups (APR-DRG) software, a grouping algorithm to categorize inpatient discharges with similar treatment characteristics requiring similar hospital resources.

1. For SFY 2026 and forward, the basis of the case mix index will be determined by the division based on the inpatient dataset utilized in the annual update of the Missouri APR-DRG reimbursement methodology.

(C) Cost report. A cost report details, for purposes of both Medicare and MO HealthNet reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.

(D) Division. Unless otherwise designated, division refers to the MO HealthNet Division (MHD), a division of the Department of Social Services charged with the administration of the MO HealthNet program.

(E) Medicaid fee-for-service (FFS) inpatient days. Medicaid FFS inpatient days are paid Medicaid FFS days for inpatient hospital services as reported by the Medicaid Management Information System (MMIS) from the second prior calendar year.

(F) Medicaid managed care (MC) inpatient days. Medicaid MC inpatient days are paid Medicaid MC days for inpatient hospital services as reported by the Managed Care Health Plans on the Hospital Services Reporting Form from the second prior calendar year.

(G) Federal reimbursement allowance (FRA). The fee assessed to hospitals for the privilege of engaging in the business of providing inpatient health care in Missouri. The FRA shall be an allowable cost to the hospital. The FRA is identified in 13 CSR 70-15.110. Effective January 1, 1999, the assessment shall be an allowable cost.

(H) State deemed Critical Access Hospital (CAH). A public hospital located in a county in the Missouri Bootheel with no more than 105 acute care inpatient beds.

(2) Inpatient Direct Medicaid Payments.

(A) Inpatient direct Medicaid payments will be made to hospitals that are reimbursed under an APR-DRG reimbursement methodology for the following allowable MO HealthNet cost:

1. The increased MO HealthNet cost resulting from the FRA assessment becoming an allowable cost on January 1, 1999.

(B) The Division will calculate the inpatient direct Medicaid payment as follows:

1. The Medicaid share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid days, FFS and MC, by the total inpatient hospital days from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current state fiscal year (SFY) to arrive at the increase allowable Medicaid cost for the inpatient FRA assessment. This amount will then be divided by the total of Medicaid FFS inpatient days and Medicaid MC inpatient days to arrive at a per day amount; and

2. The per day amount calculated in (1)(B)1. will be multiplied by the Medicaid FFS inpatient days to arrive at the FFS inpatient direct Medicaid payment.

(C) The Division will calculate the inpatient direct Medicaid payment for new hospitals as follows:

1. In the absence of adequate cost report data, a new hospital's Medicaid share of the inpatient FRA assessment shall be one hundred percent (100%) of the weighted average statewide Medicaid per day amount, as calculated in paragraph (1)(B)1., for the hospital type (i.e., acute care hospital, psychiatric hospital, long term care hospital, rehabilitation hospital); and

2. In the absence of Medicaid FFS inpatient days, a new hospital's paid days shall be one hundred percent (100%) of the average statewide Medicaid FFS inpatient days for the hospital type (i.e., acute care hospital, psychiatric hospital, long term care hospital, rehabilitation hospital). These days are then multiplied by the per day amount calculated in (1)(C)1. to arrive at the FFS inpatient direct Medicaid payment.

(D) Effective for payments made on or after July 1, 2025, only the FFS component of the Medicaid share of the inpatient assessment will be included in the inpatient direct Medicaid payment.

(3) Outpatient Direct Medicaid Payments.

(A) Outpatient direct Medicaid payments will be made to hospitals for the following allowable MO HealthNet cost:

1. The increased MO HealthNet cost resulting from the *[Federal Reimbursement Allowance (]*FRA*[)]* assessment becoming an allowable cost on January 1, 1999.

(B) The *[MO HealthNet]* Division will calculate the outpatient direct Medicaid payment as follows:

1. The Medicaid share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient Medicaid charges, *[fee-for-service (]*FFS*[)]* and *[managed care (]*MC*[)]*, by the total outpatient hospital charges*[, FFS, and MC,]* from the base year cost report to arrive at the Medicaid utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current *[state fiscal year (]*SFY*[)]* to arrive at the increased allowable Medicaid cost for the outpatient FRA assessment; and

2. The FFS outpatient ratio will be calculated by dividing the hospital's outpatient FFS Medicaid charges by the hospital's outpatient Medicaid charges, FFS*[,]* and MC. This ratio is then multiplied by the increased allowable Medicaid cost for the outpatient FRA assessment to arrive at the FFS **outpatient** direct Medicaid payment.

