CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Health Care Policy
(Amendment)

907 KAR 1:632. Vision program coverage provisions and requirements.

RELATES TO: KRS 205.520, 205.622, 205.8451(7), (9), Chapter 320, Chapter 326, 326.030, 326.040, 369.101 to 369.120, 42 C.F.R. 400.203, 431.17, 438.2, 440.40, 440.60, 447 Subpart B, ~~[42 U.S.C. 1396a-d,]~~45 C.F.R. 147.126, Parts 160 and 164, 164.306, 164.316, 42 U.S.C. 1320d to 1320d-8, 1396a-d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. 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 Kentucky Medicaid Program provisions and requirements regarding the coverage of vision services.

Section 1. Definitions.

(1) "Current procedural terminology code" or "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(2) "Department" means the Department for Medicaid Services~~[Servicers]~~ or its designee.

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Healthcare Common Procedure Coding System" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or items.

(6) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(7) "Medicaid basis" means a scenario in which:

(a) A provider provides a service to a recipient as a Medicaid-participating provider in accordance with:

1. 907 KAR 1:671; and
2. 907 KAR 1:672;

(b) The Medicaid Program is the payer for the service; and

(c) The recipient is not liable for payment to the provider for the service~~[other than any cost-sharing obligation owed by the recipient to the provider]~~.

(8) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(9) "Ophthalmic dispenser" means an individual who is qualified to engage in the practice of ophthalmic dispensing in accordance with KRS 326.030 or 326.040.

(10) "Optometrist" means an individual who is licensed as an optometrist in accordance with KRS Chapter 320.

(11) "Provider" is defined by KRS 205.8451(7).

(12) "Recipient" is defined by KRS 205.8451(9).

Section 2. General Requirements and Conditions of Participation.

(1)

(a) For the department to reimburse for a vision service or item, the service or item shall be:

1. Provided:
   a. To a recipient; and
   b. By a provider who is:
      (i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;
      (ii) Except as provided in paragraph (b) of this subsection, currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and
      (iii) Authorized by this administrative regulation to provide the given service or item;
2. Covered in accordance with this administrative regulation;
3. Medically necessary;
4. A service or item authorized within the scope of the provider's licensure; and

5. A service or item listed on the Kentucky Medicaid Vision Fee Schedule.~~[Department for Medicaid Services Vision Program Fee Schedule.]~~

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(2)

(a) To be recognized as an authorized provider of vision services, an optometrist shall:

1. Be licensed by the:

a. Kentucky Board of Optometric Examiners; or

b. Optometric examiner board in the state in which the optometrist practices if the optometrist practices in a state other than Kentucky;

2. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

3. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(b)

1. To be recognized as an authorized provider of vision services, an in-state optician shall:

a. Hold a current license in Kentucky as an ophthalmic dispenser;

b. Comply with the requirements established in KRS Chapter 326;

c. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

d. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

2. To be recognized as an authorized provider of vision services, an out-of-state optician shall:

a. Hold a current license in the state in which the optician practices as an ophthalmic dispenser;

b. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and

c. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.

(c) A physician shall be an authorized provider of vision services.

(3) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672;

(c) All applicable state and federal laws; and

(d) The confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.

(4)

(a) A provider shall:

1. Have the freedom to choose whether to provide services to a recipient; and

2. Notify the recipient referenced in paragraph (b) of this subsection of the provider's decision to accept or not accept the recipient on a Medicaid basis prior to providing any services to the recipient.

(b) A provider may provide a service to a recipient on a non-Medicaid basis:

1. If the recipient agrees to receive the service on a non-Medicaid basis; and

2. The service is not a Medicaid covered service ~~[Whether or not the:]~~

~~[a.] [Provider is a Medicaid-participating provider; or]~~

~~[b.] [Service is a Medicaid-covered service]~~.

Section 3. Vision Service Coverage.

(1) Vision service coverage shall be limited to a service listed with a CPT code or item with an HCPCS code on the Kentucky Medicaid Vision Fee Schedule~~[Department for Medicaid Services Vision Program Fee Schedule]~~ as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

(2) Vision service limits shall be as established on the Kentucky Medicaid Vision Fee Schedule~~[Department for Medicaid Services Vision Program Fee Schedule]~~ as available at: https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx.

(3) Vision service limits may be exceeded by prior authorization for children under twenty-one (21) if medically necessary.

Section 4. Coverage of Eyeglasses and Frames.

