

STATEMENT OF EMERGENCY

907 KAR 17:030E

(1) This is a new emergency administrative regulation which is being promulgated concurrently with five (5) other administrative regulations which will establish the Kentucky Medicaid Program managed care organization requirements and policies. Currently, there is one administrative regulation (907 KAR 17:005) which establishes Kentucky Medicaid program managed care organization requirements and policies for every region except region three (3). Region three (3) is comprised of Jefferson County and fifteen (15) other counties neighboring or nearby Jefferson County and its requirements and policies are established in 907 KAR 1:705. One (1) managed care organization has been responsible for managed care in region three (3) since the mid-1990s; however, managed care in that region did not encompass behavioral health services and having one (1) entity does not satisfy the Centers for Medicare and Medicaid Services (CMS) requirement of providing individuals choice of managed care organizations. Consequently, DMS has contracted with four (4) entities – including the entity that has been performing managed care organization functions since the mid-1990s – to be responsible for managed care in region three (3) and the scope of managed care in region three (3) will now include behavioral health services.

As a result, DMS is repealing the existing region three (3) managed care administrative regulation (907 KAR 1:705) and establishing uniform managed care organization requirements and policies for all Medicaid managed care organizations in Kentucky. The six (6) administrative regulations which accomplish this include this administrative regulation; 907 KAR 17:005 (Definitions for administrative regulations in Chapter 17 of Title 907); 907 KAR 17:010 (managed care organization requirements and policies related to enrollees); 907 KAR 17:015 (managed care organization requirements and policies related to providers); 907 KAR 17:020 (managed care organization service and service coverage requirements and policies); and 907 KAR 17:025 (managed care organization policies and requirements relating to utilization management and quality.) DMS is establishing managed care organization requirements across multiple administrative regulations in response to urging from the Administrative Regulation Review Subcommittee (ARRS) and ARRS staff when this administrative regulation was reviewed by the committee earlier this year. Providing a choice of managed care organizations to individuals is necessary to comply with a federal mandate and expanding the scope of managed care in region three (3) to include behavioral health services is also necessary to establish the same managed care benefit package for all Medicaid recipients enrolled in managed care in Kentucky.

(2) This action must be implemented on an emergency basis to comply with a federal mandate and to prevent a loss of federal funds as CMS has approved DMS's revised

managed care model - four (4) entities and the scope of services includes behavioral health services – for region three (3).

(3) This emergency administrative regulation shall be replaced by an ordinary administrative regulation filed with the Regulations Compiler.

(4) The ordinary administrative regulation is identical to this emergency administrative regulation.

Steven L. Beshear
Governor

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Commissioner's Office

4 (New Emergency Administrative Regulation)

5 907 KAR 17:030E. Managed care organization operational and related requirements
6 and policies.

7 RELATES TO: 194A.025(3), 42 U.S.C. 1396n(c), 42 C.F.R. 438

8 STATUTORY AUTHORITY: KRS 194A.010(1), 194A.025(3), 194A.030 (2),
9 194A.050(1), 205.520(3), 205.560, 42 U.S.C. 1396n(b), 42 C.F.R. Part 438

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
11 Services, Department for Medicaid Services, has responsibility to administer the Medi-
12 caid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to
13 comply with a requirement that may be imposed or opportunity presented by federal law
14 to qualify for federal Medicaid funds. 42 U.S.C. 1396n(b) and 42 C.F.R. Part 438 estab-
15 lish requirements relating to managed care. This administrative regulation establishes
16 the Medicaid managed care organization operational and related requirements and poli-
17 cies.

18 Section 1. Prompt Payment of Claims. (1) In accordance with 42 U.S.C.
19 1396a(a)(37), an MCO shall have prepayment and postpayment claims review proce-
20 dures that ensure the proper and efficient payment of claims and management of the
21 program.

- 1 (2) An MCO shall:
- 2 (a) Comply with the prompt payment provisions established in
- 3 1. 42 C.F.R. 447.45; and
- 4 2. KRS 205.593, KRS 304.14-135, and KRS 304.17A-700 to 304.17A-730; and

- 5 (b) Notify a requesting provider of a decision to:
- 6 1. Deny a claim; or
- 7 2. Authorize a service in an amount, duration, or scope that is less than requested.

8 (3) The payment provisions in this section shall apply to a payment to:

- 9 (a) A provider within the MCO network; and
- 10 (b) An out-of-network provider.