(C) The *[MO HealthNet]*Division will calculate the outpatient direct Medicaid payment for new hospitals as follows:

1. In the absence of *[adequate cost data]***a base year cost report**, a new hospital's Medicaid share of the outpatient FRA assessment shall be one hundred percent (100%) of the weighted average statewide Medicaid utilization percentage, as calculated in paragraph (1)(B)1., for the hospital type (i.e., acute care hospital, psychiatric hospital, long term care hospital, rehabilitation hospital). This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable Medicaid cost for the outpatient FRA assessment; and

2. In the absence of *[adequate cost data]***a base year cost report**, a new hospital's FFS outpatient ratio shall be one hundred percent (100%) of the weighted average statewide FFS outpatient ratio, as calculated in paragraph (1)(B)2., for the hospital type (i.e., acute care hospital, psychiatric hospital, long term care hospital, rehabilitation hospital). This ratio is then multiplied by the increased allowable Medicaid cost for the outpatient FRA assessment to arrive at the FFS direct Medicaid payment.

(D) Effective for payments made on or after July 1, 2022, only the FFS component of the Medicaid share of the outpatient FRA assessment will be included in the outpatient direct Medicaid payment.

(4) Acuity Adjustment Payment (AAP).

(A) Beginning with SFY 2026, hospitals that are paid on a *per diem* and meet the requirements set forth below shall receive an AAP. A hospital that is designated as a long-term acute care hospital, free-standing psychiatric hospital, or a free-standing rehabilitation hospital does not qualify to receive an AAP. For purposes of this section, Medicaid payments received shall include the following payments:

1. The Medicaid *per diem* payments, AAP, PC payment, and SLP.

(B) A hospital shall receive an AAP if the hospital's MO HealthNet case mix index is greater than a threshold set annually by the division. The preliminary AAP is calculated by multiplying the hospital's MO HealthNet case mix index times the estimated Medicaid FFS claims payments for the coming SFY. The estimated Medicaid FFS claims payments are calculated by multiplying the Medicaid FFS inpatient days times the *per diem* for the coming SFY. If the hospital's estimated Medicaid FFS claims payments for the coming SFY plus the preliminary AAP exceeds the hospital's prior SFY Medicaid FFS payments received increased by a stop-gain percentage, the preliminary AAP will be reduced so the estimated Medicaid FFS claims payments for the coming SFY plus the final AAP is equal to the stop-gain percent of the hospital's prior SFY Medicaid FFS payments received. If no reduction is necessary, the preliminary AAP shall be considered final.

(D) The annual final AAP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(5) Poison Control (PC) Payment.

(A) The PC payment shall be determined for hospitals which operated a poison control center during the base year and which continues to operate a Poison Control Center. The PC payment shall reimburse the hospital for the Medicaid share of the total poison control cost and shall be determined as follows:

1. The total poison control cost from the base year cost report will be divided by the total hospital days from the base year cost report to determine a cost per day. This cost per day will then be multiplied by the estimated Medicaid FFS inpatient days and Medicaid MC inpatient days; and

2. The annual final PC payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(6) Stop Loss Payment (SLP) for hospitals that are reimbursed under the *per diem* reimbursement methodology.

(A) Beginning with SFY 2026 hospitals that are paid on a *per diem* and meet the requirements set forth below shall receive an SLP. For purposes of this section, Medicaid payments received shall include the following payments:

1. The Medicaid *per diem* payments, AAP, PC payment, and SLP.

(B) Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire private ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the private ownership group, this amount shall represent the total stop loss amount.

1. SLP will be made if a total stop loss amount was calculated in subsection (6)(B). Each hospital that shows a decrease in Medicaid payments shall receive a SLP in the amount of the decrease in payments unless the sum of each hospital's SLP is greater than the total stop loss amount. If the sum is greater than the total stop loss amount, each hospital's SLP shall be calculated by multiplying the total stop loss amount times the ratio of the hospital's decrease in Medicaid payments to the total decrease in payments for the entire private ownership group.

2. Free-standing psychiatric hospitals. Total estimated Medicaid FFS payments for the coming SFY for each hospital shall include estimated Medicaid FFS claims payments, and any final AAP and PC payment. The total estimated Medicaid FFS payments for each hospital shall be subtracted from the hospital's prior SFY Medicaid FFS payments received then summed to calculate a total increase or decrease in payments for the entire privately owned free-standing psychiatric hospital ownership group. A positive result represents a decrease in payments and a negative amount represents an increase in payments.

