NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has responsibility to administer the Medicaid Program. KRS 205.8451 through KRS 205.8483 establish that the Cabinet for Health and Family Services and the Department for Medicaid Services shall be responsible for the control of Medicaid provider fraud and abuse. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the certification requirements and provisions regarding 1915(c) home and community based service waiver providers who are required to be certified.

Section 1. Definitions. (1) “1915(c) home and community based service” means a
service available or provided via a 1915(c) home and community based services waiver program.

(2) “1915(c) home and community based services waiver program” means a Kentucky Medicaid program established pursuant to and in accordance with 42 U.S.C. 1396n(c).

(3) Applicant” means an individual or entity applying to be a certified waiver provider.

(4) “Certification period” means a period of time that a provider has been certified or approved by the department to provide, and be reimbursed for, 1915(c) home and community based services.

(5) “Certified waiver provider” means a provider who:

(a) Is currently enrolled in the Medicaid program in accordance with 907 KAR 1:672;

(b) Is currently participating in the Medicaid program in accordance with 907 KAR 1:671;

(c) Provides Kentucky Medicaid program covered services to a recipient in a 1915(c) home and community based services waiver program; and

(d) Has been determined by the department to have met the certified waiver provider requirements established in this administrative regulation.

(6) “Citation” means a written document:

(a) Issued by the department to a certified waiver provider; and

(b) Addressing a certified waiver provider's failure to comply with:

1. This administrative regulation; or

2. Any other administrative regulation within Title 907 of the Kentucky Administrative Regulations which establishes provisions and requirements regarding a 1915(c) home and community based services waiver program.
(7) “Contingency” means certification benchmarks which the provider shall meet within the timeframe established by the department before the department renews a provider’s certification.

(8) “Corrective action plan” means a document submitted by a certified waiver provider to the department that:

(a) States the system changes, processes, or other actions that the provider shall take to prevent a future occurrence of a violation stated in a citation or findings report;

(b) States the timeframe in which the provider shall successfully implement or perform a system change, process, or other action required by the corrective action plan; and

(c) Is not valid or effective until approved by the department.

(9) “Credible allegation of fraud” is defined by 42 C.F.R. 405.370.

(10) “Department” means the Department for Medicaid Services or its designee.

(11) “Fraud” is defined by KRS 205.8451(2).

(12) “Moratorium” means the department’s prohibition against a provider providing services to a new 1915(c) home and community based services waiver participant.

(13) “New 1915(c) home and community based services waiver participant” means an individual who has never received 1915(c) home and community based services from a given provider though the individual may have previously received 1915(c) home and community based services from another provider.

(14) “Provider abuse” is defined by KRS 205.8451(8).

(15) “Repeat citation” means a citation that was previously issued by the department within the past two (2) years that did not result in a sustainable correction.

(16) “Restriction” means a limitation or condition placed on a provider by:
(a) The professional board governing the provider's profession;
(b) A court of competent jurisdiction;
(c) A federal agency with jurisdiction over the:
   1. Medicaid program; or
   2. Provider; or
(d) The department in accordance with this administrative regulation.

(17) “Sanction” means an administrative action taken by the department which:
   (a)1. Limits or bars an individual's, agency's, entity's, or organization's participation in
      the Medicaid program; or
   2. Imposes a fiscal penalty against the provider, including the:
      a. Imposition of civil penalties or interest imposed at the department's discretion; or
      b. Withholding of future payments; and
   (b) Does not include:
      1. A voluntary moratorium;
      2. Not renewing a certification;
      3. A citation; or
      4. Not approving an initial application for certification.

(18) “Unacceptable practice” means conduct which constitutes:
   (a) Fraud;
   (b) Provider abuse;
   (c) Neglect;
   (d) Exploitation;
   (e) Willful misrepresentation;
(f) An action resulting in an exclusion, sanction, finding of fact, moratorium, suspension, or termination by:

1. The licensing entity with jurisdiction over the provider’s license;
2. The certifying entity with jurisdiction over the provider’s certification; or
3. The department;

(g) Failure to disclose required information in accordance with 907 KAR 1:671, 907 KAR 1:672, or this administrative regulation;

(h) Making, causing to be made, inducing, or seeking to induce a false, fictitious, or fraudulent statement or misrepresentation of material fact when providing information to the department; or

(i) A restriction.

