

# EXHIBIT I

## QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services  
 DIVISION Division of Medical Services  
 DIVISION DIRECTOR Dawn Zekis, Interim Director  
 CONTACT PERSON Robbie Nix  
 ADDRESS P.O. Box 1437, Slot S295, Little Rock, AR 72203  
 PHONE NO. 501-320-6427 FAX NO. 501-682-2480 MAIL robert.nix@dhs.arkansas.gov  
 NAME OF PRESENTER AT COMMITTEE MEETING Marilyn Strickland  
 PRESENTER E-MAIL marilyn.strickland@dhs.arkansas.gov

### INSTRUCTIONS

- A. Please make copies of this form for future use.
- B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
- C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
- D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

**Donna K. Davis**  
**Administrative Rules Review Section**  
**Arkansas Legislative Council**  
**Bureau of Legislative Research**  
**One Capitol Mall, 5<sup>th</sup> Floor**  
**Little Rock, AR 72201**

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1. What is the short title of this rule? EPISODE-4-14

2. What is the subject of the proposed rule? To adjust the thresholds for incentive payments for Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) episodes.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes  No   
 If yes, please provide the federal rule, regulation, and/or statute citation. \_\_\_\_\_

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes  No   
 If yes, what is the effective date of the emergency rule? \_\_\_\_\_

When does the emergency rule expire? \_\_\_\_\_

Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes  No

5. Is this a new rule? Yes  No   
If yes, please provide a brief summary explaining the regulation. \_\_\_\_\_

Does this repeal an existing rule? Yes  No   
If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does. \_\_\_\_\_

Is this an amendment to an existing rule? Yes  No   
If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give the Arkansas Code citation. Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary? The purpose of the proposed rule is to adjust the thresholds for incentive payments for COPD episodes.

This proposed rule is necessary so that providers are aware of the adjusted thresholds for COPD episodes.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).  
<https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx>

9. Will a public hearing be held on this proposed rule? Yes  No   
If yes, please complete the following:

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Place: \_\_\_\_\_

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)  
July 22, 2014

11. What is the proposed effective date of this proposed rule? (Must provide a date.)  
October 1, 2014

12. Do you expect this rule to be controversial? Yes  No   
If yes, please explain. While the episode based payment improvement initiative does not change current reimbursement, there is risk that providers could incur a negative incentive adjustment that would require them to remit money back to Medicaid

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules?  
Please provide their position (for or against) if known.

Medical associations, interested providers and advocacy organizations. Their positions for or against is not known at this time.

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**FINANCIAL IMPACT STATEMENT**

**PLEASE ANSWER ALL QUESTIONS COMPLETELY**

**DEPARTMENT** Department of Human Services  
**DIVISION** Division of Medical Services  
**PERSON COMPLETING THIS STATEMENT** Lynn Burton  
**TELEPHONE NO.** 682-1857 **FAX NO.** 682-2480 **EMAIL:** Lynn.Burton@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

**SHORT TITLE OF THIS RULE** EPISODE-4-14

- 1. Does this proposed, amended, or repealed rule have a financial impact? Yes  No
- 2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes  No
- 3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes  No

If an agency is proposing a more costly rule, please state the following:

(a) How the additional benefits of the more costly rule justify its additional cost;

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(b) The reason for adoption of the more costly rule;

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(c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

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(d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

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4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

(a) What is the cost to implement the federal rule or regulation?

**Current Fiscal Year**

**Next Fiscal Year**

General Revenue \_\_\_\_\_  
Federal Funds \_\_\_\_\_  
Cash Funds \_\_\_\_\_  
Special Revenue \_\_\_\_\_  
Other (Identify) \_\_\_\_\_

General Revenue \_\_\_\_\_  
Federal Funds \_\_\_\_\_  
Cash Funds \_\_\_\_\_  
Special Revenue \_\_\_\_\_  
Other (Identify) \_\_\_\_\_

Total 0

Total \$0

(b) What is the additional cost of the state rule?