11 Section 2. Payments to an MCO. (1) The department shall provide an MCO a per en-

12 rollee, per month capitation payment whether or not the enrollee receives a service dur-

13 ing the period covered by the payment except for an enrollee whose eligibility is deter-

14 mined due to being unemployed in accordance with 45 C.F.R. 233.100.

15 (2) The monthly capitation payment for an enrollee whose eligibility is determined due

16 to being unemployed shall be prorated from the date of eligibility.

17 (3) A capitation rate referenced in subsection (1) of this section shall:

- 18 (a) Meet the requirements of 42 C.F.R. 438.6(c); and
- 19 (b) Be approved by the Centers for Medicare and Medicaid Services.

20 (4)(a) The department shall apply a risk adjustment to a capitation rate in an amount

21 that shall be budget neutral to the department.

22 (b) The department shall use the latest version of the Chronic Illness and Disability

23 Payment System to determine the risk adjustment referenced in paragraph (a) of this

1 subsection.

2 Section 3. Recoupment of Payment from an Enrollee for Fraud, Waste, or Abuse. (1)

3 If an enrollee is determined to be ineligible for Medicaid through an administrative hear-
4 ing or adjudication of fraud by the CHFS OIG, the department shall recoup a capitation
5 payment it has made to an MCO on behalf of the enrollee.

6 (2) An MCO shall request a refund from the enrollee referenced in subsection (1) of
7 this section of a payment the MCO has made to a provider for the service provided to
8 the enrollee.

9 (3) If an MCO has been unable to collect a refund referenced in subsection (2) of this
10 section within six (6) months, the Commonwealth shall have the right to recover the re-
11 fund from the enrollee.

12 Section 4. MCO Administration. An MCO shall have executive management respon-
13 sible for operations and functions of the MCO that shall include:

14 (1) An executive director who shall:

15 (a) Act as a liaison to the department regarding a contract between the MCO and the
16 department;

17 (b) Be authorized to represent the MCO regarding an inquiry pertaining to a contract
18 between the MCO and the department;

19 (c) Have decision making authority; and

20 (d) Be responsible for following up regarding a contract inquiry or issue;

21 (2) A medical director who shall be:

22 (a) A physician licensed to practice medicine in Kentucky;

23 (b) Actively involved in all major clinical programs and quality improvement compo-

1 nents of the MCO; and

2 (c) Available for after-hours consultation;

3 (3) A dental director who shall be:

4 (a) Licensed by a dental board of licensure in any state;

5 (b) Actively involved in all oral health programs of the MCO; and

6 (c) Available for after-hours consultation;

7 (4)(a) A finance officer who shall oversee the MCO's budget and accounting systems;

8 and

9 (b) An internal auditor who shall ensure compliance with adopted standards and re-
10 view expenditures for reasonableness and necessity;

11 (5) A quality improvement director who shall be responsible for the operation of:

12 (a) The MCO's quality improvement program; and

13 (b) A subcontractor's quality improvement program;

14 (6) A behavioral health director who shall be:

15 (a) A behavioral health practitioner;

16 (b) Actively involved in all of the MCO's programs or initiatives relating to behavioral
17 health; and

18 (c) Responsible for the coordination of behavioral health services provided by the
19 MCO or any of its behavioral health subcontractors;

20 (7) A case management coordinator who shall be responsible for coordinating and
21 overseeing case management services and continuity of care for MCO enrollees;

22 (8) An early and periodic screening, diagnosis, and treatment (EPSDT) coordinator
23 who shall coordinate and arrange for the provision of EPSDT services and EPSDT spe-

1 cial services for MCO enrollees;

2 (9) A foster care and subsidized adoption care liaison who shall serve as the MCO's

3 primary liaison for meeting the needs of an enrollee who is:

4 (a) A child in foster care; or

5 (b) A child receiving state-funded adoption assistance;

6 (10) A guardianship liaison who shall serve as the MCO's primary liaison for meeting

7 the needs of an enrollee who is a ward of the Commonwealth;

8 (11) A management information systems director who shall oversee, manage, and

9 maintain the MCO's management information system;

10 (12) A program integrity coordinator who shall coordinate, manage, and oversee the

11 MCO's program integrity functions;

12 (13) A pharmacy director who shall coordinate, manage, and oversee the MCO's

13 pharmacy program;

