National Indian Health Board

Regulation Review and Impact Analysis Report v. 5.01

as of January 31, 2015

Attachments
- Table A: Listing and Status Report on Regulations Reviewed
- Table B: Summary and Analysis of Agency Notices and Regulations
- Table C: NIHB Recommendations and Evaluation of Agency's Subsequent Actions
- RRIAR Index
- RRIAR Number Reference Guide

NOTE: For regulatory actions taken prior to January 1, 2013, please see the Regulation Review and Impact Analysis Report (RRIAR), v. 2.12 dated December 31, 2012. For regulatory actions taken from January 1, 2013, to December 31, 2013, please see the RRIAR, v. 3.12, dated December 31, 2013. For regulatory actions taken from January 1, 2014, to December 31, 2014, please see the RRIAR, v. 4.12, dated December 31, 2014.

The purpose of the Regulation Review and Impact Analysis Report (RRIAR) is to identify and summarize key regulations issued by the Centers for Medicare and Medicaid Services (CMS) pertaining to Medicare, Medicaid, CHIP, and health reform[1] that affect (a) American Indians and Alaska Natives and/or (b) Indian Health Service, Indian Tribe and tribal organization, and urban Indian organization providers. Furthermore, the RRIAR includes a summary of the regulatory analyses prepared by the National Indian Health Board (NIHB)[2], if any, and indicates the extent to which the recommendations made by NIHB were incorporated into any subsequent CMS actions.

In addition to this cover page, the report consists of three tables as well as a **recently added health reform index** and number reference guide –

- Table A provides a status report on the RRIAR itself, listing the regulations included in the RRIAR to date, and the components of the analysis provided under each. The regulations are organized in four sections: I. Medicaid; II. Medicare; III. Health Reform; and IV. Other.
- Table B lists key regulations issued by CMS, due dates for comments, a synopsis of the CMS action, and a summary of the analysis, if any, prepared by NIHB.
- Table C identifies the recommendations made by NIHB pertaining to each regulation, if any, and evaluates the extent to which the recommendations made by NIHB were incorporated into subsequent CMS actions.
- The RRIAR Index: Health Reform lists key terms (further sorted by subtopic, when applicable) found in regulations implementing health reform, with the corresponding RRIAR entry numbers and page numbers shown. The accompanying RRIAR Number Reference Guide: Health Reform provides a listing, by RRIAR entry number, of the notice type, short title, and issuing agency or agencies for each entry.

For regulations issued over the September 2010 through December 2012 period, please refer to the archived RRIAR v.2.12 dated December 31, 2012. For regulations issued over the January 2013 through December 2013 period, please refer to the archived RRIAR v.3.12 dated December 31, 2013.

Regulations with pending due dates for public comments –

- 27.i. Risk Corridors Transitional Policy (CMS-10532; **comments due 2/4/2015**)
- 112.d. I/T/U Payment for Physician and Non-Hospital-Based Services (IHS/RIN 0917-AA12; **comments due 2/4/2015**)
- 10.c. Medicare Shared Savings Program: ACOs (CMS-1461-P; **comments due 2/6/2015**)
- 31.nn. Notification of Objection to Covering Contraceptive Services (CMS-10535; **comments due 2/6/2015**)
- 31.gg. Coverage of Certain Preventive Services Under ACA (EBSA Form 700; **comments due 2/9/2015**)
- 8.c. ACA Requirements for Section 1115 Projects (CMS-10321; **comments due 2/10/2015**)
- 11.hh. Medicare Part C, Part D, and FFS CAHPS Survey (CMS-R-246; **comments due 2/10/2015**)
- 137.c. Transcatheter Mitral Valve Repair National Coverage Decision (CMS-10531; **comments due 2/10/2015**)
- 196. Patient Rights CoPs and Conditions for Coverage (CMS-3302-P; **comments due 2/10/2015**)
- 11.ii. Survey of Retail Community Pharmacy Prices (CMS-10241; **comments due 2/17/2015**)
- 62. External Quality Review of Medicaid MCOs (CMS-R-305; **comments due 2/17/2015**)
- 77.d. National Provider Identifier Application and Update Form (CMS-10114; **comments due 2/17/2015**)
- 134.l. Federally Qualified Health Center Cost Report Form (CMS-224-14; **comments due 2/17/2015**)
- 78.i. Prior Authorization Form for Beneficiaries Enrolled in Hospice (CMS-10538; **comments due 2/23/2015**)
- 92.hh. Annual Eligibility Redetermination Notices, et al. (CMS-10527; **comments due 2/23/2015**)
- 184.g. Survey Report Form for CLIA (CMS-1557; **comments due 2/23/2015**)

[1] "Health reform" is inclusive of (1) the Patient Protection and Affordable Care Act (Pub. L. 111-148), incorporating by reference S. 1790 as reported by the Committee on Indian Affairs of the Senate in December 2009 (containing amendments to the Indian Health Care Improvement Act, IHCIA), and as amended by the Health Care and Education Reconciliation Act (HCERA; Public Law 111–152) (collectively referred to as "ACA") and (2) the American Recovery and Reinvestment Act of 2009 (ARRA, Pub. L. 111-5)

[2] The analyses and recommendations may include those made by the Tribal Technical Advisory Group to CMS (TTAG) and other tribal organizations.

- 185.g. Safe Harbor for FQHC Arrangements (HHS-OS-0990-0322-30D; **comments due 2/23/2015**)
- 4.l. Ambulatory Surgical Center Quality Reporting Program (CMS-10530; **comments due 3/2/2015**)
- 31.pp. Summary of Benefits and Coverage and Uniform Glossary (REG-145878-14, DoL/RIN 1210-AB69, CMS-9938-P; **comments due 3/2/2015**)
- 41.e. New Safe Harbors (OIG-123-N; **comments due 3/2/2015**)
- 112.c. Expanded Access to Non-VA Care Through Veterans Choice (VA/RIN 2900-AP24; **comments due 3/5/2015**)
- 174.f. FEHBP: Rate Setting for Community-Rated Plans (OPM/RIN 3206-AN00; **comments due 3/9/2015**)
- 23.h. Administrative Requirements for DRA Section 6071 (CMS-10249; **comments due 3/10/2015**)
- 52.n. OASIS-C1/ICD-10 (CMS-10545; **comments due 3/10/2015**)
- 16.f. Annual Report on HCBS Waivers (CMS-372(S); **comments due 3/17/2015**)
- 132.e. Outpatient/Ambulatory Surgery Experience of Care Survey (CMS-10500; **comments due 3/17/2015**)
- 121.k. Verification of Clinic Data--Rural Health Clinic Form (CMS-29; **comments due 3/24/2015**)
- 7.t. Cooperative Agreement to Support State Exchanges (CMS-10371; **comments due 3/31/2015**)
- 7.v. Consumer Assistance Tools and Programs of Exchanges (CMS-10494; **comments due 3/31/2015**)
- 7.kk. Standards for Navigators and Non-Navigator Personnel (CMS-10472; **comments due 3/31/2015**)
- 12.d. Consumer Operated and Oriented Program (CMS-10392; **comments due 3/31/2015**)
- 48.b. Medical Loss Ratio Rebate Calculation Report and Notices (CMS-10418; **comments due 3/31/2015**)
- 172.b. Testing and Research for Medicare Beneficiary Survey (CMS-10549; **comments due 3/31/2015**)
- 64.c. Tribal Consultation Policy (Treasury/no ref. #; **comments due 4/2/2015**)

Comments recently submitted by NIHB, TTAG and/or other tribal organizations–

- 7.vv. 2016 Letter to Issuers in FFMs (CCIIO/no ref. #; comments submitted 1/12/2015 by TTAG)
- 92.ll. Health Benefit Plan Network Access and Adequacy Model Act (NAIC/no ref. #; comments submitted 1/12/2015 by TTAG)
- 112.e. Tribal Consultation on VA/IHS Reimbursement Agreements (VA/no ref. #; comments submitted 1/14/2015 by TSGAC)

Regulations under OMB (Office of Management and Budget) review –

- 54. ESI Coverage Verification (CMS/RIN 0938-ZB09; approved by OMB 4/26/2012 but not yet published)
- 16.b. Medicaid HCBS Waivers (CMS-2249-F2; approved by OMB 1/14/2014 but not yet published)
- 180. Flu Vaccination Standard for Certain Providers and Suppliers (CMS-3213-F; approved by OMB 4/18/2014 but not yet published)
- 164.b. Medicare Secondary Payer and "Future Medicals" (CMS-6047-P; approved by OMB 10/9/2014 but not yet published)
- 11.gg. CY 2015 Policy and Technical Changes to Parts C and D (CMS-4159-F2; sent to OMB 11/20/2014)
- 1.l. EHR Incentive Programs--Stage 3 (CMS-3310-P; sent to OMB 12/31/2014)
- 1.m. 2015 Edition HIT Certification Criteria, et al. (HHS ONC/RIN 0991-AB93; sent to OMB 12/31/2014)
- 200. Mental Health Parity Rules for Medicaid and CHIP (CMS-2333-P; sent to OMB 1/7/2015)
- 112.f. IHS Reimbursement Rates for CY 2015 (IHS/RIN 0917-ZA29; sent to OMB 1/17/2015)
- 39.e. Basic Health Program: Federal Funding Methodology for 2016 (CMS-2391-FN; sent to OMB 1/29/2015)
- 89.h. Notice of Benefit and Payment Parameters for 2016 (CMS-9944-F; sent to OMB 1/29/2015)

Recent (final) rules issued –

- 31.mm. 2016 Actuarial Value Calculator (CCIIO/no ref. #; issued 1/16/2015)

Contacts: Devin Delrow at DDelrow@nihb.org.
Comments submitted by NIHB, TTAG, and other organizations may be accessed at http://www.nihb.org/tribalhealthreform/mmpc-regulation-comments/.

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TABLE A: REGULATIONS INCLUDED TO DATE IN RRIAR TABLES B AND C UPDATED THROUGH 1/31/2015

RRIAR Ref. #	Short Title/ Current Status of Regulation/ Title/ Agency	File Code	Dates (Issue, Due, File, Subsequent Action)[1]	In Table B-- • Is the summary of Agency action included? • Is the NIHB analysis included?	In Table C-- • Is the list of NIHB recommendations included? • Has the Agency taken subsequent action? • Is an analysis of subsequent Agency action included?
			SECTION I: MEDICAID (AND DUAL MEDICAID AND MEDICARE)	Beginning on page 1 of 25	
			SECTION II: MEDICARE	Beginning on page 5 of 25	
			SECTION III: HEALTH REFORM	Beginning on page 14 of 25	
			SECTION IV: OTHER	Beginning on page 23 of 25	
			SECTION I: MEDICAID (AND DUAL MEDICAID AND MEDICARE)		
1.I.	EHR Incentive Programs--Stage 3 ACTION: Proposed Rule NOTICE: Electronic Health Record (EHR) Incentive Programs--Stage 3 AGENCY: CMS	CMS-3310-P	Issue Date: [Pending at OMB as of 12/31/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

[1] For regulations issued over the September 2010 through December 2012 period, please refer to the archived RRIAR v.2.12 dated December 31, 2012. For regulations issued over the January 2013 through December 2013 period, please refer to the archived RRIAR v.3.12 dated December 31, 2013.