A. If a hospital has a decrease in payments as calculated in paragraph (6)(B)2., the hospital will receive a payment equal to the amount of payment decrease. If the hospital has

an increase in payments as calculated in paragraph (6)(B)2., the hospital will not receive any additional payments.

(C) The annual SLP will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(7) Stop Loss Payment (SLP) for hospitals that are reimbursed under the APR-DRG reimbursement methodology.

(A) Beginning with SFY 2026 hospitals that are paid under the APR-DRG and meet the requirements set forth below shall receive a SLP.

1. Total estimated Medicaid claims-based payments from the DRG base year are calculated. The DRG claims based system is calculated based on 13 CSR 70-15.010(6). The FFS supplemental payments for the most recent SFY are added to each hospital's estimated reimbursement.

2. The estimated DRG payments are then subtracted from the *per diem* repriced claims plus the FFS supplemental payments to get an estimated difference in reimbursement.

3. If the estimated DRG payment is greater than the *per diem* repriced claims plus the FFS supplemental payments, then no SLP will be calculated.

4. If the estimated DRG payment is less than the *per diem* repriced claims plus the FFS supplemental payments, then a SLP will be calculated to hold a hospital to a maximum of a one and seven thousand five hundred forty-five ten thousandths percent (1.7545%) estimated loss.

5. SLP special considerations

A. If the following hospital types are eligible for a SLP, then their stop-loss is held to 0%:

(I) Federally deemed CAHs;

(II) Safety net hospitals as defined in subparagraph (13)(A)1.A.; and

(III) State deemed CAHs.

6. The annual SLP will be calculated for each hospital at the beginning of each SFY. The annual amount will be processed over the number of financial cycles during the SFY.

7. The SLP calculations are based on a prospective estimate using historical claims data and will not be trued up with actual claims data at the end of the SFY.

(8) Psych Adjustment (PA) Payment.

(A) Beginning with SFY 2026, hospitals that have FFS psychiatric hospital days as identified in the MMIS shall receive a PA payment.

1. The PA payment is a set dollar amount appropriated by the General Assembly pursuant to Section 11.780 of CCS SS SCS HCS HB 11 (2025), and distributed to eligible hospitals proportionately as follows:

A. The FFS psychiatric hospital days for each hospital will be divided by the total FFS psychiatric hospital days for all hospitals to determine a percentage for each hospital. This percentage will then be multiplied by the set dollar amount in paragraph (8)(A)1. to determine the PA payment. The FFS psychiatric hospital days are paid days from the second prior calendar year.

2. The annual final PA payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be paid out over the number of financial cycles during the SFY.

(9) Medicaid Direct Graduate Medical Education (GME) Payments. Beginning with SFY 2023, a GME payment calculated as the sum of the intern and resident based GME payment and the GME stop loss payment shall be made to any acute care hospital that provides graduate medical education.

(A) Intern and resident (I&R) based GME payment. The I&R based GME payment will be based on the per I&R Medicaid allocated GME costs not to exceed a maximum amount per I&R. The division will determine the number of full time equivalent (FTE) I&Rs. Total GME costs will be determined using Worksheet A of the base year cost report adjusted by the trend index. Total GME costs is multiplied by the ratio of Medicaid FFS and MC days to total days to determine the Medicaid allocated GME costs which is then divided by the number of FTE I&Rs to calculate the Medicaid allocated cost per I&R. The I&R based GME payment is calculated as the number of FTE I&Rs multiplied by the minimum established by the division or the Medicaid allocated cost per I&R.

(B) GME stop loss payment. The total I&R based GME payment for each hospital shall be subtracted from the hospital's prior SFY GME payments received then summed to calculate a total increase or decrease in payments for the entire group of hospitals that provide graduate medical education. A positive result represents a decrease in payments and a negative amount represents an increase in payments. If the result is a decrease in total payments to the hospitals, this amount shall represent the total GME stop loss amount. GME stop loss payments will be made if a total GME stop loss payment amount was calculated in the paragraph above. Each hospital that shows a decrease in GME Medicaid payments shall receive a GME stop loss payment in the amount of the decrease in payments unless the sum of each hospital's GME stop loss payment is greater than the total GME stop loss amount. If the sum is greater than the total GME stop loss amount, each hospital's GME stop loss payment shall be calculated by multiplying the total GME stop loss amount times the ratio of the hospital's decrease in GME Medicaid payments to the total decrease in GME Medicaid payments.