14 (14) A compliance director who shall be responsible for the MCO's:

15 (a) Financial and programmatic accountability, transparency, and integrity; and

16 (b) Compliance with:

17 1. All applicable federal and state law;

18 2. Any administrative regulation promulgated by the department relating to the MCO;

19 and

20 3. The requirements established in the contract between the MCO and the depart-

21 ment;

22 (15) A member services director who shall:

23 (a) Coordinate communication with MCO enrollees; and

1 (b) Respond in a timely manner to an enrollee seeking a resolution of a problem or
2 inquiry;

3 (16) A provider services director who shall:

4 (a) Coordinate communication with MCO providers and subcontractors; and

5 (b) Respond in a timely manner to a provider seeking a resolution of a problem or in-
6 quiry; and

7 (17) A claims processing director who shall ensure the timely and accurate pro-
8 cessing of claims.

9 Section 5. Health Care Data Submission and Penalties. (1)(a) An MCO shall submit
10 an original encounter record and denial encounter record, if any, to the department
11 weekly.

12 (b) An original encounter record or a denial encounter record shall be considered late
13 if not received by the department within four (4) calendar days from the weekly due
14 date.

15 (c) Beginning on the fifth calendar day late, the department shall withhold \$500 per
16 day for each day late from an MCO's total capitation payments for the month following
17 non-submission of an original encounter record and denial encounter record.

18 (2)(a) The department shall transmit to an MCO an encounter record with an error for
19 correction by the MCO.

20 (b) An MCO shall have ten (10) days to submit a corrected encounter record to the
21 department.

22 (c) If an MCO fails to submit a corrected encounter record within the time frame spec-
23 ified in paragraph (b) of this subsection, the department shall be able to assess and

1 withhold for the month following the non-submission, an amount equal to one-tenth of a
2 percent of the MCO's total capitation payments per day until the corrected encounter
3 record is received and accepted by the department.

4 Section 6. Program Integrity. An MCO shall comply with:

5 (1) 42 C.F.R. 438.608; and

6 (2) 42 U.S.C. 1396a(a)(68).

7 Section 7. Third Party Liability and Coordination of Benefits. (1) Medicaid shall be the
8 payer of last resort for a service provided to an enrollee.

9 (2) An MCO shall:

10 (a) Exhaust a payment by a third party prior to payment for a service provided to an
11 enrollee;

12 (b) Be responsible for determining a legal liability of a third party to pay for a service
13 provided to an enrollee;

14 (c) Actively seek and identify a third party liability resource to pay for a service pro-
15 vided to an enrollee in accordance with 42 C.F.R. 433.138; and

16 (d) Assure that Medicaid shall be the payer of last resort for a service provided to an
17 enrollee.

18 (3) In accordance with 907 KAR 1:011 and KRS 205.624, an enrollee shall:

19 (a) Assign, in writing, the enrollee's rights to an MCO for a medical support or pay-
20 ment from a third party for a medical service provided by the MCO; and

21 (b) Cooperate with an MCO in identifying and providing information to assist the MCO
22 in pursuing a third party that shall be liable to pay for a service provided by the MCO.

23 (4) If an MCO becomes aware of a third party liability resource after payment for a

1 service provided to an enrollee, the MCO shall seek recovery from the third party re-
2 source.

3 Section 8. Management Information System. (1) An MCO shall:

4 (a) Have a management information system that shall:

5 1. Provide support to the MCO operations; and

6 2. Except as provided in subsection (2) of this section, include a:

7 a. Member subsystem;

8 b. Third party liability subsystem;

9 c. Provider subsystem;

10 d. Reference subsystem;

11 e. Claim processing subsystem;

12 f. Financial subsystem;

13 g. Utilization and quality improvement subsystem; and

14 h. Surveillance utilization review subsystem; and

15 (b) Transmit data to the department in accordance with 42 C.F.R. 438.242.

16 (2) An MCO's management information system shall not be required to have the sub-

17 systems listed in subsection (1)(a)2. of this section if the MCO's management infor-

18 mation system:

19 (a) Has the capacity to:

20 1. Capture and provide the required data captured by the subsystems listed in sub-

21 section (1)(a)2. of this section; and

22 2. Provide the data in formats and files that shall be consistent with the subsystems

23 listed in subsection (1)(a)2. of this section; and

1 (b) Meets the requirements established in paragraph (a) of this subsection in a way
2 which shall be mapped to the subsystem concept established in subsection (1)(a)2. of
3 this section.