Section 2. Certified Waiver Provider Enrollment. (1) The provisions and requirements established in 907 KAR 1:672 regarding a Medicaid provider or person or entity who applies for enrollment as a participating Medicaid provider shall apply to a certified waiver provider or applicant.

(2) To enroll in the Medicaid program as a certified waiver provider, an applicant shall:

(a) Meet and comply with the Medicaid provider enrollment requirements, terms, and conditions established in:

1. 907 KAR 1:672; and

2. The administrative regulation or regulations located in Title 907 of the Kentucky Administrative Regulations which establish the requirements for the respective type of 1915(c) home and community based service waiver provider to which that the applicant is applying to be (for example, the requirements, terms, and conditions for Supports for
Community Living waiver providers if the applicant is applying to be a Supports for Community Living waiver service provider); and

(b) Submit to the department:

1. A valid professional license, registration, certificate, or letter of certification or approval from a certifying entity that allows the applicant to provide services within the applicant’s scope of practice; or

2. An application to be a certified waiver provider.

(3) The department shall deny enrollment if an applicant:

(a) Does not provide requested information to the department within the time period specified in the department’s:

1. Notice of omitted information; or

2. Questionnaire;

(b) Fails to:

1. Provide correct, accurate, complete, and truthful information requested by the department at any time during the application or enrollment process;

2. Update the department of any change in information previously submitted during the application or enrollment process; or

3. Demonstrate the capacity to:

a. Execute necessary administrative competency as required by the department;

b. Develop a system of care which has an infrastructure necessary to provide coordinated services, supports, treatment, and care; or

c. Follow direction provided by the department; or

(c) Is eligible for exclusion under Section 6.
Section 3. Certified Waiver Provider Participation Requirements. (1) To participate in
the Medicaid program, a provider shall:

(a) Comply with the Medicaid provider participation requirements, terms, and
conditions established in 907 KAR 1:671; and

(b) Meet and comply with the Medicaid provider enrollment requirements, terms, and
conditions established in the administrative regulation or regulations located in Title 907
of the Kentucky Administrative Regulations which establish the requirements for the
respective type of 1915(c) home and community based service waiver provider that the
applicant is applying to be (for example, the requirements, terms, and conditions for
Supports for Community Living waiver providers if the applicant is applying to be a
Supports for Community Living waiver service provider.)

(2) The provisions and requirements established in 907 KAR 1:671 regarding Medicaid
providers shall apply to a certified waiver provider.

Section 4. Citations Resulting in a Corrective Action Plan. (1)(a) If the department
issues a citation or citations to a certified waiver provider, the provider shall submit to the
department a corrective action plan.

(b)1. A certified waiver provider shall implement a corrective action plan unless the
department notifies the certified waiver provider:

a. That it does not approve the corrective action plan; and

b. Of the revisions that need to be made to the corrective action plan.

2. If a certified waiver provider is notified by the department that a corrective action
plan was not approved, the certified waiver provider shall submit a revised corrective
action plan to the department that is revised pursuant to the department’s direction.
(c) The certified waiver provider shall successfully perform everything required in the approved corrective action plan within the timeframe or timeframes established in the corrective action plan.

(d) If a certified waiver provider:

1. Fails to successfully perform everything required in an approved corrective action plan within the timeframe or timeframes established in the corrective action plan, the department shall:
   a. Extend the timeframe for corrective action plan compliance if the department determines that the provider’s progress in complying with the corrective action plan warrants an extension; or
   b. Terminate the certified waiver provider; or

2. Refuses to submit a corrective action plan to the department or modify a corrective action plan in response to the department’s instruction to modify the corrective action plan, the department shall terminate the provider.

(2) If the department terminates a provider, the:

(a) Department shall notify the provider in writing of the:

1. Reason for termination; and

2. Provider’s right to appeal the termination.

(b) Provider shall have the right to appeal the termination in accordance with 907 KAR 1:671.

Section 5. Voluntary Moratorium Pending Investigation. (1)(a) If the department has reliable evidence that leads it to believe that a certified waiver provider has committed a violation that threatens the health, safety, or welfare of a recipient, the department shall
offer the provider an opportunity to undergo a voluntary moratorium while the department conducts an investigation of the matter.