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1.m.	2015 Edition HIT Certification Criteria, et al. NOTICE: 2015 Edition Health Information Technology (Health IT) Certification Criteria, Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications AGENCY: HHS ONC	HHS ONC RIN 0991-AB93	Issue Date: [Pending at OMB as of 12/31/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
8.c.	ACA Requirements for Section 1115 Projects ACTION: Request for Comment NOTICE: Affordable Care Act Information and Collection Requirements for Section 1115 Demonstration Projects AGENCY: CMS	CMS-10341	Issue Date: 12/12/2014 Due Date: 2/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
16.b.	Medicaid HCBS Waivers ACTION: ~~Proposed~~ Final Rule NOTICE: Medicaid; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment; Setting Requirements AGENCY: CMS	CMS-2249-~~P2~~F2	Issue Date: 5/3/2012 Due Date: ~~6/4/2012~~ 7/2/2012 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued due date extension 5/3/2012; Final Rule approved by OMB 1/13/2014	• Summary of Agency action: √ • NIHB analysis of action: None.	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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16.f.	Annual Report on HCBS Waivers ACTION: Request for Comment NOTICE: Annual Report on Home and Community Based Services Waivers and Supporting Regulations AGENCY: CMS	CMS-372(S)	Issue Date: 1/16/2015 Due Date: 3/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
23.h.	Administrative Requirements for DRA Section 6071 ACTION: Request for Comment NOTICE: Administrative Requirements for Section 6071 of the Deficit Reduction Act AGENCY: CMS	CMS-10249	Issue Date: 1/9/2015 Due Date: 3/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
28.f.	Medicaid Implementation Advanced Planning Document ACTION: Notice NOTICE: Medicaid Eligibility and Enrollment (EE) Implementation Advanced Planning Document (IAPD) Template AGENCY: CMS	CMS-10536	Issue Date: 8/29/2014 Due Date: 10/28/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 12/19/2014 Due Date: 1/20/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
41.e.	New Safe Harbors ACTION: Notice NOTICE: Solicitation of New Safe Harbors and Special Fraud Alerts AGENCY: HHS OIG	OIG-123-N	Issue Date: 12/30/2014 Due Date: 3/2/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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62.	External Quality Review of Medicaid MCOs ACTION: Request for Comment NOTICE: External Quality Review (EQR) of Medicaid Managed Care Organizations (MCOs) and Supporting Regulations AGENCY: CMS	CMS-R-305	Issue Date: 5/31/2012 Due Date: 7/2/2012 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 12/19/2014 Due Date: 2/17/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
180.	Flu Vaccination Standard for Certain Providers and Suppliers ACTION: Final Rule NOTICE: Influenza Vaccination Standard for Certain Participating Providers and Suppliers AGENCY: CMS	CMS-3213-F	Issue Date: [Approved by OMB on 4/18/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
200.	Mental Health Parity Rules for Medicaid and CHIP ACTION: Proposed Rule NOTICE: Mental Health Parity and Addiction Equity Act of 2008; the Application to Medicaid Managed Care, CHIP, and Alternative Benefit Plans AGENCY: CMS	CMS-2333-P	Issue Date: [Pending at OMB as of 1/7/2015] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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201.	Use of Restraint and Seclusion in Psychiatric Facilities ACTION: Request for Comment NOTICE: Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities (PRTFs) for Individuals Under Age 21 and Supporting Regulations AGENCY: CMS	CMS-R-306	Issue Date: 1/30/2015 Due Date: 3/31/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
			SECTION II: MEDICARE		
3.m.	FFS Audit Prepayment Review and Prior Authorization Demos ACTION: Request for Comment NOTICE: Fee-for-Service Recovery Audit Prepayment Review Demonstration and Prior Authorization Demonstration AGENCY: CMS	CMS-10421	Issue Date: 4/4/2014 Due Date: 4/18/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 9/12/2014, 12/30/2014 Due Date: 11/4/2014; 1/29/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
3.o.	Certification as a Supplier of Portable X-Ray Form ACTION: Request for Comment NOTICE: Certification as a Supplier of Portable X-Ray and Portable X-Ray Survey Report Form and Supporting Regulations AGENCY: CMS	CMS-1880 and CMS-1882	Issue Date: 11/17/2014 Due Date: 1/16/2015 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 1/30/2015 Due Date: 3/2/2015	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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4.I.	Ambulatory Surgical Center Quality Reporting Program ACTION: Request for Comment NOTICE: Ambulatory Surgical Center Quality Reporting Program AGENCY: CMS	CMS-10530	Issue Date: 11/17/2014 Due Date: 1/16/2015 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 1/30/2015 Due Date: 3/2/2015	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
10.c.	Medicare Shared Savings Program: ACOs ACTION: Proposed Rule NOTICE: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations AGENCY: CMS	CMS-1461-P	Issue Date: 12/8/2014 Due Date: 2/6/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.d.	Bid Pricing Tool ACTION: Request for Comment NOTICE: Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDPs) AGENCY: CMS	CMS-10142	Issue Date: 10/5/2012 Due Date: 12/4/2012 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 1/17/2013, 10/4/2013, 12/20/2013 9/26/2014, 12/24/2014 Due Date: 2/19/2013; 12/3/2013; 1/21/2014; 11/25/2014; 1/23/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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11.f.	Plan Benefit Package and Formulary Submission ACTION: Request for Comment NOTICE: PBP and Formulary Submission for Medicare Advantage and Prescription Drug Plans AGENCY: CMS	CMS-R-262	Issue Date: 10/5/2012 Due Date: 12/4/2012 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 1/17/2013, 11/1/2013, 1/17/2014, 9/26/2014, 12/19/2014 Due Date: 2/19/2013; 12/31/2013; 2/18/2014; 11/25/2014; 1/20/2015	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.gg.	CY 2015 Policy and Technical Changes to Parts C and D ACTION: Final Rule NOTICE: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; Remaining Provisions AGENCY: CMS	CMS-4159-F2 See also 11.u.	Issue Date: [Pending at OMB as of 11/20/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.hh.	Medicare Part C, Part D, and FFS CAHPS Survey ACTION: Request for Comment NOTICE: Medicare Advantage, Medicare Part D, and Medicare Fee-For-Service Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey AGENCY: CMS	CMS-R-246	Issue Date: 12/12/2014 Due Date: 2/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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11.ii.	Survey of Retail Community Pharmacy Prices ACTION: Request for Comment NOTICE: Survey of Retail Prices: Payment and Utilization Rates and Performance Rankings AGENCY: CMS	CMS-10241	Issue Date: 12/19/2014 Due Date: 2/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
52.f.	OASIS Collection Requirements as Part of the CoPs for HHAs ACTION: Request for Comment NOTICE: OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations AGENCY: CMS	CMS-R-245	Issue Date: 6/21/2013 Due Date: 8/20/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 11/8/2013, 8/29/2014; issued extension 11/24/2014 Due Date: 12/9/2013; 9/12/2014; 1/23/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
52.l.	Home Health Agency Conditions of Participation ACTION: Proposed Rule NOTICE: Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies AGENCY: CMS	CMS-3819-P	Issue Date: 10/9/2014 Due Date: ~~12/8/2014~~ 1/7/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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52.n.	OASIS-C1/ICD-10 ACTION: Request for Comment NOTICE: Outcome and Assessment Information Set (OASIS) OASIS-C1/ICD-10 AGENCY: CMS	CMS-10545	Issue Date: 1/9/2015 Due Date: 3/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
77.d.	National Provider Identifier Application and Update Form ACTION: Request for Comment NOTICE: National Provider Identifier (NPI) Application and Update Form and Supporting Regulations in 45 CFR 142.408, 45 CFR 162.406, 45 CFR 162.408 AGENCY: CMS	CMS-10114	Issue Date: 9/12/2014 Due Date: 11/12/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 11/21/2014, 1/16/2015 Due Date: 12/22/2014; 2/17/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
78.i.	Prior Authorization Form for Beneficiaries Enrolled in Hospice ACTION: Request for Comment NOTICE: Prior Authorization Form for Beneficiaries Enrolled in Hospice AGENCY: CMS	CMS-10538	Issue Date: 10/3/2014 Due Date: 12/2/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 1/23/2015 Due Date: 2/23/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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121.i.	Site Investigation for Diagnostic Testing Facilities ACTION: Request for Comment NOTICE: Site Investigation for Independent Diagnostic Testing Facilities (IDTFs) AGENCY: CMS	CMS-10221	Issue Date: 1/16/2015 Due Date: 3/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
121.j.	Site Investigation for Suppliers of DMEPOS ACTION: Request for Comment NOTICE: Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) AGENCY: CMS	CMS-R-263	Issue Date: 1/16/2015 Due Date: 3/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
121.k.	Verification of Clinic Data--Rural Health Clinic Form ACTION: Request for Comment NOTICE: Verification of Clinic Data--Rural Health Clinic Form and Supporting Regulations AGENCY: CMS	CMS-29	Issue Date: 1/23/2015 Due Date: 3/24/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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132.e.	Outpatient/Ambulatory Surgery Experience of Care Survey ACTION: Request for Comment NOTICE: Outpatient and Ambulatory Surgery Experience of Care Survey AGENCY: CMS	CMS-10500	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 12/27/2013; issued revision 1/16/2015 Due Date: 1/27/2014; 3/17/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
132.g.	HCAHPS Survey Mode Experiment ACTION: Request for Comment NOTICE: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Mode Experiment AGENCY: CMS	CMS-10542	Issue Date: 11/28/2014 Due Date: 1/27/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
132.h.	EDPEC Survey Mode Experiment ACTION: Request for Comment NOTICE: Emergency Department Patient Experience of Care (EDPEC) Survey Mode Experiment AGENCY: CMS	CMS-10543	Issue Date: 11/28/2014 Due Date: 1/27/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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134.I.	Federally Qualified Health Center Cost Report Form ACTION: Request for Comment NOTICE: Federally Qualified Health Center Cost Report Form AGENCY: CMS	CMS-224-14	Issue Date: 12/19/2014 Due Date: 2/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
137.c.	Transcatheter Mitral Valve Repair National Coverage Decision ACTION: Request for Comment NOTICE: Transcatheter Mitral Valve Repair (TMVR) National Coverage Decision (NCD) AGENCY: CMS	CMS-10531	Issue Date: 12/12/2014 Due Date: 2/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
164.b.	Medicare Secondary Payer and "Future Medicals" ACTION: Proposed Rule NOTICE: Medicare Secondary Payer and "Future Medicals" AGENCY: CMS	CMS-6047-P	Issue Date: [Approved by OMB 10/9/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action
172.b.	Testing and Research for Medicare Beneficiary Survey ACTION: Request for Comment NOTICE: Generic Clearance for Questionnaire Testing and Methodological Research for the Medicare Current Beneficiary Survey AGENCY: CMS	CMS-10549	Issue Date: 1/30/2015 Due Date: 3/31/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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184.e.	Fecal Occult Blood Testing Under CLIA ACTION: Proposed Rule NOTICE: Clinical Laboratory Improvement Amendments (CLIA); Fecal Occult Blood (FOB) Testing AGENCY: CMS	CMS-3271-P	Issue Date: 11/7/2014 Due Date: 1/6/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
184.f.	Laboratory Personnel Report ACTION: Request for Comment NOTICE: Laboratory Personnel Report (CLIA) and Supporting Regulations AGENCY: CMS	CMS-209	Issue Date: 11/28/2014 Due Date: 1/27/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
184.g.	Survey Report Form for CLIA ACTION: Request for Comment NOTICE: Survey Report Form for Clinical Laboratory Improvement Amendments (CLIA) and Supporting Regulations AGENCY: CMS	CMS-1557	Issue Date: 12/24/2014 Due Date: 2/23/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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196.	Patient Rights CoPs and Conditions for Coverage ACTION: Proposed Rule NOTICE: Medicare and Medicaid Program; Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage AGENCY: CMS	CMS-3302-P	Issue Date: 12/12/2014 Due Date: 2/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
			SECTION III: HEALTH REFORM		
7.t.	Cooperative Agreement to Support State Exchanges ACTION: Request for Comment NOTICE: Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges AGENCY: CMS	CMS-10371	Issue Date: 5/24/2013 Due Date: 7/23/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 8/16/2013; issued emergency review request 9/16/2013, 11/7/2014; issued revision 1/30/2015 Due Date: 9/16/2013; 9/23/2013; 11/14/2014; 3/31/2015	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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7.v.	Consumer Assistance Tools and Programs of Exchanges ACTION: Request for Comment NOTICE: Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors AGENCY: CMS	CMS-10494	Issue Date: 7/17/2013 Due Date: 9/14/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 6/27/2014, 1/30/2015 Due Date: 7/28/2014; 3/31/2015	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
7.kk.	Standards for Navigators and Non-Navigator Personnel ACTION: Request for Comment NOTICE: Standards for Navigators and Non-Navigator Assistance Personnel AGENCY: CMS	CMS-10472	Issue Date: 6/27/2014 Due Date: 7/28/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 1/30/2015 Due Date: 3/31/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
7.vv.	2016 Letter to Issuers in FFMs ACTION: Guidance NOTICE: Draft 2016 Letter to Issuers in the Federally-Facilitated Marketplaces AGENCY: CCIIO	CCIIO (no reference number)	Issue Date: 12/19/2014 Due Date: 1/12/2015 TTAG File Date: 1/12/2015 Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• TTAG recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:

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7.ww.	Special Protections for AI/ANs ACTION: Guidance NOTICE: Health Insurance Marketplace Protections for American Indians and Alaska Natives AGENCY: CMS	CMS (no reference number)	Issue Date: 1/27/2015 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
7.xx.	AI/AN Trust Income and MAGI ACTION: Guidance NOTICE: American Indian and Alaska Native Trust Income and MAGI AGENCY: CMS	CMS (no reference number)	Issue Date: 1/27/2015 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
12.d.	Consumer Operated and Oriented Program ACTION: Request for Comment NOTICE: Consumer Operated and Oriented (CO-OP) Program AGENCY: CMS	CMS-10392	Issue Date: 9/8/2014 Due Date: 11/4/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 11/21/2014, 1/30/2015 Due Date: 12/22/2014; 3/31/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
27.i.	Risk Corridors Transitional Policy ACTION: Request for Comment NOTICE: Risk Corridors Transitional Policy AGENCY: CMS	CMS-10532	Issue Date: 9/8/2014 Due Date: 11/4/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 1/5/2015 Due Date: 2/4/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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29.q.	Penalty Relief Related to Advance Payments of PTC ACTION: Guidance NOTICE: Penalty Relief Related to Advance Payments of the Premium Tax Credit for 2014 AGENCY: IRS	Notice 2015-9	Issue Date: 1/26/2015 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
31.gg.	Coverage of Certain Preventive Services Under ACA ACTION: Request for Comment NOTICE: Coverage of Certain Preventive Services Under the Affordable Care Act AGENCY: IRS	EBSA Form 700	Issue Date: 8/27/2014 Due Date: 10/27/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 12/11/2014 Due Date: 2/9/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
31.mm.	2016 Actuarial Value Calculator ACTION: Guidance NOTICE: ~~Draft~~ 2016 Actuarial Value Calculator AGENCY: CCIIO	CCIIO (no reference number)	Issue Date: 11/21/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued Final Guidance 1/16/2015	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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31.nn.	Notification of Objection to Covering Contraceptive Services ACTION: Request for Comment NOTICE: Employer Notification to HHS of its Objection to Providing Coverage for Contraceptive Services AGENCY: CMS	CMS-10535	Issue Date: 12/8/2014 Due Date: 2/6/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
31.oo.	Amendments to Excepted Benefits ACTION: Proposed Rule NOTICE: Amendments to Excepted Benefits AGENCY: IRS/DoL/CMS	REG-132751-14 DoL RIN 1210-AB70 CMS-9946-P2	Issue Date: 12/23/2014 Due Date: 1/22/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
31.pp.	Summary of Benefits and Coverage and Uniform Glossary ACTION: Proposed Rule NOTICE: Summary of Benefits and Coverage and Uniform Glossary AGENCY: IRS/DoL/CMS	REG-145878-14 DoL RIN 1210-AB69 CMS-9938-P	Issue Date: 12/30/2014 Due Date: 3/2/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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39.e.	Basic Health Program: Federal Funding Methodology for 2016 ACTION: ~~Proposed~~ Final Methodology NOTICE: Basic Health Program; Federal Funding Methodology for Program Year 2016 AGENCY: CMS	CMS-2391-~~P~~FN	Issue Date: 10/23/2014 Due Date: 11/24/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Sent Final Methodology to OMB 1/29/2015	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
48.b.	Medical Loss Ratio Rebate Calculation Report and Notices ACTION: Request for Comment NOTICE: Annual MLR and Rebate Calculation Report and MLR Rebate Notices AGENCY: CMS	CMS-10418	Issue Date: 12/4/2012 Due Date: 2/4/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 2/22/2013, 11/22/2013, 1/31/2014, 1/30/2015 Due Date: 3/25/2013; 1/21/2014; 3/5/2014; 3/31/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
54.	ESI Coverage Verification ACTION: Notice NOTICE: Employer-Sponsored Coverage Verification: Preliminary Informational Statement AGENCY: CMS	CMS RIN 0938-ZB09	Issue Date: [Approved by OMB 4/26/2012] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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64.c.	Tribal Consultation Policy ACTION: Notice NOTICE: Tribal Consultation Policy AGENCY: Treasury	Treasury (no reference number)	Issue Date: 12/3/2014 Due Date: 4/2/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
89.h.	Notice of Benefit and Payment Parameters for 2016 ACTION: ~~Proposed~~ Final Rule NOTICE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 AGENCY: CMS	CMS-9944-~~PF~~	Issue Date: 11/26/2014 Due Date: 12/22/2014 TTAG File Date: 12/22/2014 Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 1/29/2015	• Summary of Agency action: √ • NIHB analysis of action: √	• TTAG recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:
92.v.	Q&A on Outreach by Medicaid MCOs to Former Enrollees ACTION: Guidance NOTICE: Question and Answer on Outreach by Medicaid Managed Care Contractors and Health Insurance Issuers to Former Enrollees AGENCY: CCIIO	CCIIO (no reference number)	Issue Date: 2/21/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued revised Guidance 1/15/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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92.hh.	Annual Eligibility Redetermination Notices, et al. ACTION: Request for Comment NOTICE: Annual Eligibility Redetermination, Product Discontinuation, and Renewal Notices AGENCY: CMS	CMS-10527	Issue Date: 11/4/2014 Due Date: 1/5/2015 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 1/23/2015 Due Date: 2/23/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
92.kk.	Summary of Benefits and Coverage and Uniform Glossary ACTION: Request for Comment NOTICE: Summary of Benefits and Coverage and Uniform Glossary AGENCY: CMS	CMS-10407	Issue Date: 11/24/2014 Due Date: 1/23/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
92.ll.	Health Benefit Plan Network Access and Adequacy Model Act ACTION: Request for Comment NOTICE: Health Benefit Plan Network Access and Adequacy Model Act (Draft) AGENCY: NAIC	NAIC (no reference number)	Issue Date: 11/12/2014 Due Date: 1/12/2015 TTAG File Date: 1/12/2015 Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• TTAG recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:

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112.c.	Expanded Access to Non-VA Care Through Veterans Choice ACTION: Proposed Rule NOTICE: Expanded Access to Non-VA Care Through Veterans Choice Program AGENCY: VA	VA RIN 2900-AP24	Issue Date: 11/5/2014 Due Date: 3/5/2015 NIHB File Date: Date of Subsequent Agency Action, if any: Issued start date notice 11/21/2014	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
112.d.	I/T/U Payment for Physician and Non-Hospital-Based Services ACTION: Proposed Rule NOTICE: Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital-Based Care AGENCY: IHS	IHS RIN 0917-AA12	Issue Date: 12/5/2014 Due Date: ~~1/20/2015~~ 2/4/2015 NIHB File Date: Date of Subsequent Agency Action, if any: Issued due date extension 1/14/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
112.e.	Tribal Consultation on VA/IHS Reimbursement Agreements ACTION: Notice NOTICE: Section 102(c) of the Veterans Access, Choice, and Accountability Act of 2014 AGENCY: VA	VA (no reference number)	Issue Date: 12/30/2014 Due Date: 1/14/2015 TSGAC File Date: 1/14/2015 Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• TSGAC recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:

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112.f.	IHS Reimbursement Rates for CY 2015 ACTION: Notice NOTICE: Reimbursement Rates for Calendar Year 2015 AGENCY: IHS	IHS RIN 0917-ZA29	Issue Date: [Pending at OMB as of 1/17/2015] Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
174.f.	FEHBP: Rate Setting for Community-Rated Plans ACTION: Proposed Rule NOTICE: Federal Employees Health Benefits Program; Rate Setting for Community-Rated Plans AGENCY: OPM	OPM (RIN 3206-AN00)	Issue Date: 1/17/2015 Due Date: 3/9/2015 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
			SECTION IV: OTHER		
109.d.	COBRA Coverage Requirements for Group Health Plans ACTION: Request for Comment NOTICE: Continuation Coverage Requirements Application to Group Health Plans AGENCY: IRS	REG-209485-86/TD 8812 (OMB 1545-1581)	Issue Date: 10/8/2014 Due Date: 12/8/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 12/30/2014 Due Date: 1/29/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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125.	Interest Rate on Overdue Debts ACTION: Notice NOTICE: Notice of Interest Rate on Overdue Debts AGENCY: HHS	HHS (no reference number)	Issue Date: 12/28/2012 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued revisions 3/5/2013, 4/23/2013, 7/23/2013, 11/12/2013, 9/2/2014, 10/27/2014, 1/27/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
185.g.	Safe Harbor for FQHC Arrangements ACTION: Request for Comment NOTICE: Safe Harbor for Federally Qualified Health Centers Arrangements AGENCY: HHS OIG	HHS-OS-0990-0322-60D HHS-OS-0990-0322-30D	Issue Date: 10/1/2014 Due Date: 12/1/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued reinstatement 1/23/2015 Due Date: 2/23/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
189.b.	Annual Update of the HHS Poverty Guidelines ACTION: Notice NOTICE: Annual Update of the HHS Poverty Guidelines AGENCY: HHS	HHS (no reference number)	Issue Date: 1/22/2015 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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TABLE A: REGULATIONS INCLUDED TO DATE IN RRIAR TABLES B AND C UPDATED THROUGH 1/31/2015

RRIAR Ref. #	Short Title/ Current Status of Regulation/ Title/ Agency	File Code	Dates (Issue, Due, File, Subsequent Action)[1]	In Table B-- • Is the summary of Agency action included? • Is the NIHB analysis included?	In Table C-- • Is the list of NIHB recommendations included? • Has the Agency taken subsequent action? • Is an analysis of subsequent Agency action included?
199.a.	National CLAS Standards in Health and Health Care ACTION: Request for Comment NOTICE: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: Evaluation of Awareness, Adoption, and Implementation AGENCY: HHS	HHS-OS-0990-New-60D HHS-OS-0990-New-30D	Issue Date: 9/26/2014 Due Date: 11/25/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 12/19/2014 Due Date: 1/20/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
199.b.	CLAS County Data ACTION: Guidance NOTICE: CLAS County Data AGENCY: CCIIO	CCIIO (no reference number)	Issue Date: 12/12/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued revised Guidance 1/7/2015	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

: regulation review complete : regulation currently under review : regulation release pending

National Indian Health Board

TABLE B: SUMMARY OF NOTICES & REGULATIONS
UPDATED THROUGH 1/31/2015

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
1.l.	EHR Incentive Programs--Stage 3 ACTION: Proposed Rule NOTICE: Electronic Health Record (EHR) Incentive Programs--Stage 3 AGENCY: CMS	CMS-3310-P	Issue Date: [Pending at OMB as of 12/31/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This proposed rule would establish policies related to Stage 3 of meaningful use for the Medicare and Medicaid EHR Incentive Programs. Stage 3 will focus on improving health care outcomes and further advance interoperability. SUMMARY OF NIHB ANALYSIS:	
1.m.	2015 Edition HIT Certification Criteria, et al. NOTICE: 2015 Edition Health Information Technology (Health IT) Certification Criteria, Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications AGENCY: HHS ONC	HHS ONC RIN 0991-AB93	Issue Date: [Pending at OMB as of 12/31/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This proposed rule (2015 Edition health IT certification criteria or 2015 Edition) would establish a new 2015 Edition Base Electronic Health Record (EHR) definition and modify the HHS ONC Health IT Certification Program to make it more broadly applicable to other types of health IT health care settings and programs that might leverage the HHS ONC Health IT Certification Program. The 2015 Edition also would establish the technical capabilities and specify the related standards and implementation specifications that Certified EHR Technology would need to include to, at a minimum, support the achievement of meaningful use by eligible professionals eligible hospitals and critical access hospitals under the Medicare and Medicaid EHR Incentive Programs when such edition is required for use under these programs. SUMMARY OF NIHB ANALYSIS:	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
3.m.	FFS Audit Prepayment Review and Prior Authorization Demos ACTION: Request for Comment NOTICE: Fee-for-Service Recovery Audit Prepayment Review Demonstration and Prior Authorization Demonstration AGENCY: CMS	CMS-10421	Issue Date: 4/4/2014 Due Date: 4/18/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 9/12/2014, 12/30/2014 Due Date: 11/4/2014; 1/29/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Fee-for-Service Recovery Audit Prepayment Review Demonstration and Prior Authorization Demonstration; *Use*: On 7/23/2012, OMB approved the collections required for two demonstrations of prepayment review and prior authorization. The first demonstration allows Medicare Recovery Auditors to review claims on a pre-payment basis in certain States. The second demonstration established a prior authorization program for Power Mobility Device (PMD) claims in certain States. For the Recovery Audit Prepayment Review Demonstration, CMS and its agents request additional documentation, including medical records, to support submitted claims. As discussed in more detail in Chapter 3 of the Program Integrity Manual, additional documentation includes any medical documentation, beyond what appears on the face of the claim that supports the item or service billed. For Medicare to consider coverage and payment for any item or service, the information submitted by the provider or supplier (e.g., claims) must include supporting documentation from patient medical records. When conducting complex medical review, the contractor specifies documentation they require in accordance with Medicare rules and policies. In addition, providers and suppliers can supply additional documentation not explicitly listed by the contractor. CMS and its agents might request this supporting information on a routine basis in instances where diagnoses on a claim do not clearly indicate medical necessity, or in instances of suspected fraud. For the Prior Authorization of PMDs Demonstration, CMS has piloted prior authorization for PMDs. Prior authorization allows submission for review of the applicable documentation that supports a claim before delivery of the item or rendering of the service. CMS has begun this demonstration in California, Florida, Illinois, Michigan, New York, North Carolina and Texas based on beneficiary address as reported to the Social Security Administration and recorded in the Common Working File (CWF). For the demonstration, the (ordering) physician or treating practitioner can complete a prior authorization request and submit it to the appropriate DME MAC for an initial decision. The supplier also can submit the request on behalf of the physician or treating practitioner. Under this demonstration, the submitter will submit to the DME MAC a request for prior authorization and all relevant documentation to support Medicare coverage of the PMD item. With this emergency FR notice, CMS announces its plans to expand the	

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					demonstration from the seven aforementioned States to 12 new States, bringing the total number of participating States to 19; however, the original demonstration requirements will remain the same in all 19 States. The new States include Pennsylvania, Ohio, Louisiana, Missouri, Maryland, New Jersey, Indiana, Kentucky, Georgia, Tennessee, Washington, and Arizona. http://www.gpo.gov/fdsys/pkg/FR-2014-04-04/pdf/2014-07577.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 9/12/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-09-12/pdf/2014-21798.pdf CMS on 12/30/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-12-30/pdf/2014-30468.pdf	
3.o.	Certification as a Supplier of Portable X-Ray Form ACTION: Request for Comment NOTICE: Certification as a Supplier of Portable X-Ray and Portable X-Ray Survey Report Form and Supporting Regulations AGENCY: CMS	CMS-1880 and CMS-1882	Issue Date: 11/17/2014 Due Date: 1/16/2015 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 1/30/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension without change of a currently approved collection; *Title*: Certification as a Supplier of Portable X-Ray and Portable X-Ray Survey Report Form and Supporting Regulations; *Use*: Suppliers of portable X-ray services expressing an interest in and requesting participation in the Medicare program initially complete CMS-1880. This form initiates the process of obtaining a decision as to whether they meet the conditions of coverage as a portable X-ray supplier. It also promotes data reduction or introduction to, and retrieval from, the Certification and Survey Provider Enhanced Reporting (CASPER) by the CMS Regional Offices (ROs). The State survey agency uses CMS-1882 to provide data collected during an onsite survey of a supplier of portable X-ray services to determine compliance with the applicable conditions of participation and to report this information to the Federal Government. The form primarily serves as a coding worksheet designed to facilitate data reduction and retrieval into the ASPEN system at the CMS Regional Offices. The form includes basic information on compliance (i.e., met, not met, explanatory statements) and	

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			Due Date: 3/2/2015		does not require any descriptive information regarding the survey activity itself. CMS has the responsibility and authority for certification decisions based on supplier compliance with the applicable conditions of participation. CMS has access to the information needed to make these decisions only through the use of information abstracted from the survey report form. SUMMARY OF NIHB ANALYSIS: No comments recommended. SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 1/30/2015 issued an extension of this PRA request with no changes. http://www.gpo.gov/fdsys/pkg/FR-2015-01-30/pdf/2015-01777.pdf	
4.I.	Ambulatory Surgical Center Quality Reporting Program ACTION: Request for Comment NOTICE: Ambulatory Surgical Center Quality Reporting Program AGENCY: CMS	CMS-10530	Issue Date: 11/17/2014 Due Date: 1/16/2015 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 1/30/2015 Due Date: 3/2/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Ambulatory Surgical Center Quality Reporting Program; *Use*: CMS quality reporting programs promote higher quality, more efficient health care for Medicare beneficiaries. CMS has implemented quality measure reporting programs for multiple settings, including for ambulatory surgical centers (ASCs). Section 109(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) amended section 1833(i) of the Social Security Act (the Act) by re-designating clause (iv) as clause (v) and adding new clause (iv) to paragraph (2)(D) and by adding new paragraph (7). Section 1833(i)(2)(D)(iv) of the Act authorizes, but does not require, the HHS Secretary to implement the revised ASC payment system "in a manner so as to provide for a reduction in any annual update for failure to report on quality measures in accordance with paragraph (7)." Section 1833(i)(7)(A) of the Act states that the HHS Secretary can provide that any ASC failing to submit quality measures in accordance with paragraph (7) will incur a 2.0 percentage point reduction to any annual increase provided under the revised ASC payment system for such year. Sections 1833(t)(17)(C)(i) and (ii) of the Act require the HHS Secretary to develop measures appropriate for the measurement of the quality of care furnished in outpatient settings. Section 3014 of ACA modified section 1890(b) of the Act to require CMS to develop quality and efficiency measures through a "consensus-based entity." To fulfill this requirement, CMS formed the Measure Applications Partnership (MAP) to review measures consistent with these requirements. In implementing this and other quality	