(C) Hospitals who implement a GME program prior to July 1 of the SFY and do not have a base year cost report to determine GME costs shall receive an I&R based GME payment based on the statewide average per resident amount (PRA) determined as follows:

1. The number of FTE I&Rs shall be reported to the division by June 1 prior to the beginning of the SFY in order to have a GME payment calculated; and

2. The I&R based GME payment shall be calculated as the number of FTE I&Rs multiplied by the Medicaid capped statewide average PRA. The Medicaid capped statewide average PRA is calculated as follows:

A. By applying a straight average to the list of hospital PRA's with the following criteria:

(I) A hospital's PRA used in the straight average shall be the minimum as established by the division or the hospital's actual PRA.

(D) Hospitals who expand a currently federally approved GME program as of July 1 of the SFY shall have the ability to submit updated I&R numbers to the division.

1. The number of expanded FTE I&Rs shall be reported to the division by June 1 prior to the beginning of the SFY in order to have a GME payment calculated; and

2. The I&R based GME payment shall be calculated as the expanded number of FTE I&Rs multiplied by the minimum of the hospital specific PRA or Medicaid capped statewide average PRA as described in subsection (9)(A).

(E) The hospital's I&R based GME payment plus GME stop loss payment, if applicable, will be calculated for each hospital at the beginning of each SFY. The annual amount will be paid on a quarterly basis during the SFY.

(10) Medicaid Indirect Medical Education (IME) Payment. Beginning with SFY 2026, an IME payment will be paid to public acute care safety net hospitals who serve as the primary teaching hospitals for the state's two (2) public medical schools, University of Missouri – Columbia School of Medicine and University of Missouri – Kansas City School of Medicine. The payment will be for the difference between IME payments paid under the DRG methodology and one hundred percent (100%) of allowable funds. The payment will be calculated as follows:

(A) IME Add-on Amount = Wage Adjusted Rate * IME factor;

1. Wage Adjusted Rate is defined in 13 CSR 70-15.010(6)(G)4.A.(I)(a); and

2. IME factor is defined in 13 CSR 70-15.010(6)(G)3.C.

(B) Case-mix index as defined in subsection (1)(B).

(C) Claim count: FFS and MC paid claims from the second prior SFY

1. Example: SFY 2026 IME payment will utilize SFY 2024 claim counts; and

2. Future updates will utilize FFS and MC paid claims from the second full prior calendar year (i.e. for SFY 2027 beginning July 1, 2026, calendar year 2024 paid claims will be utilized).

(D) Formula: IME Add-on Amount * Case-mix index * Claim count.

(E) The hospital's IME payment will be calculated for each eligible hospital at the beginning of each SFY. The annual amount will be processed on a quarterly basis during the SFY.

(11) Children's Outlier (CO) Payment. Effective for discharges on or after July 1, 2025, Children's Outlier payments will no longer be made.

(A) The outlier year is based on a discharge date between July 1 and June 30.

(B) Beginning July 1, 2022, for fee-for-service claims only, outlier payments for medically necessary inpatient services involving exceptionally high cost or exceptionally long lengths of stay for MO HealthNet-eligible children under the age of six (6) will be made to hospitals meeting the federal DSH requirements in paragraph (10)(B)1. and for MO HealthNet-eligible infants under the age of one (1) will be made to any other Missouri Medicaid hospital.

1. The following criteria must be met to be eligible for outlier payments for children one (1) year of age to children under six (6) years of age:

A. If the facility offered nonemergency obstetric services as of December 21, 1987, there must be at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to these services under the Missouri Medicaid plan. In the case of a hospital located in a rural area (area outside of a metropolitan statistical area, as defined by the federal Executive Office of Management and Budget), the term obstetrician includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This section does not apply to hospitals either with

inpatients predominantly under eighteen (18) years of age or which did not offer nonemergency obstetric services as of December 21, 1987;

B. As determined from the base year audited Medicaid cost report, the hospital must have either—

(I) A Medicaid inpatient utilization rate (MIUR) at least one (1) standard deviation above the state's mean MIUR for all Missouri hospitals. The MIUR will be expressed as the ratio of total Medicaid days (TMD) (including such patients who receive benefits through a managed care entity) provided under a state plan divided by the provider's total number of inpatient days (TNID). 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;

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

or

(II) A low-income utilization rate (LIUR) in excess of twenty-five percent (25%). 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) 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.