(b) If the certified waiver provider refuses to undergo a voluntary moratorium while the department conducts an investigation, the department shall terminate the provider in accordance with Section 4(2).

(c) 1. Within thirty (30) days of completing an investigation referenced in subsection (1)(a) and (b) of this section, the department shall issue a findings report to the certified waiver provider.

   2. If the findings report indicates that the certified waiver provider did not commit a violation that threatened the health, safety, or welfare of a recipient, the moratorium shall immediately be lifted.

   3. If the findings report indicates that the certified waiver provider committed a violation that threatened the health, safety, or welfare of a recipient, but the department does not initiate termination, the department shall:

      a. Offer the provider an opportunity to continue the voluntary moratorium in which the provider creates and submits a corrective action plan to the department; or

      b. Initiate termination of the certified waiver provider if the provider chooses to not continue the voluntary moratorium.

4. If the findings report indicates that the certified waiver provider committed a violation that threatened the health, safety, or welfare of a recipient that warrants termination, the department shall terminate the provider in accordance with Section 4(2).

(d) 1. If a certified waiver provider undergoes a voluntary moratorium, the provider
shall not accept any new 1915(c) home and community based waiver services participant
to their program until the department determines that the provider has completed all of the
actions required within the timeframe established pursuant to the corrective action plan
referred to in paragraph (c)3.a. of this subsection.

2. If a certified waiver provider that agreed to undergo a voluntary moratorium fails to
complete all of the actions required within the timeframe established in the corrective
action plan, the department shall:

   a. Extend the timeframe for corrective action plan compliance if the department
determines that the provider’s progress in complying with the corrective action plan
warrants an extension; or

   b. Terminate the provider in accordance with Section 4(2); or

3. If the department determines that the certified waiver provider successfully
implemented the corrective action plan, the department shall lift the moratorium.

(2)(a) If during a recertification or follow-up of an investigation or complaint, a repeat
citation is warranted regarding a system or process which creates a deficiency regarding
more than one (1) requirement in this administrative regulation or any administrative
regulation within Title 907 of the Kentucky Administrative Regulations which establishes
requirements regarding a 1915(c) home and community based services waiver program,
the department shall:

   1. Offer the certified waiver provider an opportunity to undergo a voluntary moratorium
in which the provider creates and submits a corrective action plan to the department; or

   2. Terminate the provider in accordance with Section 4(2) if the provider chooses to not
undergo a voluntary moratorium.
(b) If the certified waiver provider agrees to undergo a voluntary moratorium, the provisions and requirements established in subsection (1)(d) of this section shall apply.

Section 6. Exclusion Due to Employee, Volunteer, or Contractor. (1) Except as established in subsection (2) of this section, the department shall exclude an applicant or provider from Medicaid program participation:

(a) If an individual who is an employee, contractor, or volunteer with the applicant or provider has:

1. Engaged in an unacceptable practice; or

2. Acted in a way which resulted in the individual or any entity with whom the individual previously worked, volunteered, or had a contractual relationship or currently works, volunteers, or has a contractual relationship being excluded from Medicaid program participation at any time; or

(b) If the department determines that enrolling the applicant or provider would not be in the best interest of:

1. Current or future recipients; or

2. The department.

(2)(a) The department shall not exclude an applicant or provider from Medicaid program participation as a result of the actions of an individual referenced in subsection (1)(a) of this section if the department determines that the individual’s actions were unforeseen by the applicant or provider.

(b) To demonstrate to the department that an individual’s actions, as referenced in subsection (1)(a) of this section, were unforeseen, the applicant or provider shall prove that the applicant or provider:
1. Did not know of the individual’s actions;
2. Had work rules in place designed to prevent the actions from occurring;
3. Communicated the work rules referenced in subparagraph 2 of this paragraph to all of its employees;
4. Took steps to discover the actions which violated the work rules; and
5. Consistently enforced the standard when a violation of the work rules occurred.

Section 7. Suspension of Payment Due to a Credible Allegation of Fraud. (1)(a) In accordance with 42 C.F.R. 455.23, 42 U.S.C. 1395y(o), 42 U.S.C. 1396b(i)(2)(C), and 42 C.F.R. 447.90, the department shall suspend payment to any provider if a credible allegation of fraud regarding the provider exists except as established in paragraph (b) of this subsection.