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					reporting programs, CMS seeks to support National Quality Strategy goals of health for individuals, better health for populations, and lower costs for health care. CMS uses this information to direct contractors, including Quality Improvement Organizations (QIOs), to focus on particular areas of improvement and to develop quality improvement initiatives. CMS makes this information available to ASCs for their use in internal quality improvement initiatives. Most importantly, Medicare beneficiaries, as well as to the general public, can use this information to assist them in making decisions about their health care. http://www.gpo.gov/fdsys/pkg/FR-2014-11-17/pdf/2014-27137.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended. SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 1/30/2015 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-01-30/pdf/2015-01777.pdf	
7.t.	Cooperative Agreement to Support State Exchanges ACTION: Request for Comment NOTICE: Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges AGENCY: CMS	CMS-10371	Issue Date: 5/24/2013 Due Date: 7/23/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 8/16/2013;		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges; *Use*: All states (which include the 50 states, consortia of states, territories, and the District of Columbia) that received a State Planning and Establishment Grant for Exchanges under ACA qualify for the Cooperative Agreement to Support Establishment of State Operated Insurance Exchanges. Section 1311 of ACA offers the opportunity for each state to establish an Exchange (or Marketplace) and provides for grants to states for the planning and establishment of these Exchanges. To provide appropriate and timely guidance and technical assistance, the HHS Secretary must have access to timely, periodic information regarding state progress. Consequently, the information collection associated with these grants serves to facilitate reasonable and appropriate federal monitoring of funds, providing statutorily-mandated assistance to states to implement Exchanges in accordance with federal requirements, and to ensure states have all necessary information required to proceed, minimizing retrospective	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			issued emergency review request 9/16/2013, 11/7/2014; issued revision Due Date: 9/16/2013; 9/23/2013; 11/14/2014; 3/31/2015		corrective action. http://www.gpo.gov/fdsys/pkg/FR-2013-05-24/pdf/2013-12469.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended. SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 8/16/2013 issued a revision of this PRA request. The submitted revision adds sets of Outcomes and Operational Metrics to state data collection requirements; CMS will use the resulting data to evaluate Marketplace performance and overall effectiveness of ACA. Key areas of measurement include the effectiveness of eligibility determination and enrollment processes, the impact on affordability for consumers, and the effect of Marketplace participation on health insurances markets. Furthermore, these metrics facilitate actionable feedback and technical assistance to states for quality improvement efforts during the critical early period of operations. http://www.gpo.gov/fdsys/pkg/FR-2013-08-16/pdf/2013-20023.pdf No comments recommended. This information collection requires reporting on a number of measures. Performance standards are not quantified and included in the materials. These materials do not mention the need to report on exemptions from tax penalty requested, processed, etc. CMS on 9/16/2013 issued a request for an emergency OMB review of this information collection, with comments due 9/23/2013. According to CMS, an emergency review is needed because the approval of the data collection tools for outcomes and operational metrics is essential to ensuring that State-based Marketplaces provide substantive operational and monitoring data to the agency in a uniform format from the beginning of the enrollment period, 10/1/2013. http://www.gpo.gov/fdsys/pkg/FR-2013-09-16/pdf/2013-22517.pdf CMS on 11/7/2014 issued a request for an emergency OMB review of this information collection, with comments due 11/14/2014. http://www.gpo.gov/fdsys/pkg/FR-2014-11-07/pdf/2014-26584.pdf CMS on 1/30/2015 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-01-30/pdf/2015-01790.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
7.v.	Consumer Assistance Tools and Programs of Exchanges ACTION: Request for Comment NOTICE: Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors AGENCY: CMS	CMS-10494	Issue Date: 7/17/2013 Due Date: 9/14/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 6/27/2014, 1/30/2015 Due Date: 7/28/2014; 3/31/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors; *Use*: Section 1413 of ACA directs the HHS Secretary to establish, subject to minimum requirements, a streamlined enrollment system for qualified health plans offered through the Exchange and insurance affordability programs. In addition, section 1321(a)(1) of ACA directs and authorizes the HHS Secretary to issue regulations setting standards for meeting the requirements under title I of ACA, with respect to, among other things, the establishment and operation of Exchanges. Pursuant to this authority, CMS has finalized regulations establishing the certified application counselor program at 45 CFR 155.225. Specifically, 45 CFR 155.225(a) requires an Exchange to establish a certified application counselor program that complies with the requirements of the rule. Section 155.225(b)(1) allows each Exchange to designate certain organizations, including organizations designated by state Medicaid or CHIP agencies, which will certify their staff and volunteers to act as certified application counselors. In accordance with 45 CFR 155.225(b)(2), Exchanges can choose to certify directly individuals who seek to act as certified application counselors, designate certain organizations which will certify staff or volunteers to perform application services, or both. http://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17149.pdf This information collection does not include any associated forms. Appendices with registration screen shots and data collection elements, as well as a Supporting Statement for this PRA request, are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10494.html. SUMMARY OF NIHB ANALYSIS: No comments recommended (comments were submitted previously on the related CMS-9955-F). SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 6/27/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-06-27/pdf/2014-15073.pdf No comments recommended.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					CMS on 1/30/2015 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-01-30/pdf/2015-01790.pdf	
7.kk.	Standards for Navigators and Non-Navigator Personnel ACTION: Request for Comment NOTICE: Standards for Navigators and Non-Navigator Assistance Personnel AGENCY: CMS	CMS-10472	Issue Date: 6/27/2014 Due Date: 7/28/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 1/30/2015 Due Date: 3/31/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a previously approved information collection; *Title*: Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; *Use*: Section 1321(a)(1) of ACA directs and authorizes the HHS Secretary to issue regulations setting standards for meeting the requirements under title I of ACA, with respect to, among other things, the establishment and operation of Exchanges. Pursuant to this authority, regulations finalized at 45 CFR 155.210(e)(6) and 45 CFR 155.215(g) require Navigators, as well as those non-Navigator personnel to whom 45 CFR 155.215 applies, to inform consumers of the functions and responsibilities of Navigators and non-Navigator assistance personnel (as applicable) and obtain authorization for the disclosure of consumer information to the Navigator or non-Navigator assistance personnel prior to obtaining personally identifiable information from the consumer. Navigators and non-Navigator assistance personnel to whom 45 CFR 155.215 applies also must maintain a record of the authorization provided in a form and manner as determined by the Exchange. http://www.gpo.gov/fdsys/pkg/FR-2014-06-27/pdf/2014-15073.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 1/30/2015 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-01-30/pdf/2015-01790.pdf	
7.vv.	2016 Letter to Issuers in FFMs ACTION: Guidance NOTICE: Draft 2016 Letter to Issuers in the Federally-	CCIIO (no reference number)	Issue Date: 12/19/2014 Due Date: 1/12/2015 TTAG File	TTAG response:	SUMMARY OF AGENCY ACTION: This draft 2016 Letter to Issuers in the Federally-Facilitated Marketplaces (Letter) provides issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-Facilitated Marketplaces (FFMs) or the Federally-Facilitated Small Business Health Options Programs (FF-SHOPs) with operational and technical guidance to help them successfully participate in those Marketplaces in 2016. Unless otherwise specified, references to the FFMs include the FF-SHOPs.	See Table C.

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Facilitated Marketplaces AGENCY: CCIIO		Date: 1/12/2015 Date of Subsequent Agency Action, if any:		Throughout this Letter, CMS identifies the areas in which states performing plan management functions in the FFMs have flexibility to follow an approach different from that articulated in this guidance. CMS notes that the policies articulated in this Letter apply to the certification process for plan years beginning in 2016. Previously published rules concerning market-wide and QHP certification standards, eligibility and enrollment procedures, and other Marketplace-related topics appear in 45 CFR Subtitle A, Subchapter B. Additional proposed requirements appear in a proposed rule titled, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016" (2016 Payment Notice proposed rule), CMS-9944-P (see 89.h.), published on 11/26/2014. CMS expects issuers to consult all applicable regulations, in conjunction with the final version of this Letter, to ensure full compliance with the requirements of ACA. Throughout the plan year, QHPs might have to correct deficiencies identified in CMS post-certification activities, as a result of the investigation of consumer complaints or oversight by state regulators or by CMS, or as a result of an industry-standard internal compliance and risk management program. QHP issuers in the FFMs also might have to meet other requirements for plan years beginning in 2016, as indicated in future rulemaking. CMS welcomes comments on this proposed guidance. To the extent that this guidance summarizes policies proposed through other rulemaking processes not yet finalized, such as the rulemaking process for the 2016 Payment Notice proposed rule, stakeholders should comment on those underlying policies through the ongoing rulemaking processes and not through the comment process for this Letter. Please send comments on other aspects of this Letter to FFEcomments@cms.hhs.gov by 1/12/2015. Interested parties should organize comments by subsections of this Letter. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016DraftLettertoIssuers12-19-2014.pdf SUMMARY OF NIHB ANALYSIS: This draft 2016 Issuer Letter marks the latest in a series of Issuer Letters, which guide QHP issuer operations in FFM states. Tribal representatives still have comments pending on CMS-9944-P. In that document, CMS proposed to require Summary of Benefit and Coverage documents for each plan	

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					variation. In addition, tribal representatives made several recommendations regarding Indian-specific cost-sharing variations. Tribal representatives should comment on the draft 2016 Issuer Letter, both to make recommended changes and to indicate support for language contained in the document. An analysis comparing the draft 2016 Issuer Letter with the 2015 Issuer Letter is embedded below.  Analysis- Draft 2016 v Final 2015 CCIIO Is	
7.ww.	Special Protections for AI/ANs ACTION: Guidance NOTICE: Health Insurance Marketplace Protections for American Indians and Alaska Natives AGENCY: CMS	CMS (no reference number)	Issue Date: 1/27/2015 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This fact sheet explains the protections for AI/ANs in the Marketplace, Medicaid, and CHIP. This fact sheet addresses special enrollment periods, zero and limited cost-sharing plans, Medicaid and CHIP protections, and Indian-specific exemptions. http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/AIANs-SpecialProtections-Fact-Sheet.pdf SUMMARY OF NIHB ANALYSIS:	
7.xx.	AI/AN Trust Income and MAGI ACTION: Guidance NOTICE: American Indian and Alaska Native Trust Income and MAGI	CMS (no reference number)	Issue Date: 1/27/2015 Due Date: None NIHB File Date:		SUMMARY OF AGENCY ACTION: This fact sheet describes Modified Adjusted Gross Income (MAGI) and what that means for AI/AN Trust Income. This fact sheet includes frequently asked questions and answers and a list of specific types of AI/AN exempt income. http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/AIAN-Trust-Income-and-MAGI-FactSheet.pdf SUMMARY OF NIHB ANALYSIS:	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	AGENCY: CMS		Date of Subsequent Agency Action, if any:			
8.c.	ACA Requirements for Section 1115 Projects ACTION: Request for Comment NOTICE: Affordable Care Act Information and Collection Requirements for Section 1115 Demonstration Projects AGENCY: CMS	CMS-10341	Issue Date: 12/12/2014 Due Date: 2/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Affordable Care Act Information and Collection Requirements for Section 1115 Demonstration Projects; *Use*: CMS needs this collection to ensure that states comply with regulatory and statutory requirements related to the development, implementation, and evaluation of demonstration projects. States seeking waiver authority under Section 1115 must meet certain requirements for public notice, the evaluation of demonstration projects, and reports to the HHS Secretary on the implementation of approved demonstrations. http://www.gpo.gov/fdsys/pkg/FR-2014-12-12/pdf/2014-29172.pdf SUMMARY OF NIHB ANALYSIS:	
10.c.	Medicare Shared Savings Program: ACOs ACTION: Proposed Rule NOTICE: Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations AGENCY: CMS	CMS-1461-P	Issue Date: 12/8/2014 Due Date: 2/6/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This proposed rule addresses changes to the Medicare Shared Savings Program (Shared Savings Program), including provisions relating to the payment of Accountable Care Organizations (ACOs) participating in the Shared Savings Program. Under the Shared Savings Program, providers of services and suppliers that participate in an ACO continue to receive traditional Medicare fee-for-service (FFS) payments under Parts A and B, but the ACO might qualify to receive a shared savings payment if it meets specified quality and savings requirements. http://www.gpo.gov/fdsys/pkg/FR-2014-12-08/pdf/2014-28388.pdf SUMMARY OF NIHB ANALYSIS:	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
11.d.	Bid Pricing Tool ACTION: Request for Comment NOTICE: Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDPs) AGENCY: CMS	CMS-10142	Issue Date: 10/5/2012 Due Date: 12/4/2012 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 1/17/2013, 10/4/2013, 12/20/2013, 9/26/2014, 12/24/2014 Due Date: 2/19/2013; 12/3/2013; 1/21/2014; 11/25/2014; 1/23/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP); *Use*: Medicare Advantage organizations (MAO) and Prescription Drug Plans (PDP) must submit an actuarial pricing "bid" for each plan offered to Medicare beneficiaries for approval by the Centers for Medicare & Medicaid Services (CMS). MAOs and PDPs use the Bid Pricing Tool (BPT) software to develop their actuarial pricing bid, with the information provided in the BPT used as the basis for the plan's enrollee premiums and CMS payments for each contract year. The tool collects data such as medical expense development, administrative expenses, profit levels, and projected plan enrollment information. CMS reviews and analyzes the information provided in the BPT and decides whether to approve the plan pricing proposed by each organization. CMS is requesting to continue its use of the BPT for the collection of information for CY 2014 through CY 2016. SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 1/17/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-01-17/pdf/2013-00858.pdf CMS on 10/4/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf CMS on 12/20/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30334.pdf CMS on 9/26/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-09-26/pdf/2014-22990.pdf CMS on 12/24/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-12-24/pdf/2014-30026.pdf	
11.f.	Plan Benefit Package and Formulary Submission	CMS-R-262	Issue Date: 10/5/2012		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Plan Benefit Package (PBP) and Formulary	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	ACTION: Request for Comment NOTICE: PBP and Formulary Submission for Medicare Advantage and Prescription Drug Plans AGENCY: CMS		Due Date: 12/4/2012 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 1/17/2013, 11/1/2013, 1/17/2014, 9/26/2014, 12/19/2014 Due Date: 2/19/2013; 12/31/2013; 2/18/2014; 11/25/2014; 1/20/2015		Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP); *Use*: Medicare Advantage (MA) and Prescription Drug Plan (PDP) organizations must submit plan benefit packages—which consist of the Plan Benefit Package (PBP) software, formulary file, and supporting documentation, as necessary—for all Medicare beneficiaries residing in their service area. MA and PDP organizations use the PBP software to describe their organization's plan benefit packages, including information on premiums, cost sharing, authorization rules, and supplemental benefits, as well as generate a formulary to describe their list of drugs, including information on prior authorization, step therapy, tiering, and quantity limits. In addition, CMS uses the PBP and formulary data to review and approve the plan benefit packages proposed by each MA and PDP organization. SUMMARY OF NIHB ANALYSIS: A link to a detailed list of changes to the PBP software appears below. In addition, if issues with the current formulary development process or the use of the formulary have occurred, this PRA request might provide an opportunity to comment on them. The changes proposed are to be implemented and effective by CY 2014. http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-262.html SUMMARY OF SUBSEQUENT AGENCY ACTION: Based on operational changes and policy clarifications to Medicare and continued input and feedback by the industry, CMS has made the necessary changes to the plan benefit package submission. http://www.gpo.gov/fdsys/pkg/FR-2013-01-17/pdf/2013-00858.pdf CMS on 11/1/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-11-01/pdf/2013-26107.pdf CMS on 1/17/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-17/pdf/2014-00915.pdf CMS on 9/26/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-09-26/pdf/2014-22990.pdf CMS on 12/19/2014 issued a revision of this PRA request. CMS has revised this	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					package subsequent to the publication of the 60-day notice in the 9/26/2014 FR (79 FR 57931). http://www.gpo.gov/fdsys/pkg/FR-2014-12-19/pdf/2014-29739.pdf	
11.gg.	CY 2015 Policy and Technical Changes to Parts C and D ACTION: Final Rule NOTICE: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs; Remaining Provisions AGENCY: CMS	CMS-4159-F2 See also 11.u.	Issue Date: [Pending at OMB as of 11/20/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This final rule sets forth programmatic and operational changes to the Medicare Advantage (MA) and prescription drug benefit programs for CY 2015. SUMMARY OF NIHB ANALYSIS:	
11.hh.	Medicare Part C, Part D, and FFS CAHPS Survey ACTION: Request for Comment NOTICE: Medicare Advantage, Medicare Part D, and Medicare Fee-For-Service Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey	CMS-R-246	Issue Date: 12/12/2014 Due Date: 2/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Medicare Advantage, Medicare Part D, and Medicare Fee-For-Service Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey; *Use*: The Medicare consumer assessment of healthcare providers and systems (CAHPS) surveys serve to provide information to Medicare beneficiaries to help them make more informed choices among health and prescription drug plans available to them. The surveys also provide data to help CMS and others monitor the quality and performance of Medicare health and prescription drug plans and identify areas to improve the quality of care and services provided to enrollees of these plans. http://www.gpo.gov/fdsys/pkg/FR-2014-12-12/pdf/2014-29172.pdf SUMMARY OF NIHB ANALYSIS:	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 1/31/2015