4 (3) If an MCO subcontracts for services, the MCO shall provide guidelines for its sub-
5 contractor to the department for approval.

6 Section 9. Kentucky Health Information Exchange (KHIE). (1) An MCO shall:

7 (a) Make an attempt to have a PCP in the MCO's network connect to KHIE within:

8 1. One (1) year of enrollment in the MCO's network; or

9 2. A timeframe approved by the department if greater than one (1) year; and

10 (b) Encourage a provider in its network to establish connectivity with the KHIE.

11 (2) The department shall:

12 (a) Administer an electronic health record incentive payment program; and

13 (b) Inform an MCO of a provider that has received an electronic health record incen-
14 tive payment.

15 Section 10. MCO Qualifications and Maintenance of Records. (1) An MCO shall:

16 (a) Be licensed by the Department of Insurance as a health maintenance organiza-
17 tion or an insurer;

18 (b) Have a governing body;

19 (c) Have protection against insolvency in accordance with:

20 1. 806 KAR 3:190; and

21 2. 42 C.F.R. 438.116;

22 (d) Maintain all books, records, and information related to MCO providers, recipients,
23 or recipient services, and financial transactions for:

1 1. A minimum of five (5) years in accordance with 907 KAR 1:672; and

2 2. Any additional time period as required by federal or state law; and

3 (e) Submit a request for disclosure of information subject to open records laws, KRS
4 61.870 to 61.884, received from the public to the department within twenty-four (24)
5 hours.

6 (2) Information shall not be disclosed by an MCO pursuant to a request it received
7 pursuant to subsection (1)(e) of this section without prior written authorization from the
8 department.

9 (3) The books, records, and information referenced in subsection (1)(d) of this section
10 shall be available upon request of a reviewer or auditor during routine business hours at
11 the MCO's place of operations.

12 (4) MCO staff shall be available upon request of a reviewer or auditor during routine
13 business hours at the MCO's place of operations.

14 Section 11. Prohibited Affiliations. The policies or requirements:

15 (1) Imposed on a managed care entity in 42 U.S.C. 1396u-2(d)(1) shall apply to an
16 MCO; and

17 (2) Established in 42 C.F.R. 438.610 shall apply to an MCO.

18 Section 12. Termination of MCO Participation in the Medicaid Program. If necessary,
19 a contract with an MCO shall be terminated and the termination shall be in accordance
20 with KRS Chapter 45A.

21 Section 13. Centers for Medicare and Medicaid Services Approval and Federal Fi-
22 nancial Participation. A policy established in this administrative regulation shall be null
23 and void if the Centers for Medicare and Medicaid Services:

- 1 (1) Denies or does not provide federal financial participation for the policy; or
- 2 (2) Disapproves the policy.

907 KAR 17:030E

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 17:030E
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 Kentucky Medicaid program managed care organization (MCO) operational and related requirements. Previously, those policies were contained in one (1) administrative regulation - (907 KAR 17:005) – which contained all MCO policies and requirements (excluding policies related to the MCO operating in region three (3)). Region three (3) is a sixteen (16) county region which includes Jefferson County and previously only contained one (1) MCO. A separate regulation, 907 KAR 1:705, established the requirements and policies for the lone MCO in region three (3).

The contract between DMS and the lone MCO in region three (3) is expiring and earlier this year DMS published a request for proposal for bids to perform MCO responsibilities in region three (3). Through that process DMS awarded contracts with four (4) entities – including the incumbent entity that was the sole region three (3) entity. As a result DMS is repealing 907 KAR 1:705 and establishing uniform requirements and policies for MCOs for all regions – one set of requirements and policies. DMS is doing this by addressing MCO requirements and policies across six (6) administrative regulations rather than the aforementioned 907 KAR 17:005. DMS is dividing the policies across multiple regulations in response to urging from the Administrative Regulation Review Subcommittee when it reviewed 907 KAR 17:005 earlier this year. Thus, this is a new administrative regulation but it contains policies that were previously stated in 907 KAR 17:005. The only amended policy in this administrative regulation is the elimination of the MCO reporting requirements, the Management Information System Requirements, the Third Party Liability/Coordination of Benefits as incorporating the materials is unnecessary.