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

2. The following criteria must be met for the services to be eligible for outlier review:

A. The patient must be a MO HealthNet-eligible infant under the age of one (1) year, or for hospitals that meet the federal DSH requirements, a MO HealthNet-eligible child under the age of six (6) years, as of the date of discharge; and

B. One (1) of the following conditions must be satisfied:

(I) The total reimbursable charges for dates of service must be at least one hundred fifty percent (150%) of the sum of claim payments for each claim; or

(II) The dates of service must exceed sixty (60) days and less than seventy-five percent (75%) of the total service days were reimbursed by MO HealthNet.

3. Claims eligible for outlier review must—

A. Have been submitted in their entirety for claims processing;

B. The claim must have been paid; and

C. An annual outlier file, for paid claims only, must be submitted to the division no later than December 31 of the second calendar year following the end of the outlier year (i.e., claims for outlier year 2022 are due no later than December 31, 2024).

4. After the review, reimbursable costs for each claim will be determined using the following data from the audited Medicaid hospital cost report for the year ending in the same calendar year as the outlier year (i.e., Medicaid hospital cost reports ending in 2022 will be used for the 2022 outlier year):

A. Average routine (room and board) costs for the general and special care units for all days of the stay eligible per the outlier review; and

B. Ancillary cost-to-charge ratios applied to claim ancillary charges determined eligible for reimbursement per the outlier review.

5. The outlier payments will be determined for each hospital as follows:

A. Sum all reimbursable costs for all eligible outlier claims to equal total reimbursable costs;

B. Subtract total claim payments, which includes MO HealthNet claims payments, third-party payments, and co-pays, from total reimbursable costs to equal excess cost; and

C. Multiply excess costs by fifty percent (50%).

(12) Safety Net Hospitals

(A) Inpatient hospital providers may qualify as a safety net hospital based on the following criteria. Hospitals shall qualify for a period of only one (1) SFY and must requalify at the beginning of each SFY to continue their safety net hospital designation.

1. As determined from the most recent DSH survey for the Medicaid inpatient utilization rate (MIUR) and low income utilization rate (LIUR) and from the base year cost report for the licensed beds and the occupancy rate:

A. A public non-state governmental acute care hospital with a LIUR of at least twenty percent (20%), a MIUR greater than one (1) standard deviation from the mean, is licensed for fifty (50) inpatient beds or more, and has an occupancy rate of at least forty percent (40%). The hospital must meet one (1) of the federally mandated Disproportionate Share Hospital (DSH) qualifications;

2. The hospital is owned or operated by the Board of Curators as defined in Chapter 172, RSMo; or

3. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.

(13) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and Medicaid provider number shall have their Medicaid reimbursement combined under the surviving hospital's (the hospital's whose Medicare and Medicaid provider number remained active) Medicaid provider number.

(A) The other Medicaid payments, if applicable, shall be:

1. Combined under the surviving hospital's Medicaid provider number for the remainder of the SFY in which the merger occurred; and

2. Calculated for subsequent SFYs based on the combined data from the base year cost report for each facility.

(14) Payment Assurance. The state will pay each hospital, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the hospital according to the standards and methods set forth in the rules implementing the hospital reimbursement program.

(15) Directed Payments. Effective July 1, 2022, the Missouri Medicaid managed care organizations shall make inpatient and outpatient directed payments to in-state in-network hospitals pursuant to 42 CFR 438.6(c) as approved by the Centers for Medicare & Medicaid Services.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2022. This rule was previously filed as part of 13 CSR 70-15.010. Emergency rule filed April 30, 2020, effective May 15, 2020, expired Feb. 24, 2021. Original rule filed April 30, 2020, effective Nov. 30, 2020. Emergency amendment filed Aug. 26, 2021, effective Sept. 10, 2021, expired March 8, 2022. Amended: Filed Aug. 26, 2021, effective March 30, 2022. Emergency amendment filed June 14, 2022, effective July 1, 2022, expired Feb. 23, 2023. Amended: Filed June 14, 2022, effective Jan. 30, 2023. Emergency amendment filed June 20, 2025, effective July 7, 2025, expired Feb. 26, 2026. Amended: Filed June 23, 2025.*

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

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately $557.6 million 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, P.O. Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the ***Missouri Register****. A public hearing will not be scheduled.*