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	AGENCY: CMS					
11.ii.	Survey of Retail Community Pharmacy Prices ACTION: Request for Comment NOTICE: Survey of Retail Prices: Payment and Utilization Rates and Performance Rankings AGENCY: CMS	CMS-10241	Issue Date: 12/19/2014 Due Date: 2/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Survey of Retail Prices: Payment and Utilization Rates and Performance Rankings; *Use*: This study has two parts. Part I focuses on the retail community pharmacy consumer prices. It also includes reporting by the states of payment and utilization rates for the 50 most widely prescribed drugs and comparing state drug payment rates with the national retail survey prices. (Effective 7/1/2013, CMS has suspended Part I of the survey, pending funding decisions.) Part II focuses on the retail community pharmacy ingredient costs. This segment surveys the average acquisition costs of all covered outpatient drugs purchased by retail community pharmacies, with prices updated on at least a monthly basis. http://www.gpo.gov/fdsys/pkg/FR-2014-12-19/pdf/2014-29741.pdf SUMMARY OF NIHB ANALYSIS:	
12.d.	Consumer Operated and Oriented Program ACTION: Request for Comment NOTICE: Consumer Operated and Oriented (CO-OP) Program AGENCY: CMS	CMS-10392	Issue Date: 9/8/2014 Due Date: 11/4/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Consumer Operated and Oriented (CO-OP) Program; *Use*: The Consumer Operated and Oriented Plan (CO-OP) program, established by section 1322 of ACA, provides for loans to establish at least one consumer-operated, qualified nonprofit health insurance issuer in each State. Issuers supported by the CO-OP program will offer at least one qualified health plan at the silver level of benefits and one at the gold level of benefits in the individual market State Health Benefit Exchanges (Exchanges). CO-Ops will offer at least two-thirds of policies or contracts open to individuals and small employers. CO-OPs will use any profits generated to lower premiums, improve benefits, improve the quality of health care delivered to their members, expand enrollment, or otherwise contribute to the stability of coverage offered. By increasing competition in the health insurance market and operating with a strong consumer focus, the CO-OP program will provide consumers more choices, greater plan accountability, increased competition to lower prices, and better models of care, benefiting all consumers, not just CO-OP members.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			11/21/2014, 1/30/2015 Due Date: 12/22/2014; 3/31/2015		The CO-OP program will provide nonprofits with loans to fund start-up costs and State reserve requirements in the form of Start-up Loans and Solvency Loans. An applicant can apply for (1) joint Start-up and Solvency Loans; or (2) only a Solvency Loan. Planning Loans seek to help loan recipients determine the feasibility of operating a CO-OP in a target market. Start-up Loans seek to assist loan recipients with the many start-up costs associated with establishing a new health insurance issuer. Solvency Loans seek to assist loan recipients with meeting the solvency requirements of States in which the applicant seeks to be licensed to issue qualified health plans. http://www.gpo.gov/fdsys/pkg/FR-2014-09-05/pdf/2014-21180.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 11/21/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-11-21/pdf/2014-27640.pdf CMS on 1/30/2015 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-01-30/pdf/2015-01790.pdf	
16.b.	Medicaid HCBS Waivers ACTION: ~~Proposed~~ Final Rule NOTICE: Medicaid; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment; Setting Requirements AGENCY: CMS	CMS-2249-~~P2~~F2	Issue Date: 5/3/2012 Due Date: ~~6/4/2012~~ 7/2/2012 NIHB File Date: None Date of Subsequent		SUMMARY OF AGENCY ACTION: This proposed rule would revise Medicaid regulations to define and describe State plan home and community-based services (HCBS) under the Social Security Act (the Act) as added by the Deficit Reduction Act of 2005 and amended by ACA. This rule would offer States new flexibility in providing necessary and appropriate services to elderly and disabled populations. In particular, this rule would not require the eligibility link between HCBS and institutional care that exists under the Medicaid HCBS waiver program. This rule would describe Medicaid coverage of the optional State plan benefit to furnish HCBS and receive Federal matching funds. This proposed rule also would amend Medicaid regulations consistent with the requirements of ACA, which amended the Act to provide authority for a 5-year duration for certain demonstration projects or waivers, at the discretion of the HHS Secretary,	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Agency Action, if any: Issued due date extension 5/3/2012; Final Rule approved by OMB 1/13/2014		when they involve individuals dually eligible for Medicaid and Medicare benefits. In addition, this rule would provide an additional limited exception to the general requirement that payment for services under a State plan go directly to the individual practitioner providing a service when the Medicaid program serves as the primary source of reimbursement for a class of individual practitioners. This exception would allow payments to other parties to benefit the providers by ensuring health, welfare, and training. Finally, this rule would amend Medicaid regulations to provide home and community-based setting requirements of ACA for the Community First Choice State plan option. SUMMARY OF NIHB ANALYSIS:	
16.f.	Annual Report on HCBS Waivers ACTION: Request for Comment NOTICE: Annual Report on Home and Community Based Services Waivers and Supporting Regulations AGENCY: CMS	CMS-372(S)	Issue Date: 1/16/2015 Due Date: 3/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Annual Report on Home and Community Based Services Waivers and Supporting Regulations; *Use*: CMS uses this report to compare actual data to the approved waiver estimates. In conjunction with the waiver compliance review reports, CMS will compare the information provided to that in the Medicaid Statistical Information System (MSIS) (CMS-R-284; OMB 0938-0345) report and FFP claimed on the state Quarterly Expenditure Report (CMS-64; OMB 0938-1265) to determine whether to continue the state home and community-based services waiver. State estimates of cost and utilization for renewal purposes are based upon the data compiled in the CMS-372(S) reports. http://www.gpo.gov/fdsys/pkg/FR-2015-01-16/pdf/2015-00627.pdf SUMMARY OF NIHB ANALYSIS:	
23.h.	Administrative Requirements for DRA Section 6071 ACTION: Request for Comment	CMS-10249	Issue Date: 1/9/2015 Due Date: 3/10/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Administrative Requirements for Section 6071 of the Deficit Reduction Act; *Use*: State Operational Protocols should provide enough information such that: The CMS Project Officer and other federal officials can use it to understand the operation of the demonstration and/or prepare for potential site visits without needing additional information; the State Project Director can use it as the	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Administrative Requirements for Section 6071 of the Deficit Reduction Act AGENCY: CMS		NIHB File Date: Date of Subsequent Agency Action, if any:		manual for program implementation; and external stakeholders can use it to understand the operation of the demonstration. CMS uses the financial information collection in its financial statements and shares it with the auditors who validate the financial position of the agency. The national evaluation contractor uses the Money Follows the Person Rebalancing Demonstration (MFP) Finders File, MFP Program Participation Data File, and MFP Services File to assess program outcomes, while CMS uses the information to monitor program implementation. The national evaluation contractor uses MFP Quality of Life data to assess program outcomes. The evaluation determines how participant quality of life changes after transitioning to the community. The national evaluation contractor and CMS use the semi-annual progress report to monitor program implementation at the grantee level. http://www.gpo.gov/fdsys/pkg/FR-2015-01-09/pdf/2015-00175.pdf SUMMARY OF NIHB ANALYSIS:	
27.i.	Risk Corridors Transitional Policy ACTION: Request for Comment NOTICE: Risk Corridors Transitional Policy AGENCY: CMS	CMS-10532	Issue Date: 9/8/2014 Due Date: 11/4/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 1/5/2015 Due Date: 2/4/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Risk Corridors Transitional Policy; *Use*: Section 1342 of ACA provides for the establishment of a temporary risk corridors program that will apply to qualified health plans in the individual and small group markets for the first three years of Exchange operation. Under a final rule (CMS-9954-F) published in the 3/11/2014 Federal Register (79 FR 13834), each issuer conducting business in the individual and small group markets in states that adopted the transitional policy must submit enrollment data, including enrollment in transitional policies (i.e., individual or small group health insurance coverage in states that adopted the transitional policy announced in the CMS letter dated 11/14/2013), on the "Transitional Adjustment Reporting Form" prescribed by CMS for each state in which the issuer conducts business. CMS will use the data collection to amend the risk corridors program provisions in 45 CFR Part 153 to mitigate any unexpected losses for issuers of plans subject to risk corridors attributable to the effects of this transitional policy. Specifically, CMS will use the data to calculate the risk corridors adjustment percentage, if any, in transitional states. http://www.gpo.gov/fdsys/pkg/FR-2014-09-05/pdf/2014-21180.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 1/5/2015 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-01-05/pdf/2014-30800.pdf	
28.f.	Medicaid Implementation Advanced Planning Document ACTION: Notice NOTICE: Medicaid Eligibility and Enrollment (EE) Implementation Advanced Planning Document (IAPD) Template AGENCY: CMS	CMS-10536	Issue Date: 8/29/2014 Due Date: 10/28/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 12/19/2014 Due Date: 1/20/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Medicaid Eligibility and Enrollment (EE) Implementation Advanced Planning Document (IAPD) Template; *Use*: To assess the appropriateness of state requests for enhanced federal financial participation for expenditures related to Medicaid eligibility determination systems, CMS will review the submitted information and documentation to make an approval determination for the advanced planning document. http://www.gpo.gov/fdsys/pkg/FR-2014-08-29/pdf/2014-20590.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/19/2014 issued a new version of this PRA request. CMS has revised this package subsequent to the publication of the 60-day notice in the 8/29/2014 FR (79 FR 51571). http://www.gpo.gov/fdsys/pkg/FR-2014-12-19/pdf/2014-29739.pdf	
29.q.	Penalty Relief Related to Advance Payments of PTC ACTION: Guidance	Notice 2015-9	Issue Date: 1/26/2015 Due Date: None		SUMMARY OF AGENCY ACTION: This notice provides limited relief for taxpayers who have a balance due on their 2014 income tax return as a result of reconciling advance payments of the premium tax credit against the premium tax credit allowed on the tax return. Specifically, this notice provides relief from the penalty under § 6651(a)(2) of the Internal Revenue Code for late payment of a balance due and the penalty under §	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Penalty Relief Related to Advance Payments of the Premium Tax Credit for 2014 AGENCY: IRS		NIHB File Date: Date of Subsequent Agency Action, if any:		6654(a) for underpayment of estimated tax. To qualify for the relief, taxpayers must meet certain requirements described in this notice. This relief applies only for the 2014 taxable year. • The § 6651(a)(2) penalty is not imposed if the taxpayer shows that the failure was due to reasonable cause and not willful neglect. • the Service will abate the § 6651(a)(2) penalty for taxable year 2014 for taxpayers who (i) are otherwise current with their filing and payment obligations; (ii) have a balance due for the 2014 taxable year due to excess advance payments of the premium tax credit; and (iii) report the amount of excess advance credit payments on their 2014 tax return timely filed, including extensions • the Service will waive the § 6654 penalty for taxable year 2014 for an underpayment of estimated tax for taxpayers who have an underpayment attributable to excess advance credit payments if the taxpayers (i) are otherwise current with their filing and payment obligations; and (ii) report the amount of the excess advance credit payments on a 2014 tax return timely filed, including extensions • Taxpayers should be aware that this Notice does not extend the time to file a return. • Additionally, § 6601 imposes interest on amounts of tax not paid by the due date, determined without regard to an extension of time for payment. Taxpayers will be required to pay interest on the balance due from the original deadline to pay, which is generally April 15, 2015, even if they qualify for penalty relief under this Notice. • Taxpayers who file their returns after April 15, 2015 must fully pay the underlying liability by April 15, 2016 to be eligible for relief under this Notice. Interest will accrue until the underlying liability is fully paid. • To request a waiver of the § 6654(a) penalty as provided in this Notice, taxpayers should check box A in Part II of Form 2210, complete page 1 of the form, and include the form with their return, along with the statement: "Received excess advance payment of the premium tax credit." This relief does not apply to any underpayment of the individual shared responsibility payment resulting from the application of § 5000A because such underpayments are not subject to either the § 6651(a)(2) penalty or the § 6654(a) penalty.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					http://www.irs.gov/pub/irs-drop/n-15-09.pdf SUMMARY OF NIHB ANALYSIS:	
31.gg.	Coverage of Certain Preventive Services Under ACA ACTION: Request for Comment NOTICE: Coverage of Certain Preventive Services Under the Affordable Care Act AGENCY: IRS	EBSA Form 700	Issue Date: 8/27/2014 Due Date: 10/27/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 12/11/2014 Due Date: 2/9/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: EBSA Form 700--Certification; *Use*: The Departments of Labor and the Treasury and HHS, concurrent with the publication of this information collection request, issued interim final regulations regarding coverage of certain preventive services under section 2713 of the Public Health Service Act (PHS Act), added by ACA, as amended, and incorporated into ERISA and the Internal Revenue Code. Section 2713 of the PHS Act requires coverage without cost sharing of certain preventive health services by non grandfathered group health plans and health insurance coverage. These services include women's preventive health services, as specified in guidelines supported by HRSA. As authorized by the current regulations and consistent with the HRSA Guidelines, group health plans established or maintained by certain religious employers (and group health insurance coverage provided in connection with such plans) are exempt from the otherwise applicable requirement to cover certain contraceptive services. Additionally, under current regulations, accommodations are available with respect to the contraceptive coverage requirement for group health plans established or maintained by eligible organizations (and group health insurance coverage provided in connection with such plans), and student health insurance coverage arranged by eligible organizations that are institutions of higher education, that effectively exempt them from this requirement. The regulations require organizations seeking accommodation to self-certify that they meet the definition of an eligible organization. Organizations must send a copy of the self-certification to an issuer or third-party administrator. Organization seeking the accommodation must maintain the self-certification/notification in a manner consistent with the record retention requirements under section 107 of the ERISA, which generally requires maintenance of records for six years. EBSA Form 700 serves as the form used by eligible organizations for their self-certification. The interim final regulations augment the final regulations and revise the EBSA Form 700 ICR in light of the Supreme Court interim order in connection with an application for an injunction in *Wheaton College v. Burwell* (2014) (Wheaton order). Specifically, the interim final regulations continue to allow eligible organizations to notify an issuer or third-party	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					administrator using EBSA Form 700, as set forth in the July 2013 final regulations. In addition, the interim final regulations permit an alternative process, consistent with the Wheaton order, under which eligible organizations could notify the HHS Secretary that they will not act as the plan administrator or claims administrator with respect to, or contribute to the funding of, coverage of all or a subset of contraceptive services. The notification must include information sufficient to identify the plan, plan type (including whether it is a church plan within the meaning of ERISA section 3(33)), and the identity and mailing addresses of any third-party administrators. http://www.gpo.gov/fdsys/pkg/FR-2014-08-27/pdf/2014-20253.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: IRS on 12/11/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-12-11/pdf/2014-29060.pdf	
31.mm.	2016 Actuarial Value Calculator ACTION: Guidance NOTICE: ~~Draft~~ 2016 Actuarial Value Calculator AGENCY: CCIIO	CCIIO (no reference number)	Issue Date: 11/21/2014 Due Date: None NIHB File Date: None Date of Subsequent Agency Action, if any: Issued Final Guidance 1/16/2015		SUMMARY OF AGENCY ACTION: Under the Essential Health Benefits, Actuarial Value, and Accreditation final rule at 78 FR 12834 (EHB Final Rule) published in the Federal Register on February 25, 2013, HHS requires use of an Actuarial Value (AV) Calculator by issuers of non-grandfathered health insurance plans offered in the individual and small group markets, both inside and outside of the Affordable Insurance Exchanges (Exchanges, or Marketplaces) for the purposes of determining levels of coverage. Section 1302(d)(2)(A) of ACA stipulates that calculation of AV must occur based on the provision of essential health benefits (EHB) to a standard population. The statute groups health plans into four tiers: bronze, with an AV of 60 percent; silver, with an AV of 70 percent; gold, with an AV of 80 percent; and platinum, with an AV of 90 percent. The EHB Final Rule allows a *de minimis* variation of +/- 2 percentage points of AV for each tier. The AV Calculator represents an empirical estimate of the AV calculated in a manner that provides a close approximation to the actual average spending by a wide range of consumers in a standard population. This draft document details the specific methodologies used in the AV calculation.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					The revised version of this draft document incorporates updates to account for the draft 2016 AV Calculator. The first part of this draft document provides background that includes an overview of the regulation that allows HHS to make updates to the AV Calculator, as well as the updates incorporated into the draft 2016 AV Calculator. For the second part of the document, CCIIO provides a detailed description of the development of the standard population and the AV Calculator methodology. The first section details the data and methods used in constructing the continuance tables used to calculate AV in combination with the user inputs. The second section describes the AV Calculator interface and the calculation of actuarial value based on the interface and the continuance tables. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2016-AVC-Methodology-MASTER-for-112114.pdf The draft 2016 AV Calculator is available at http://www.cms.gov/cciio/resources/regulations-and-guidance/index.html. SUMMARY OF NIHB ANALYSIS: No Indian-specific or tribal-specific elements are referenced in the AV calculator methodology. In particular, on page 29, there is a discussion of the ability to use the AV Calculator to determine if silver-level cost-sharing variations offered for individuals with incomes at or below 250% FPL (73%, 87%, 94%) meet the AV targets. There is not a similar discussion of the "zero cost-sharing variation" or the "limited cost-sharing variation." In other regulations (CMS-9964-F), CMS assigned an AV of 100% to the zero cost-sharing variation and an AV of 87% or 94% to the limited cost-sharing variation, depending on the metal tier selected. It may be warranted to ask CMS if not including the two Indian-specific cost-sharing variations in the page 29 discussion (and in the AV Calculator) was an oversight-- and therefore limits the usefulness of the AV calculator--or was intentional. If, for example, the zero cost-sharing variation was included in the AV Calculator, issuers might be able to check their cost-sharing protection design against the AV Calculator to confirm that it meets the 100% AV standard. NOTE: Given that the limited cost-sharing variation was assigned an AV of 87%, it is uncertain whether the AV Calculator would work for this cost-sharing variation, as the lower AV level for the limited cost-sharing variation must be a factor of enrollees not	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					securing a referral (which would reduce the cost-sharing protections experienced by the enrollee) rather than the plan having some cost-sharing requirements for certain services. SUMMARY OF SUBSEQUENT AGENCY ACTION: CCIIO on 1/16/2014 issued a final version of this guidance. This document revises the 2015 version and updates the draft 2016 version, released on 11/21/2014, in response to comments received. Specifically, this document incorporates updates to account for the final 2016 AV Calculator. The first part of this document provides background that includes an overview of the regulation allowing HHS to make updates to the AV Calculator, as well as the updates incorporated into the final 2016 AV Calculator. For the second part of the document, CCIIO provides a detailed description of the development of the standard population and the AV Calculator methodology. The first section details the data and methods used in constructing the continuance tables involved in calculating AV in combination with the user inputs. The second section describes the AV Calculator interface and the calculation of actuarial value based on the interface and the continuance tables. The final 2016 AV Calculator is available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-AV-Calculator-011514.xlsm. CCIIO notes that this does not affect any 2015 plans and applies only for 2016 plans. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2016-AV-Calculator-Methodology.pdf	
31.nn.	Notification of Objection to Covering Contraceptive Services ACTION: Request for Comment NOTICE: Employer Notification to HHS of its Objection to Providing Coverage for Contraceptive Services	CMS-10535	Issue Date: 12/8/2014 Due Date: 2/6/2015 NIHB File Date: Date of Subsequent Agency		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Employer Notification to HHS of its Objection to Providing Coverage for Contraceptive Services; *Use*: The proposed rules titled "Coverage of Certain Preventive Services Under the Affordable Care Act" (79 FR 51118) would continue to require each closely-held, for-profit corporation seeking treatment as an eligible organization to provide notification that it will not act as the plan administrator or claims administrator with respect to, or contribute to the funding of, coverage of all or a subset of contraceptive services. Issuers and third party administrators providing payments for contraceptive services for participants and beneficiaries in plans of eligible organizations would have to meet the notice requirements as set forth in the 2013 final regulations.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	AGENCY: CMS		Action, if any:		http://www.gpo.gov/fdsys/pkg/FR-2014-12-08/pdf/2014-28632.pdf SUMMARY OF NIHB ANALYSIS:	
31.oo.	Amendments to Excepted Benefits ACTION: Proposed Rule NOTICE: Amendments to Excepted Benefits AGENCY: IRS/DoL/CMS	REG-132751-14 DoL RIN 1210-AB70 CMS-9946-P2	Issue Date: 12/23/2014 Due Date: 1/22/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This document contains proposed rules that would amend the regulations regarding excepted benefits under ERISA, the Internal Revenue Code (the Code), and the Public Health Service Act related to limited wraparound coverage. Excepted benefits generally are exempt from the requirements added to those laws by HIPAA and ACA. http://www.gpo.gov/fdsys/pkg/FR-2014-12-23/pdf/2014-30010.pdf SUMMARY OF NIHB ANALYSIS: These proposed regulations provide a series of conditions that must apply for certain wraparound benefits to qualify as "excepted benefits," thereby not impacting the ability of an employee to access premium tax credits in an Exchange if the individual otherwise qualifies for premium tax credits. Background: The 2013 proposed regulations outlined requirements under which certain employer-sponsored wraparound coverage provided under a group health plan would qualify as excepted benefits when offered to individuals who could have received the benefits provided in the wraparound coverage through their primary employer-sponsored group health plan but did not enroll in that plans because it was unaffordable. The 2013 proposed regulations sought to allow a plan sponsor to pursue equity in coverage by maintaining a comparable level of benefits for all potential enrollees, including not only higher-income workers enrolled in the primary employer-sponsored group health plan but also lower-income workers enrolled in non-grandfathered individual market coverage. Under the 2013 proposed regulations, employer-provided wraparound coverage would constitute excepted benefits (limited wraparound coverage) and therefore would not disqualify an employee from eligibility for the premium tax credit and cost-sharing reductions, if five conditions were met. After consideration of comments on the 2013 proposed regulations, the Departments are publishing these proposed regulations to address limited wraparound coverage and solicit comment before promulgation of final regulations on limited wraparound benefits.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
31.pp.	Summary of Benefits and Coverage and Uniform Glossary ACTION: Proposed Rule NOTICE: Summary of Benefits and Coverage and Uniform Glossary AGENCY: IRS/DoL/CMS	REG-145878-14 DoL RIN 1210-AB69 CMS-9938-P	Issue Date: 12/30/2014 Due Date: 3/2/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This document contains proposed regulations regarding the summary of benefits and coverage (SBC) and the uniform glossary for group health plans and health insurance coverage in the group and individual markets under ACA. It proposes changes to the regulations that implement the disclosure requirements under section 2715 of the Public Health Service Act (PHS Act) to help plans and individuals better understand their health coverage, as well as to gain a better understanding of other coverage options for comparison. It proposes changes to documents required for compliance with section 2715 of the PHS Act, including a template for the SBC, instructions, sample language, a guide for coverage example calculations, and the uniform glossary. A CMS fact sheet on these proposed regulations is available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/SBC-Proposed-Rule-Fact-Sheet-122214.pdf An HHS press release describing these proposed regulations is embedded below.  HHS Interg Notification SBC 2014 Links to a number of proposed supporting materials related the SBC and uniform glossary appear below: Proposed SBC Blank Template: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/blank-template-12-19-14-FINAL.pdf Proposed Uniform Glossary: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Uniform-Glossary-12-19-14-FINAL.pdf Proposed SBC Sample Completed Template: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Sample-completed-sbc-12-19-14-FINAL.pdf Proposed Why This Matters language for SBC "No" Answers: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Why-This-	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					Matters-No-Answers-FINAL.pdf Proposed Why This Matters language for SBC "Yes" Answers: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Why-This-Matters-Yes-Answers-FINAL.pdf Proposed Instructions for Completing the SBC--Individual Health Insurance Coverage: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Instructions-Individual-12-19-14-FINAL.pdf Proposed Instructions for Completing the SBC--Group Health Plan Coverage: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Instructions-Group-12-19-14-FINAL.pdf Proposed Guide for Coverage Examples Calculations--Maternity Scenario: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Maternity-Scenario-MarketScan-Data-DRAFT-v4-NHE-2.pdf Proposed Coverage Examples Narrative--Maternity Scenario: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/maternity-narrative.pdf Proposed Guide for Coverage Examples Calculations--Diabetes Scenario: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Diabetes-Scenario-MarketScan-Data-DRAFT-v3-NHE.PDF SUMMARY OF NIHB ANALYSIS: These proposed regulations, which would make modifications to the content of the Summary of Benefits and Coverage (SBC) documents, contain no Indian-specific provisions. Other recent proposed regulations pertaining to the SBC documents appeared in CMS-9944-P (see 89.h.). Tribal representatives provided comments on CMS-9944-P, which would mandate the release of an SBC by an issuer for each cost-sharing variation. A review of these proposed regulations is embedded below.	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 1/31/2015