- (b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid managed care organization requirements and policies relating to utilization management and quality. The amendment is necessary to prevent the unnecessary incorporation by reference of documents into an administrative regulation.
- (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 Medicaid managed care organization requirements and policies relating to utilization management and quality.
- (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation will assist in the ef-

fective administration of the authorizing statutes by establishing Medicaid managed care organization requirements and policies relating to utilization management and quality.

- (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: Medicaid providers who participate with any or all managed care organizations, Medicaid recipients enrolled in managed care (currently, there are over 700,000 such individuals) and the four (4) managed care organizations providing Medicaid covered services under contract with the Commonwealth will be affected by the administrative regulation.
- (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: No action is required.
 - (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.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). The administrative regulation establishes definitions for managed care regulation. Definitions will benefit the affected entities by providing clarity to terms used in the Medicaid managed care regulations.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
 - (a) Initially: No cost is necessary to implement the amendment to this administrative regulation. DMS's projected managed care expenditures for state fiscal year (SFY 2013) are \$3,198,870,633.
 - (b) On a continuing basis: No cost is necessary to implement the amendment to this administrative regulation. DMS's projected managed care expenditures for state fiscal year (SFY 2013) are \$3,303,448,347.

- (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 comprised of general fund and restricted 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 or indirectly increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is neither applied nor necessary as the administrative regulation applies equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 17:030E

Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, there are federal requirements for states which implement managed care and those requirements are contained in 42 CFR Part 438. This administrative regulation established MCO operational and related requirements.
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."
3. Minimum or uniform standards contained in the federal mandate. A managed care program is not federally mandated for Medicaid programs; however, Medicaid managed care organizations must meet certain federal requirements established in 42 CFR Part 438. This administrative regulation establishes MCO operational and related requirements and those requirements include:

MCOs are required to make adequate provisions against the risk of insolvency., A provision meets the requirements for a plan if the plan meets the solvency standards established by the state for private plans or is licensed or certified by the state as a risk-bearing entity; recipients must be protected from any liability in case of insolvency or failure to receive payment from the state; an MCO may not affiliate knowingly with individuals debarred, suspended, or otherwise excluded from doing business with the federal government; an MCO may not have such an individual as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity; an MCO may not have an employment, consulting, or other agreement with such an individual for the provision of items and services that are significant and material to the entity's obligations under its contract with the state; an MCO may not enter into a contract with any state that does not have in effect conflict-of-interest safeguards with respect to officers and employees of the state with responsibilities relating to contracts with such organizations or to the default enrollment process that are at least as effective as the federal safeguards provided under §27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423); an MCO must require each physician providing services to eligible enrollees have a unique identifier; States must establish standards for a range of intermediate sanctions that a state may impose on plans that: (1) fail to provide medically necessary items and services; (2) impose excessive premiums or charges; (3) discriminate against enrollees on the basis of health status; (4) misrepresent or falsify information; or (5) fail to comply with the applicable requirements of federal law on payment to Medicaid-participating HMOs re-

garding physician incentive plans; states may also may impose intermediate sanctions against a managed care entity that improperly distributes marketing materials; Intermediate sanctions may consist of civil money penalties; states may terminate a contract with an MCO and enroll the entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the state plan other than through a managed care entity); the Centers for Medicare and Medicaid Services (CMS) must review and approve all contracts with MCOs; and MCOs pay affiliated healthcare providers for items and services on a timely basis in accordance with federal law deadlines for claims payment unless the healthcare provider and the organization agree to an alternate payment schedule.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No, this change relates to provision of managed care (which is not federally mandated) but does not impose additional or stricter requirements than the federal managed care organization requirements.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. Stricter requirements are not being imposed.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 17:030E

Agency Contact Person: Stuart Owen (502) 564-4321

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

Yes X No _____

If yes, complete 2-4.

2. 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. Additionally, county-owned hospitals, university hospitals, local health departments, and primary care centers owned by government entities will be affected by this administrative regulation.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 CFR 438 and this administrative regulation authorizes the action taken by this administrative regulation.
4. 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? No cost is necessary to implement this amended administrative regulation. DMS's projected managed care expenditures for SFY 2013 are \$3,198,870,633.
 - (d) How much will it cost to administer this program for subsequent years? No cost is necessary to implement this amended administrative regulation. DMS's projected managed care expenditures for SFY 2014 are \$3,303,448,347.