**Current Fiscal Year**

**Next Fiscal Year**

General Revenue \$4,827 (SAVINGS)

Federal Funds \$11,430 (SAVINGS)

Cash Funds \_\_\_\_\_

Special Revenue \_\_\_\_\_

Other (Identify) \_\_\_\_\_

Total \$16,527 (SAVINGS)

General Revenue \$3,813 (ADDITIONAL COST)

Federal Funds \$9,031 (ADDITIONAL COST)

Cash Funds \_\_\_\_\_

Special Revenue \_\_\_\_\_

Other (Identify) \_\_\_\_\_

Total \$12,844 (ADDITIONAL COST)

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

**Current Fiscal Year**

**Next Fiscal Year**

\$ 0

\$ 0

6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

**Current Fiscal Year**

**Next Fiscal Year**

16,257  
\$ (SAVINGS)

12,844  
(ADDITIONAL  
\$ L COST)

The Medicaid program projects program costs resulting from the adjusting of thresholds in the Perinatal episodes in the amounts above.

7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars (\$100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes  No

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

- (1) a statement of the rule's basis and purpose;
- (2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;
- (3) a description of the factual evidence that:
  - (a) justifies the agency's need for the proposed rule; and
  - (b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;
- (4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;
- (6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and
- (7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
  - (a) the rule is achieving the statutory objectives;
  - (b) the benefits of the rule continue to justify its costs; and
  - (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

### **Summary for Episode 4-14**

Effective October 1, 2014, Arkansas Medicaid proposes to adjust the thresholds for incentive payments for Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) episodes. The acceptable threshold for the COPD episodes will now be \$1,876.00 while the commendable threshold for the COPD episodes will now be \$1,339.00.







**Division of Medical Services**  
Program Development & Quality Assurance



P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437  
501-320-6428 · Fax: 501-682-2480  
TDD/TTY: 501-682-6789

**TO:** Arkansas Medicaid Health Care Providers – Episodes of Care  
**DATE:** October 1, 2014  
**SUBJECT:** Provider Manual Update Transmittal EPISODE-4-14

**PROPOSED**

| <u>REMOVE</u> |       | <u>INSERT</u> |         |
|---------------|-------|---------------|---------|
| Section       | Date  | Section       | Date    |
| 221.600       | _____ | 221.600       | 10-1-14 |

**Explanation of Updates**

Section 221.600 is updated to correct the amounts for Incentive Payment Thresholds for Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) Episodes.

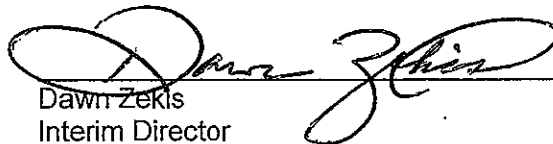
The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Arkansas Payment Improvement Initiative Center at 1-866-322-4696 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 301-8311.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: [www.medicaid.state.ar.us](http://www.medicaid.state.ar.us).

Thank you for your participation in the Arkansas Medicaid Program.

  
Dawn Zekis  
Interim Director

*TOC not required*

**221.000 ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE  
PULMONARY DISEASE (COPD) EPISODES**

**221.600 Thresholds for Incentive Payments**

10-1-14

- A. The acceptable threshold is \$1,876.00.
- B. The commendable threshold is \$1,339.00.
- C. The gain sharing limit is \$859.00.
- D. The gain sharing percentage is 50%.
- E. The risk sharing percentage is 50%.

**PROPOSED**

*Mark Up**TOC not required***221.000 ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE  
PULMONARY DISEASE (COPD) EPISODES****221.600 Thresholds for Incentive Payments**

10-1-14

- A. The acceptable threshold is \$1,4691,876.00.
- B. The commendable threshold is \$1,0461,339.00.
- C. The gain sharing limit is \$859.00.
- D. The gain sharing percentage is 50%.
- E. The risk sharing percentage is 50%.