(1) To be eligible for eyeglasses covered by the department, a recipient shall~~[:]~~

~~[(a)] [Be under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21) years of age; and]~~

~~[(b)]~~ have a diagnosed visual condition that:

(a) ~~[1.]~~ Requires the use of eyeglasses;

(b) ~~[2.]~~ Is within one (1) of the following categories:
1. ~~[a.]~~ Amblyopia;
2. ~~[b.]~~ Post surgical eye condition;
3. ~~[c.]~~ Diminished or subnormal vision; or
4. ~~[d.]~~ Other diagnosis which indicates the need for eyeglasses; and

(c) ~~[3.]~~ Requires a prescription correction in the stronger lens no weaker than:
1. ~~[a.]~~ +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
2. ~~[b.]~~ 0.50 diopter of vertical prism; or
3. ~~[c.]~~ A total of two (2) diopter of lateral prism.

(2) Provisions regarding any limit on the number of eyeglasses covered shall be as established in 907 KAR 1:631.

(3) For the department to cover:
(a) A frame, the frame shall be:
1. First quality;
2. Free of defects;~~[and]~~
3. Deluxe; and
4. Have a warranty of at least one (1) year; or

(b) A lens, the lens shall be:
1. First quality;
2. Free of defects;
3. Meet the United States Food and Drug Administration's impact resistance standards; ~~[and]~~
4. Polycarbonate and scratch coated; and
5. If medically necessary, inclusive of prisms.

(4) The dispensing of eyeglasses shall include:
(a) Single vision prescriptions;
(b) Bi-focal vision prescriptions;
(c) Multi-focal vision prescriptions;
(d) Progressive lens prescriptions;
(e) Services to frames; or
(f) ~~[(e)]~~ Delivery of the completed eyeglasses which shall include:
1. Instructions in the use and care of the eyeglasses; and
2. Any adjustment, minor or otherwise, for a period of one (1) year.

(5) A provider shall be responsible, at no additional cost to the department or the recipient, for:
(a) An inaccurately filled prescription;
(b) Defective material; or
(c) An improperly fitted frame.

Section 5. Contact Lenses, Tint, and Plano Safety Glasses.
(1) The department shall ~~[not]~~reimburse for contact lenses substituted for eyeglasses if a medical indication prevents the use of eyeglasses~~[unless:]~~
~~[(a)] [The corrected acuity in a recipient's stronger eye is twenty (20)/fifty (50) and shall be improved with the use of contact lenses;]~~
~~[(b)] [The visual prescription is of + 8.00 diopter or greater; or]~~
~~[(c)] [The recipient's diagnosis is 4.00 diopter anisometropia]~~.

(2) The department's reimbursement for contact lenses shall include daily contact lenses.

(3) The department shall not reimburse for tint unless the prescription specifically indicates a diagnosis of photophobia.

(4) ~~[(3)]~~ The department shall not reimburse for plano safety glasses unless the glasses are medically indicated for the recipient.

Section 6. Noncovered Services or Items. The department shall not reimburse for:
(1) Tinting if not medically necessary;
(2) Photochromics if not medically necessary;
(3) Anti-reflective coatings if not medically necessary;
(4) Other lens options which are not medically necessary;
(5) Low vision services;
(6) A press-on prism if not medically necessary; or
(7) A service with a CPT code or item with an HCPCS code that is not listed on the Kentucky Medicaid Vision Fee Schedule~~[Department for Medicaid Services Vision Program Fee Schedule]~~.

Section 7. Required Provider Documentation.
(1)

(a) In accordance with 42 C.F.R. 431.17, a provider shall maintain medical records of a service provided to a recipient for the period of time currently required by the United States Health and Human Services Secretary unless the department requires a retention period, pursuant to 907 KAR 1:671, longer than the period required by the United States Health and Human Services Secretary.

(b) If, pursuant to 907 KAR 1:671, the department requires a medical record retention period longer than the period required by the United States Health and Human Services Secretary, the medical record retention period established in 907 KAR 1:671 shall be the minimum record retention period.

(c) A provider shall maintain medical records of a service provided to a recipient in accordance with:

1. 45 C.F.R. 164.316; and
2. 45 C.F.R. 164.306.

(2) A provider shall maintain the following documentation in a recipient's medical record:

(a) Any covered service or covered item provided to the recipient;

(b) For each covered service or covered item provided to the recipient:

1. A signature by the individual who provided the service or item signed on the date the service or item was provided;
2. The date that the service or item was provided; and
3. Demonstration that the covered service or covered item was provided to the recipient;

(c) The diagnostic condition necessitating the service or item; and

(d) The medical necessity as substantiated by an appropriate medical order.

Section 8. No Duplication of Service.

(1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech-language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the same service provided to the same recipient during the same time period via the physician services program.