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					 CMS-9938-P Summary of Benefits a	
39.e.	Basic Health Program: Federal Funding Methodology for 2016 ACTION: ~~Proposed~~ Final Methodology NOTICE: Basic Health Program; Federal Funding Methodology for Program Year 2016 AGENCY: CMS	CMS-2391-~~P~~FN	Issue Date: 10/23/2014 Due Date: 11/24/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Sent Final Methodology to OMB 1/29/2015		SUMMARY OF AGENCY ACTION: This document provides the methodology and data sources necessary to determine federal payment amounts made in program year 2016 to states that elect to establish a Basic Health Program under ACA to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges. http://www.gpo.gov/fdsys/pkg/FR-2014-10-23/pdf/2014-25257.pdf CMS recently released three new documents related to BHP, including: • Proposed 2016 BHP Payment Notice: This document provides the methodology and data sources necessary to determine federal payment amounts made in program year 2016 to states that elect to establish a BHP. https://www.federalregister.gov/articles/2014/10/23/2014-25257/basic-health-program-federal-funding-methodology-for-program-year-2016 • BHP Blueprint: States will use this document to make an official request for certification of a BHP as set forth in 42 CFR §600.110. This document, designed to collect the program design choices of the state and to provide a full description of the operations and management of the program and its compliance with the federal rules, reflects the BHP final rule that codified program establishment standards, eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and HHS oversight relating to BHP. In this document, "Section 2: Public Input" includes the following instructions, "If the state has federally recognized tribes, list them below. Provide an assurance that they were included in public comment and note if comments were received [by checking the relevant boxes]." http://www.medicaid.gov/basic-health-program/downloads/bhp-blueprint.pdf • State Report for Health Insurance Exchange Premiums: This document	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					collects information from states operating State-Based Marketplaces to support the determination of federal payment amounts to states that elect to establish a BHP. http://www.medicaid.gov/basic-health-program/downloads/premium-data-collection-tool.zip SUMMARY OF NIHB ANALYSIS: No comments recommended, as CMS proposes to use the same methodology in use for 2015 for 2016. While the BHP final rule in March 2014 codified the overall statutory requirements and basic procedural framework for the funding methodology, it did not contain the specific information necessary to determine federal payments. CMS anticipated that the methodology would be based on data and assumptions that would reflect ongoing operations and experience of BHP programs as well as the operation of the Exchanges. For this reason, the BHP final rule indicated that the development and publication of the funding methodology, including any data sources, would be addressed in a separate annual BHP Payment Notice. Payment rates published in draft form in this notice are expected to be finalized in February 2015 and would apply to BHP program year 2016, beginning in January 2016. (In the 3/12/2014 FR (79 FR 13887), CMS published the final payment methodology, titled ‘‘Basic Health Program; Federal Funding Methodology for Program Year 2015,’’that sets forth the methodology that will be used to calculate the federal BHP payments for the 2015 program year.) In this notice, CMS is proposing a methodology that is the same as the 2015 payment methodology, with updated values but no changes in methods. Through CMS-2380-F and CMS-2380-FN, tribal representatives made a series of recommendations. These recommendations were either adopted by CMS or, if not adopted, responded to by the agency in the preamble to the final action.	
41.e.	New Safe Harbors ACTION: Notice	OIG-123-N	Issue Date: 12/30/2014		SUMMARY OF AGENCY ACTION: In accordance with section 205 of HIPAA, this annual notice solicits proposals and recommendations for developing new and modifying existing safe harbor provisions under the Federal anti-kickback statute	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Solicitation of New Safe Harbors and Special Fraud Alerts AGENCY: HHS OIG		Due Date: 3/2/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		(section 1128B(b) of the Social Security Act), as well as developing new HHS OIG Special Fraud Alerts. http://www.gpo.gov/fdsys/pkg/FR-2014-12-30/pdf/2014-30156.pdf SUMMARY OF NIHB ANALYSIS: This notice provides another opportunity to tribal representatives to make a case for I/T/U-specific safe harbors.	
48.b.	Medical Loss Ratio Rebate Calculation Report and Notices ACTION: Request for Comment NOTICE: Annual MLR and Rebate Calculation Report and MLR Rebate Notices AGENCY: CMS	CMS-10418	Issue Date: 12/4/2012 Due Date: 2/4/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 2/22/2013, 11/22/2013, 1/31/2014, 1/30/2015 Due Date: 3/25/2013; 1/21/2014; 3/5/2014;		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Annual MLR and Rebate Calculation Report and MLR Rebate Notices; *Use*: Under Section 2718 of the Affordable Care Act and implementing regulation at 45 CFR part 158, a health insurance issuer (issuer) offering group or individual health insurance coverage must submit a report to the Secretary concerning the amount the issuer spends each year on claims, quality improvement expenses, non-claims costs, federal and state taxes and licensing and regulatory fees, and the amount of earned premium. An issuer must provide an annual rebate if the amount it spends on certain costs compared to its premium revenue (excluding federal and states taxes and licensing and regulatory fees) does not meet a certain ratio, referred to as the medical loss ratio (MLR). SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 2/22/2013 issued a revision of this PRA request. The 60-day Federal Register notice published on 12/4/2012 (77 FR 71801), pertained to the 2012 MLR Annual Reporting Form and Instructions, and the comment period closed on 2/4/2013. CMS received a total of 4 public comments on 25 specific issues regarding the notice of the revised MLR PRA package. Most of the comments addressed clarifying the instructions or correcting typographical errors, the removal of calculated cells and the ability of issuers to copy and paste data onto the form, and the inclusion of a credibility indicator for small issuers to eliminate the need for small issuers to fill out the complete MLR reporting form. CMS have taken into consideration all of the proposed suggestions and has made changes to the 2012 MLR	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			3/31/2015		Annual Reporting Form and Instructions. http://www.gpo.gov/fdsys/pkg/FR-2013-02-22/pdf/2013-04015.pdf CMS on 11/22/2013 issued a revision of this PRA request. Based upon experience in the MLR data collection and evaluation process, CMS has updated its annual burden hour estimates to reflect the actual numbers of submissions, rebates, and rebate notices. The 2013 MLR Reporting Form and instructions also reflect changes for the 2013 reporting year and beyond set forth in the March 2012 update to 45 CFR 158.120(d)(5) regarding aggregation of student health plans on a nationwide basis, similar to expatriate plans. In addition, the instructions address recent applicability guidance issued by the Departments of Labor and Treasury and HHS concerning expatriate plan reporting prior to plan years ending before or on 12/31/2015. In 2014, issuers likely will send fewer notices and rebate checks to policyholders and subscribers, resulting in a reduction in burden. However, the requirement to report data on student health plans will increase burden for some issuers. CMS estimates a net reduction in total information collection burden. http://www.gpo.gov/fdsys/pkg/FR-2013-11-22/pdf/2013-28049.pdf CMS on 1/31/2014 issued a revision of this PRA request. According to CMS, the 60-day notice published in the 11/22/2013 FR (78 FR 70059) pertained to the 2013 MLR Annual Reporting Form and Instructions, with comments closing on 1/21/2014. CMS received a total of 2 public comments on 12 specific issues regarding the notice of the revised MLR PRA package. Most of the comments addressed clarifying of the instructions, updates for recent guidance issuance, treatment of Student Health Plans, treatment of ACA fees, adjusted MLR standard experience aggregation, annual mini-med multipliers for credibility determination, reporting for both QIA and non-claims costs, and reporting requirements for businesses in run-off. CMS has considered all of the proposed suggestions and has revised the 2013 MLR Annual Reporting Form and Instructions. http://www.gpo.gov/fdsys/pkg/FR-2014-01-31/pdf/2014-02061.pdf CMS on 1/30/2015 issued a revision of this PRA request. Based upon experience in the MLR data collection and evaluation process, CMS has updated its annual burden hour estimates to reflect the actual numbers of submissions, rebates, and rebate notices. In addition, CMS has updated its annual burden hour estimates to reflect the additional burden related to the risk corridors data submission requirements.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					The 2014 MLR Reporting Form and instructions reflect changes for the 2014 reporting year and beyond set forth in the March 2013 update to 45 CFR part 158 regarding the MLR reporting and rebate distribution deadlines and the accounting for the transitional reinsurance, risk adjustment, and risk corridors. CMS also has revised the 2014 MLR Reporting Form and instructions to include the reporting elements required under the risk corridors data submission requirements in 45 CFR 153.530. In 2015, issuers likely will send fewer notices and rebate checks to policyholders and subscribers, reducing burden for QHP issuers. However, the requirement to report the risk corridors data will increase burden for QHP issuers. CMS estimates a net reduction in total burden from 294,911 to 271,600. http://www.gpo.gov/fdsys/pkg/FR-2015-01-30/pdf/2015-01790.pdf	
52.f.	OASIS Collection Requirements as Part of the CoPs for HHAs ACTION: Request for Comment NOTICE: OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations AGENCY: CMS	CMS-R-245	Issue Date: 6/21/2013 Due Date: 8/20/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 11/8/2013, 8/29/2014; issued extension 11/24/2014		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: OASIS Collection Requirements as Part of the CoPs for HHAs and Supporting Regulations; *Use*: Home Health Agencies (HHAs) must use the OASIS data set as a condition of participation (CoP) in the Medicare program. Since 1999, Medicare CoPs have mandated that HHAs use the OASIS data set when evaluating adult non-maternity patients receiving skilled services. Agencies integrate OASIS, a core standard assessment data set, into their own patient-specific, comprehensive assessment to identify patient need for home care that meets their medical, nursing, rehabilitative, social, and discharge planning needs. http://www.gpo.gov/fdsys/pkg/FR-2013-06-21/pdf/2013-14878.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 11/8/2013 issued a revision of this PRA request. Subsequent to the publication of the 60-day FR notice on 6/21/2013, CMS has revised the data set by rewording the text. http://www.gpo.gov/fdsys/pkg/FR-2013-11-08/pdf/2013-26822.pdf CMS on 8/9/2014 issued a revision of this PRA request. According to CMS, OMB	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Due Date: 12/9/2013; 9/12/2014; 1/23/2015		approved the OASIS-C1 information collection request on 2/6/2014. CMS originally planned to use OASIS-C1 to coincide with the original implementation of ICD-10 on 10/1/2014. However, on 4/1/2014, the Protecting Access to Medicare Act of 2014 (PAMA) took effect. This legislation prohibits CMS from adopting ICD-10 coding prior to 10/1/2015. Because CMS based OASIS-C1 on ICD-10 coding, it cannot implement OASIS-C1 prior to 10/1/2015. The passage of the PAMA Act left CMS with the dilemma of how to collect OASIS data in the interim. CMS created the OASIS-C1/ICD-9 version, an interim version of the OASIS-C1 data item set, in response to the legislatively mandated ICD-10 delay. Five items in OASIS-C1 require ICD-10 codes. In the OASIS-C1/ICD-9 version, CMS has replaced these items with the corresponding items from OASIS-C that use ICD-9 coding. The OASIS-C1/ICD-9 version also incorporates updated clinical concepts, modified item wording and response categories, and improved item clarity. In addition, the OASIS-C1/ICD-9 version includes a significant decrease in provider burden through the deletion of a number of non-essential data items from the OASIS-C data item set. http://www.gpo.gov/fdsys/pkg/FR-2014-08-29/pdf/2014-20577.pdf CMS on 11/24/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-11-24/pdf/2014-27756.pdf	
52.I.	Home Health Agency Conditions of Participation ACTION: Proposed Rule NOTICE: Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies AGENCY: CMS	CMS-3819-P	Issue Date: 10/9/2014 Due Date: ~~12/8/2014~~ 1/7/2015 NIHB File Date: None Date of		SUMMARY OF AGENCY ACTION: This proposed rule would revise the current conditions of participation (CoPs) that home health agencies (HHAs) must meet to participate in the Medicare and Medicaid programs. The proposed requirements would focus on the care delivered to patients by home health agencies, reflect an interdisciplinary view of patient care, allow home health agencies greater flexibility in meeting quality care standards, and eliminate unnecessary procedural requirements. These changes would serve as an integral part of an overall CMS effort to achieve broad-based, measurable improvements in the quality of care furnished through the Medicare and Medicaid programs, while eliminating unnecessary procedural burdens on providers.	