(b) The department shall not suspend payment to a provider if a credible allegation of fraud regarding the provider exists if the:

1. Payment is for an emergency item or service that was not furnished in the emergency room of a hospital; or
2. Department determines that good cause not to suspend payment exists in accordance with 42 C.F.R. 455.23.

(2) In accordance with 42 C.F.R. 455.23, the department shall suspend payment to a provider only in part if good cause to suspend payment only in part exists in accordance with 42 C.F.R. 455.23(f).

(3) The department shall comply with the notice of suspension of payment requirements established in 42 C.F.R. 455.23(b).

(4) The duration of a suspension of payment shall be in accordance with 42 C.F.R.
Section 8. Additional Actions Regarding a Certified Waiver Provider. (1) In addition to an action established in 907 KAR 1:671 regarding a Medicaid provider, the department may impose or do the following regarding a certified waiver provider:

(a) Impose a contingency;
(b) Terminate a provider’s participation in the Medicaid program;
(c) Establish liability for a civil payment in accordance with KRS 205.8467;
(d) Procure restitution of:
   1. Departmental costs in accordance with KRS 205.8467; or
   2. An overpayment; or
(e) Impose a lien in accordance with KRS 205.8471.

(2) The department shall impose a contingency if during a recertification more than one deficiency is found which requires immediate correction in order for the certified waiver provider to be recertified.

(3) In addition to the reasons for terminating a provider’s participation in the Medicaid program established in 907 KAR 1:671, the department may terminate a certified waiver provider’s participation in the Medicaid program if:

(a) The provider engages in an unacceptable practice;
(b) The department continues to impose an exclusion or sanction after twelve (12) months of an exclusion or sanction occurring; or
(c) During a recertification or follow-up of an investigation or complaint, a repeat citation is warranted regarding:
   1. A recipient’s health, safety, or welfare; or
2. A system or process which creates a deficiency regarding more than one (1)
requirement in:
   a. This administrative regulation; or
   b. Any administrative regulation within Title 907 of the Kentucky Administrative
   Regulations which establishes requirements regarding a 1915(c) home and community
   based services waiver program.

(4) If the department terminates a certified waiver provider’s participation in the
Medicaid program, the department shall terminate in accordance with Section 4(2).

Section 9. Not Renewing a Provider’s Participation and Not Enrolling an Applicant. (1)
The department may not renew a certified waiver provider’s participation in the Medicaid
Program for any reason except for a reason which is prohibited by state or federal law.

(2) The department may not enroll an applicant as a provider in the Medicaid Program
for any reason except for a reason which is prohibited by state or federal law.

Section 10. Applicability of Actions to 1915(c) Home and Community Based
Service Waiver Programs. If the department acts, as established in this administrative
regulation, regarding a certified waiver provider due to the provider’s behavior in one (1)
1915(c) home and community based services waiver program, the action regarding the
certified waiver provider shall apply in every 1915(c) home and community based
services waiver program in which the provider is participating. For example, if the
department terminates a certified waiver provider in the supports for community living
program, the provider shall be terminated from every 1915(c) home and community
based services waiver program in which the provider is participating.

(2) If a certified waiver provider volunteers to undergo a moratorium, the voluntary
A voluntary moratorium;  
(b) Not renewing a certification;  
(c) A citation; or  
(d) Not approving an initial certification.
907 KAR 7:005

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services
PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on October 21, 2013, at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing October 14, 2013, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation through October 31, 2013. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.
REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 7:005
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This is a new administrative regulation which establishes Medicaid certified waiver provider requirements and policies. These providers provide services to 1915(c) home and community based waiver program participants. 1915(c) home and community based waiver programs enable individuals who have nursing facility level of care needs (or needs that can be served in an intermediate care facility for individuals with an intellectual disability) to remain in and receive care in their homes or in a community setting rather than in an institutional setting. Some 1915(c) home and community based waiver program providers are licensed and do not require certification in order to provide services in the given 1915(c) home and community based waiver program in which they participate; thus, the requirements and policies in this administrative regulation do not apply to those entities.