Section 9. Third Party Liability. A provider shall comply with KRS 205.622.

Section 10. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with the claim or medical record.

Section 11. Use of Electronic Signatures.

(1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;
2. Identify each electronic signature for which an individual has access; and
3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;
2. Attest to the signature's authenticity; and
3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;
2. The signed consent form; and
3. The original filed signature.

Section 12. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 13. Appeal Rights. An appeal of a department decision regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

Section 14. Incorporation by Reference.

(1) "Kentucky Medicaid Vision Fee Schedule" ~~["Department for Medicaid Services Vision Program Fee Schedule"]~~, April 2023~~[May 13, 2014]~~, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, Monday through Friday, 8

a.m. to 4:30 p.m. or online at the department's Web site at https://www.chfs.ky.gov/agencies/dms/Pages/feesrates.aspx[~~http://www.chfs.ky.gov/dms/incorporated.htm~~].

LISA D. LEE, Commissioner
ERIC C. FRIEDLANDER, Secretary

APPROVED BY AGENCY: April 7, 2023
FILED WITH LRC: April 12, 2023 at 8:00 a.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall, if requested, be held on June 26, 2023, at 9:00 a.m. using the CHFS Office of Legislative and Regulatory Affairs Zoom meeting room. The Zoom invitation will be emailed to each requestor the week prior to the scheduled hearing. Individuals interested in attending this virtual hearing shall notify this agency in writing by June 19, 2023, 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. This hearing is open to the public. Any person who attends virtually 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 be heard at the public hearing, you may submit written comments on this proposed administrative regulation until June 30, 2023. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to the contact person. Pursuant to KRS 13A.280(8), copies of the statement of consideration and, if applicable, the amended after comments version of the administrative regulation shall be made available upon request.

CONTACT PERSON: Krista Quarles, Policy Analyst, Office of Legislative and Regulatory Affairs, 275 East Main Street 5 W-A, Frankfort, Kentucky 40621; phone 502-564-6746; fax 502-564-7091; email CHFSregs@ky.gov.

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Contact Person:Jonathan Scott, Executive Advisor

(1) Provide a brief summary of:

(a) What this administrative regulation does:
This administrative regulation establishes Medicaid program coverage policies and requirements regarding vision services.

(b) The necessity of this administrative regulation:
This administrative regulation is necessary to establish Medicaid program coverage provisions and requirements regarding vision services.

(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 program coverage provisions and requirements regarding vision services.

(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 authorizing statutes by establishing Medicaid program coverage provisions and requirements regarding vision services; by complying with a federal mandate; and by protecting Kentucky taxpayer monies from being spent if federal matching funds are not provided.

(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:
The amendment changes the administrative regulation by implementing a state plan amendment that allows for adults to receive vision services. The amendment also clarifies cost sharing requirements, how providers can deliver services on a non-Medicaid basis, requires a higher quality of frame, lens, and lens enhancements to be available to Medicaid recipients. In addition, clarification is made that contact lenses are covered and that daily contact lenses will be available to Medicaid recipients. Finally, updated references to the department's vision fee schedule are included.

(b) The necessity of the amendment to this administrative regulation:
This amendment is necessary to update the administrative regulation to reflect current vision policy, and to implement the approval of recent state plan amendments.

(c) How the amendment conforms to the content of the authorizing statutes:
The amendment conforms to the content of the authorizing statutes by implementing a state plan amendment and updating the administrative regulation to conform to recent statutory and regulatory updates to the Medicaid program.

(d) How the amendment will assist in the effective administration of the statutes:
The amendment assists in the effective administration of the statutes by providing a periodic update of the vision program, and to implement recently effective state plan amendments, administrative regulations, and statutes.

(3) List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation:
This administrative regulation will impact all adult and children recipients in the Medicaid program by enhancing the quality of vision products that can be offered to recipients. There are currently 1.7 million individuals in the Medicaid program. The adult population that is newly eligible could include as many as 900,000 individuals from the traditional and expansion Medicaid populations. In addition, this administrative regulation will affect vision service providers participating 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:
No action is required of the regulated entities other than to properly bill for services and adhere to program integrity requirements.

(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):

Individual beneficiaries will benefit from access to vision services, such as eyeglasses and contact lenses. Vision services providers will benefit from the opportunity to provide services to an additional population of Medicaid beneficiaries. (5) Provide an estimate of how much it will cost to implement this administrative regulation:

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially:

The Department for Medicaid Services (DMS) anticipates an increase of about $0.75 for each adult beneficiary's per member per month capitation (PMPM) managed care organization (MCO) capitation rate. This upfront expenditure should be balanced against expected savings that could be generated within the Medicaid adult population. Consistent with national trends, DMS expects that Medicaid vision coverage will increase the likelihood of working full-time for adult beneficiaries. This could result in individuals leaving the Medicaid program as a result of receiving full-time employment. The department – due to the efficiencies created – will meet its budgetary requirements as established in House Bill 1 of the 2022 Regular Session.