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			Subsequent Agency Action, if any: Issued due date extension 12/1/2014		SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/1/2014 issued a notice (CMS-3819-N) that extends the comment period for the proposed rule titled "Conditions of Participation for Home Health Agencies" and published in the 10/9/2014 FR (79 FR 61164). This notice extends the comment period for the proposed rule, which would have ended on 12/8/2014, for 30 days. http://www.gpo.gov/fdsys/pkg/FR-2014-12-01/pdf/2014-28266.pdf	
52.n.	OASIS-C1/ICD-10 ACTION: Request for Comment NOTICE: Outcome and Assessment Information Set (OASIS) OASIS-C1/ICD-10 AGENCY: CMS	CMS-10545	Issue Date: 1/9/2015 Due Date: 3/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Outcome and Assessment Information Set (OASIS) OASIS-C1/ICD-10; *Use*: Home health agencies (HHAs) must collect the outcome and assessment information data set (OASIS) to participate in the Medicare program. CMS requests a new OMB control number for the proposed revised OASIS item set, referred to hereafter as OASIS-C1/ICD-10. OMB on 10/7/2014 approved the current version of the OASIS-C1/ICD-9 data set (OMB 0938-0760), which will remain in use until the implementation of the ICD-10 coding system, currently scheduled for 10/1/2015. http://www.gpo.gov/fdsys/pkg/FR-2015-01-09/pdf/2015-00175.pdf SUMMARY OF NIHB ANALYSIS:	
54.	ESI Coverage Verification ACTION: Notice NOTICE: Employer-Sponsored Coverage Verification: Preliminary Informational Statement AGENCY: CMS	CMS RIN 0938-ZB09	Issue Date: [Approved by OMB 4/26/2012 but not yet published] Due Date: NIHB File		SUMMARY OF AGENCY ACTION: SUMMARY OF NIHB ANALYSIS:	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Date: Date of Subsequent Agency Action, if any:			
64.c.	Tribal Consultation Policy ACTION: Notice NOTICE: Tribal Consultation Policy AGENCY: Treasury	Treasury (no reference number)	Issue Date: 12/3/2014 Due Date: 4/2/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This notice announces an interim policy outlining the guiding principles for all Department of Treasury (Treasury) bureaus and offices engaging with tribal Governments on matters with tribal implications. Treasury will update the policy periodically and refine it as needed to reflect ongoing engagement and collaboration with tribal partners. http://www.gpo.gov/fdsys/pkg/FR-2014-12-03/pdf/2014-28383.pdf SUMMARY OF NIHB ANALYSIS:	
77.d.	National Provider Identifier Application and Update Form ACTION: Request for Comment NOTICE: National Provider Identifier (NPI) Application and Update Form and Supporting Regulations in 45 CFR 142.408, 45 CFR 162.406, 45 CFR 162.408	CMS-10114	Issue Date: 9/12/2014 Due Date: 11/12/2014 NIHB File Date: None Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: National Provider Identifier (NPI) Application and Update Form and Supporting Regulations in 45 CFR 142.408, 45 CFR 162.406, 45 CFR 162.408; *Use*: Health care providers use the National Provider Identifier (NPI) Application and Update Form to apply for NPIs and furnish updates to the information they supplied on their initial applications, as well as to deactivate their NPIs if necessary. CMS has revised the NPI Application/Update form to provide additional guidance on how to complete the form accurately. This collection includes clarification on information required on applications/changes. Minor changes on the application/update form include adding a "Subpart" check box in the Other Name section and a revision within the PRA Disclosure Statement. This collection also includes changes to the instructions. http://www.gpo.gov/fdsys/pkg/FR-2014-09-12/pdf/2014-21798.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	AGENCY: CMS		Issued extension 11/21/2014, 1/16/2015 Due Date: 12/22/2014; 2/17/2015		SUMMARY OF NIHB ANALYSIS: SUMMARY OF AGENCY ACTION: CMS on 11/21/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-11-21/pdf/2014-27640.pdf CMS on 1/16/2015 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-01-16/pdf/2015-00626.pdf	
78.i.	Prior Authorization Form for Beneficiaries Enrolled in Hospice ACTION: Request for Comment NOTICE: Prior Authorization Form for Beneficiaries Enrolled in Hospice AGENCY: CMS	CMS-10538	Issue Date: 10/3/2014 Due Date: 12/2/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 1/23/2015 Due Date: 2/23/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Prior Authorization Form for Beneficiaries Enrolled in Hospice; *Use*: The prescriber or hospice (or the Part D sponsor, if the prescriber or hospice provides the information verbally) of the beneficiary would complete the form. The Part D sponsor would use the Information provided on the form to establish coverage of the drug under Medicare Part D. Per statute, drugs necessary for the palliation and management of the terminal illness and related conditions do not qualify for payment under Part D. The standard form provides a vehicle for the hospice provider, prescriber, or sponsor to document that the drug prescribed is "unrelated" to the terminal illness and related conditions. It also gives a hospice organization the option to communicate a change in the hospice status and care plan of the beneficiary to Part D sponsors. http://www.gpo.gov/fdsys/pkg/FR-2014-10-03/pdf/2014-23613.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF AGENCY ACTION: CMS on 1/23/2015 issued a new version of this PRA request. CMS has revised this package subsequent to the publication of the 60-day notice in 10/3/2014 FR (79 FR 59772). http://www.gpo.gov/fdsys/pkg/FR-2015-01-23/pdf/2015-01127.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
89.h.	Notice of Benefit and Payment Parameters for 2016 ACTION: ~~Proposed~~ Final Rule NOTICE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 AGENCY: CMS	CMS-9944-~~PF~~	Issue Date: 11/26/2014 Due Date: 12/22/2014 TTAG File Date: 12/22/2014 Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 1/29/2015	TTAG response:	SUMMARY OF AGENCY ACTION: This proposed rule would set forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-Facilitated Exchanges. It also would provide additional standards for the annual open enrollment period for the individual market for benefit years beginning on or after 1/1/2016, essential health benefits, qualified health plans, network adequacy, quality improvement strategies, the Small Business Health Options Program, guaranteed availability, guaranteed renewability, minimum essential coverage, the rate review program, the medical loss ratio program, and other related topics. http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf A fact sheet on this proposed rule is available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Fact-Sheet-11-20-14.pdf SUMMARY OF NIHB ANALYSIS: This proposed rule might provide an opportunity to revisit the CMS regulation on cost-sharing protections for AI/ANs as it pertains to families with AI/AN and non-AI/AN members. A draft memo from Mim Dixon is embedded below.  Memo re New Strategy for Definitio Detailed analysis: This proposed rule addresses, at least in part, two recommendations made by tribal representatives: 1. CMS is placing in regulations the requirement contained in the 2015 Issuer Letter whereby issuers are to offer contracts to all Indian health care providers in the QHP's service area. The exact language of the provision (shown below from the preamble to the proposed rule and the proposed regulatory language) might need adjustment.	See Table C.