Among the requirements or provisions are: that if the Department for Medicaid Services (DMS) - or its agent which is the Department for Behavioral Health, Intellectual and Developmental Disabilities (DBHDID) - issues a citation to a provider, the provider must prepare and submit a corrective action plan (to correct the deficiency) as well as satisfy all requirements of the corrective action plan or face possible termination from the Medicaid program; that if DMS or DBHDID determine that a provider has reliable evidence that a provider has committed a violation that threatens the health, safety, or welfare of a recipient, the provider may undergo a voluntary termination (in which it cannot accept any new recipients under its care), while DMS/DBHDID completes an investigation and if the investigation corroborates the initial evidence, the provider must submit a corrective action plan and satisfy all requirements of the corrective action plan within the timeframe established in the corrective action plan or face termination from the Medicaid program; that DMS will exclude a potential provider or existing provider from Medicaid program participation if the provider has any staff that in the past that engaged in an unacceptable practice (which is defined) or in any way that would have resulted in the provider being excluded (unless DMS determines that the individual's actions were unforeseen by the applicant or provider); that DMS may exclude a provider from participation is it determines that enrolling the provider would not be in the interest of recipients; that DMS may suspend a provider from Medicaid program participation if a credible allegation of fraud exists; that DMS won't renew a provider's participation – during the provider’s recertification period - until/unless the
provider resolves deficiencies (by meeting certain benchmarks within an established time frame) discovered during the recertification process; that any action regarding a provider in one (1) home and community based waiver program shall apply to all home and community based waiver programs in which the provider participates; and that if DMS terminates a provider from Medicaid program participation it won’t accept an application for enrollment from the provider until at least five (5) years have lapsed.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish uniform Medicaid certified waiver provider requirements and policies in order to enhance DMS’s ability protect the health, safety, and welfare of home and community based waiver participants.

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing uniform Medicaid certified waiver provider requirements and policies in order to enhance DMS’s ability protect the health, safety, and welfare of home and community based waiver participants.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing uniform Medicaid certified waiver provider requirements and policies in order to enhance DMS’s ability protect the health, safety, and welfare of home and community based waiver participants.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.

(b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.

(c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.

(d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Providers of 1915(c) home and community based services will be affected by this administrative regulation. Currently, there are roughly 340 such providers enrolled in the Kentucky Medicaid program.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Regulated entities will have to comply with Medicaid participation requirements,
not commit unacceptable practices, and successfully perform corrective action plans subsequent to receiving a citation or to undergoing a voluntary moratorium due to an action which threatened the health, safety, or welfare of a recipient.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed, but providers may experience costs in establishing safeguards necessary to protect the health, safety, and welfare of recipients.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). By complying with the administrative regulation, regulated entities will be able to be reimbursed by the Kentucky Medicaid program for providing services to Medicaid recipients served in a 1915(c) home and community based service waiver program.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:
(a) Initially: DMS anticipates that the administrative regulation will be budget neutral for DMS.
(b) On a continuing basis: DMS anticipates that the administrative regulation will be budget neutral for DMS.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and state matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor directly nor indirectly increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is not applied as the policies apply uniformly to providers governed by this administrative regulation.
Administrative Regulation Number: 907 KAR 7:005
Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. Medicaid home and community based waiver programs are not mandated by federal law or regulation; however, 42 U.S.C. 1396n(c) establishes home and community based waiver requirements. 42 U.S.C. 1396n(c)(2) establishes requirements germane to this administrative regulation.

2. State compliance standards. KRS 205.520(3) states, “Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

KRS 205.8451 through KRS 205.8483 require the Department for Medicaid Services to establish measures and safeguards to control Medicaid program fraud and abuse as well as includes various related requirements.

KRS 205.6318(8) requires the Cabinet for Health and Family Services to “Review penalties for deterrent value for medical providers that are found to have abused Medicaid regulations and statutes.”

3. Minimum or uniform standards contained in the federal mandate. Medicaid waiver programs are not mandated by federal law or regulation. Medicaid home and community based waiver programs are not mandated by federal law or regulation; however, 42 U.S.C. 1396n(c) establishes home and community based waiver requirements. A key requirement of 42 U.S.C. 1396n(c) – addressed by this administrative regulation – is the following located in 42 U.S.C. 1396n(c)(2):

“(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—
(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services.”

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter requirements.
1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? None.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? None.
   (c) How much will it cost to administer this program for the first year? DMS anticipates that the administrative regulation will be budget neutral for DMS.
   (d) How much will it cost to administer this program for subsequent years? DMS anticipates that the administrative regulation will be budget neutral for DMS.