(b) On a continuing basis:

DMS anticipates that movement out of the Medicaid program will intensify in future years. DMS further anticipates that the preventive care will reduce later utilization. The department will revisit the PMPM for this service category with contracted actuaries prior to making future budget requests.

(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, state matching funds, and agency 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:

No increase in funding will be necessary to implement this administrative regulation.

(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?

Tiering is no longer applied within this administrative regulation as vision services are now available to all Medicaid recipients.

FEDERAL MANDATE ANALYSIS COMPARISON

(1) Federal statute or regulation constituting the federal mandate.
42 U.S.C. 1396a(a)(30)(A), 42 U.S.C. 1396a(a)(33), 42 C.F.R. 441.56(c)(1), 42 C.F.R. 441.30, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.

(2) State compliance standards.
Vision services for Medicaid recipients are not mandated by Kentucky law; however, the Department for Medicaid Services is required by KRS 205.8453 to "institute other measures necessary or useful in controlling fraud and abuse." KRS 205.520(3) states: "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.
Coverage of vision services is mandated only for certain children within the early and periodic screening, diagnosis and treatment (EPSDT) program for individuals under age twenty-one (21). 42 C.F.R. 441.30 states, "The plan must provide for payment of optometric services as physician services, whether furnished by an optometrist or a physician, if— (a) The plan does not provide for payment for services provided by an optometrist, except for eligibility determinations under §§435.531 and 436.531 of this subchapter, but did provide for those services at an earlier period; and (b) The plan specifically provides that physicians' services include services an optometrist is legally authorized to perform." Additionally, state Medicaid programs are required to take measures to monitor that services are appropriate. States are required to establish a plan for review of the appropriateness and quality of care and services furnished to Medicaid recipients by appropriate health care professionals. The plan helps protect against overutilization or unnecessary care and to assure that reimbursement is consistent with efficiency, economy and quality of care. 42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to: "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services" 45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

(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.
Stricter requirements are not imposed.

FISCAL NOTE

(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 (DMS) will be affected by the administrative regulation.

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

KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1), and 45 C.F.R. 147.126.

(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?

The amendment is not expected to generate revenue for state or local government.

(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?

The amendment is not expected to generate revenue for state or local government.

(c) How much will it cost to administer this program for the first year?

The Department for Medicaid Services (DMS) anticipates an increase of about $0.75 for each adult beneficiary's per member per month capitation (PMPM) managed care organization (MCO) capitation rate. This up-front expenditure should be balanced against expected savings that could be generated within the Medicaid adult population. Consistent with national trends, DMS expects that Medicaid vision coverage will increase the likelihood of working full-time for adult beneficiaries. This could result in individuals leaving the Medicaid program as a result of receiving full-time employment. The department – due to the efficiencies created – will meet its budgetary requirements as established in House Bill 1 of the 2022 Regular Session. (b) On a continuing basis:

(d) How much will it cost to administer this program for subsequent years?

DMS anticipates that movement out of the Medicaid program will intensify in future years. DMS further anticipates that the preventive care will reduce later utilization. The department will revisit the PMPM for this service category with contracted actuaries prior to making future budget requests.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year?

DMS anticipates cost savings for vision services providers who will be able to receive Medicaid reimbursement for a previously uncovered population of 900,000 people. The vision services providers would have previously sought private pay reimbursement for these services and many recipients may have not accessed services as a result. In addition, other services – such as higher quality eyeglasses and daily contacts - are now available to the entirety of the Medicaid population. This will provide a stable source of funding for these services.

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years?

DMS anticipates cost savings on an ongoing basis for vision services providers because expanded services, and higher quality products will now be from a more stable funding source.

(c) How much will it cost the regulated entities for the first year?

DMS does not anticipate that regulated entities will incur costs as a result of this amendment in the first year.

(d) How much will it cost the regulated entities for subsequent years?

DMS does not anticipate that regulated entities will incur costs as a result of this amendment in subsequent years.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Cost Savings (+/-):

Expenditures (+/-):

Other Explanation:

(5) Explain whether this administrative regulation will have a major economic impact, as defined below.

"Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)] The administrative regulation will not have a major economic impact – as defined by KRS 13A.010 – on regulated entities. DMS anticipates that this amendment may result in additional reimbursement for ophthalmologists and optometrists.