EXHIBIT C

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 Andrew Allison, PhD
CONTACT PERSON Angela Littrell
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 682-8333 **FAX NO.** 682-2480 **E-MAIL** angela.littrell@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Marilyn Strickland
PRESENTER E-MAIL marilyn.strickland@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
Room 315, State Capitol
Little Rock, AR 72201

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1. What is the short title of this rule?

   Section V-5-12 (Form DMS-7708)

2. What is the subject of the proposed rule?

   Practitioner Identification Number Request Form

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

   Section 1902(kk)(7) of the Affordance Care Act

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act?
   Yes ____ No__X__.

   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 __X__ If yes, please provide a brief summary explaining the regulation.

   Does this repeal an existing rule? Yes___ No__X__ If yes, a copy of the repealed rule is to be included with your completed questionnaire.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__X__ 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 Arkansas Code citation.

   Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary?

   CMS identified Physician Assistants who furnish services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as eligible professionals to receive Electronic Health Record (EHR) incentive payment. In order to receive payment, a Physician Assistant must have an assigned practitioner identification number and be associated with an FQHC or RHC. Currently, Arkansas Medicaid does not enroll nor provide Physician Assistants with a practitioner identification number. In order to ensure that eligible Physician Assistants receive EHR incentive payments, Arkansas Medicaid has developed a Practitioner Identification Number Request Form as a means to enroll, link and assign practitioner identification numbers to eligible Physician Assistants who furnish services in an FQHC or RHC.

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 __X__.
   If yes, please complete the following:
   Date:_____
   Time:_____
   Place:_____

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

    August 21, 2012

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

    November 1, 2012

12. Do you expect this rule to be controversial? Yes_____ No __X__ If yes, please explain.

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.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Tom Show
TELEPHONE NO. 682-2483 **FAX NO.** 682-2480 **EMAIL:** tom.show@arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE – Section V-5-12 (Form DMS-7708)

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes ____ No X .

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes ____ No X .

   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

Current Fiscal Year	**Next Fiscal Year**
General Revenue_____	General Revenue_____
Federal Funds_____	Federal Funds_____
Cash Funds_____	Cash Funds_____
Special Revenue_____	Special Revenue_____
Other (Identify)_____	Other (Identify)_____
Total_____	Total_____

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

Current Fiscal Year	**Next Fiscal Year**

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain.

Current Fiscal Year	**Next Fiscal Year**
None	None

Summary for
Section V-5-12 (Form DMS-7708)

The Centers for Medicare & Medicaid Services (CMS) announced the final rule to implement the provisions of the American Recovery and Reinvestment Act of 2009 (Recovery Act) that provide incentive payments for the adoption and meaningful use of certified electronic health record (EHR) technology.

CMS identified Physician Assistants who furnish services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as eligible professionals to receive Electronic Health Record (EHR) incentive payment. In order to receive payment, a Physician Assistant must have an assigned practitioner identification number and be associated with an FQHC or RHC. Currently, Arkansas Medicaid does not enroll nor provide Physician Assistants with a practitioner identification number. In order to ensure that eligible Physician Assistants receive EHR incentive payments, Arkansas Medicaid has developed a Practitioner Identification Number Request Form as a means to enroll, link and assign practitioner identification numbers to eligible Physician Assistants who furnish services in an FQHC or RHC.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: Arkansas Medicaid Health Care Providers – All Providers

DATE: November 1, 2012

SUBJECT: Provider Manual Update Transmittal SecV-5-12

PROPOSED

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
DMS-7708	08/08	DMS-7708	11/12

Explanation of Updates

Form DMS-7708 is updated to include new provider categories and EHR incentive payment application information for Physician Assistants.

This transmittal and the enclosed form are for informational purposes only. **Please do not complete the enclosed form.**

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 HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

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.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Medicaid Provider Enrollment Unit
P.O. Box 8105, Little Rock, AR 72203-8105
501-376-2211 Local and out of state · Fax: 501-374-0746 ·
1-800-457-4454 In state WATS

Practitioner Identification Number Request Form

Please check one of the following:

Physician Assistant (for EHR Incentive) ☐ Resident ☐ Other ☐ _____

Practitioner Name _____
(Please print)

NPI/Taxonomy Code _____
(NPI required for Physician Assistant and Resident)

PROPOSED

Social Security Number _____

Address _____

_____

_____
City **State** **ZIP+4**

_____
County **Phone Number** (Include area code)

Residents Only _____
Place of Residency **Effective Date of Residency**

Physician Assistants who apply to receive an EHR incentive payment must also complete a W-9 form and indicate below the FQHC or RHC primary facility with which they are associated:

_____
FQHC or RHC facility

Note: We must have your original signature. A photo copied or stamped signature is unacceptable.

Practitioner's Signature _____

Date _____

Mail this completed form to:

Medicaid Provider Enrollment Unit
HP Enterprise Services
P.O. Box 8105
Little Rock, AR 72203-8105

Mark up

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Medicaid Provider Enrollment Unit
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501-376-2211 Local and out of state · Fax: 501-374-0746 ·
1-800-457-4454 In state WATS

Practitioner Identification Number Request Form

Please check one of the following:

Physician Assistant (for EHR Incentive) ☐ Resident ☐ Other ☐ _____

Practitioner Name _____
(Please print)

NPI/Taxonomy Code _____
(NPI required for Physician Assistant and Resident)

Social Security Number _____

Address _____

_____

_____
City **State** **ZIP+4**

_____
County **Phone Number** (Include area code)

Residents Only _____
Place of Residency **Effective Date of Residency**

Physician Assistants who apply to receive an EHR incentive payment must also complete a W-9 form and indicate below the FQHC or RHC primary facility with which they are associated:

_____
FQHC or RHC facility

Note: We must have your original signature. A photo copied or stamped signature is unacceptable.

Practitioner's Signature _____

Date _____

Mail this completed form to:

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HP Enterprise Services
P.O. Box 8105
Little Rock, AR 72203-8105