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					Requirement to offer to contract PREAMBLE: Essential Community Providers: "The rule proposes to codify the standard used for 2015 for the FFM, that issuers seeking qualified health plan certification in the FFM subject to the general essential community provider standard would be required to offer provider contracts to: (a) all available Indian health providers in the service area; and (b) at least one essential community provider in each essential community provider category (i.e., Federally Qualified Health Clinics, Ryan White providers, family planning providers, hospitals, and others) in each county in the service area, where a provider in that category is available." PROPOSED REGULATION: "(ii) The issuer of the plan offers contracts to-- (A) All available Indian health providers in the service area, applying the special terms and conditions necessitated by federal law and regulations as referenced in the recommended model QHP addendum for Indian health providers developed by HHS…" [§ 155.235(a)(2)(ii)] 2. CMS also is establishing a requirement on issuers to issue a Summary of Benefits and Coverage for each plan variation. Requirement to issue Summary of Benefits and Coverage (SBC) PREAMBLE: "While individual health insurance issuers (including QHP issuers) must provide an SBC for each benefit package, current regulations do not specifically address an issuer's responsibilities to provide an SBC reflecting a QHP with cost-sharing reductions applied, known as a plan variation of the QHP. Consequently, a consumer who is eligible for cost-sharing reductions may receive an SBC that does not accurately represent the cost sharing he or she will be responsible for when receiving essential health benefits. Under the authority stated above, we propose to amend § 156.420 to add § 156.420(h) and require QHP issuers to provide SBCs that accurately represent plan variations in a manner consistent with the requirements set forth at § 147.200 to ensure that consumers have access to SBCs that accurately represent cost-sharing responsibilities for all coverage options, including plan variations, and are provided adequate notice of the plan variations." PROPOSED REGULATION: § 156.420 Plan variations. * * * * * (h) *Notice.* No later	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					than the first day of the Exchange open enrollment period for the 2016 benefit year, for each plan variation that an issuer offers in accordance with the rules of this section, an issuer must provide a summary of benefits and coverage that accurately represents each plan variation consistent with the requirements set forth in § 147.200 of this subchapter." 3. The proposed rule also codifies the exemption process for the hardship exemption from the tax penalty for IHS-eligible persons. [§ 155.605(g)(6)(iii)] 4. The proposed rule also corrects a subsection reference in order to refer to the definition of Indian under Medicaid (the subsection that was recently changed.) PREAMBLE: "Second, we propose amending § 155.605(g)(6)(i) to correct the citation to 42 CFR 447.50 by changing it to 42 CFR 447.51, which cross-references the Medicaid definition for Indian." A list of select provisions in the proposed rule is attached.  Select Provisions in CMS-9944 2014-12- Also attached is a copy of the tribal recommendations on requiring issuers to provide a SBC (Summary of Benefits and Coverage) for each (Indian-specific) plan variation.  TTAG Letter to CCIIO - QHPs and AI·	
92.v.	Q&A on Outreach by Medicaid MCOs to Former Enrollees ACTION: Guidance	CCIIO (no reference number)	Issue Date: 2/21/2014 Due Date: None		SUMMARY OF AGENCY ACTION: Medicaid managed care organizations (MCOs), which provide coverage to beneficiaries on a risk basis, have existed since before the enactment of ACA. Many individuals once enrolled in a Medicaid managed care plan might no longer qualify for Medicaid as determined by States. Many issuers that contract with States as MCOs have become involved in offering Qualified Health Plans (QHPs) on	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Question and Answer on Outreach by Medicaid Managed Care Contractors and Health Insurance Issuers to Former Enrollees AGENCY: CCIIO		NIHB File Date: Date of Subsequent Agency Action, if any: Issued revised Guidance 1/15/2015		the Federally-Facilitated Marketplace or in State-Based Marketplaces, providing coverage to previously uninsured individuals. This guidance answers the question of whether an issuer with a Medicaid MCO contract can reach out to former enrollees who States disenrolled because of a loss of Medicaid eligibility to assist them in enrolling in health coverage offered by the issuer through the Marketplace. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/medicaid-mco-enrollee-outreach-faq-2-21-14.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CCIIO on 1/15/2015 issued a revised version of this guidance. This document removes the following sentence from the end of the answer included in the previous version of this guidance: "However, a Medicaid MCO may not reach out to current Medicaid beneficiaries." http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/MCOs-1-15-15.pdf	
92.hh.	Annual Eligibility Redetermination Notices, et al. ACTION: Request for Comment NOTICE: Annual Eligibility Redetermination, Product Discontinuation, and Renewal Notices AGENCY: CMS	CMS-10527	Issue Date: 11/4/2014 Due Date: 1/5/2015 NIHB File Date: NIHB File Date: None Date of Subsequent Agency		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Annual Eligibility Redetermination, Product Discontinuation, and Renewal Notices; *Use*: Section 1411(f)(1)(B) of ACA directs the HHS Secretary to establish procedures to redetermine the eligibility of individuals on a periodic basis in appropriate circumstances. Section 1321(a) of ACA provides authority for the HHS Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, Qualified Health Plans (QHPs), and other components of title I of ACA. Under section 2703 of the Public Health Service Act (PHS Act), as added by ACA, and sections 2712 and 2741 of the PHS Act, enacted by HIPAA, health insurance issuers in the group and individual markets must guarantee the renewability of coverage unless an exception applies. The final rule "Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs;	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Action, if any: Issued extension 1/23/2015 Due Date: 2/23/2015		Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges" (79 FR 52994) provides that an Exchange can choose to conduct the annual redetermination process for a plan year (1) in accordance with the existing procedures described in 45 CFR 155.335; (2) in accordance with procedures described in guidance issued by the Secretary for the coverage year; or (3) using an alternative proposed by the Exchange and approved by the HHS Secretary. The guidance document "Guidance on Annual Redeterminations for Coverage for 2015" contains the procedures that the Secretary has specified for the 2015 coverage year, as noted in (2) above. These procedures will apply to the Federally-Facilitated Exchange. Under this option, the Exchange will provide three notices, which the Exchange can combine. The final rule also amends the requirements for product renewal and re-enrollment (or non-renewal) notices sent by QHP issuers in the Exchanges and specifies content for these notices. The accompanying guidance document "Form and Manner of Notices When Discontinuing or Renewing a Product in the Group or Individual Market" provides standard notices for product discontinuation and renewal sent by issuers of individual market QHPs and issuers in the individual market. Issuers in the small group market can use the draft Federal standard small group notices released in the June 26, 2014, bulletin "Draft Standard Notices When Discontinuing or Renewing a Product in the Small Group or Individual Market" or any forms of the notice otherwise permitted by applicable laws and regulations. States enforcing ACA can develop their own standard notices for product discontinuances, renewals, or both, provided the State-developed notices provide at least the same level of protection as the Federal standard notices. http://www.gpo.gov/fdsys/pkg/FR-2014-11-04/pdf/2014-26041.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 1/23/2015 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-01-23/pdf/2015-01127.pdf No comments recommended.	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 1/31/2015

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
92.kk.	Summary of Benefits and Coverage and Uniform Glossary ACTION: Request for Comment NOTICE: Summary of Benefits and Coverage and Uniform Glossary AGENCY: CMS	CMS-10407	Issue Date: 11/24/2014 Due Date: 1/23/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Summary of Benefits and Coverage and Uniform Glossary; *Use*: Section 2715 of the Public Health Service Act directs HHS, the Department of Labor (DoL), and the Department of the Treasury (collectively, the Departments), in consultation with the National Association of Insurance Commissioners (NAIC) and a working group comprised of stakeholders, to "develop standards for use by a group health plan and a health insurance issuer in compiling and providing to applicants, enrollees, and policyholders and certificate holders a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage." To implement these disclosure requirements, collection of information requests relate to the provision of the following: summary of benefits and coverage, which includes coverage examples; a uniform glossary of health coverage and medical terms; and a notice of modifications. http://www.gpo.gov/fdsys/pkg/FR-2014-11-24/pdf/2014-27756.pdf Documents associated with this PRA request, including a blank "Summary of Coverage" template, which tribal representatives have requested that CMS require QHPs to provide for Indian-specific cost-sharing variations, are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1251222.html. SUMMARY OF NIHB ANALYSIS:	
92.ll.	Health Benefit Plan Network Access and Adequacy Model Act ACTION: Request for Comment NOTICE: Health Benefit Plan Network Access and Adequacy Model Act (Draft)	NAIC (no reference number)	Issue Date: 11/12/2014 Due Date: 1/12/2015 TTAG File Date: 1/12/2015	TTAG response:	SUMMARY OF AGENCY ACTION: This draft Act includes model language regarding network adequacy in health plans. The Act seeks to: • Establish standards for the creation and maintenance of networks by health carriers; and • Assure the adequacy, accessibility, transparency, and quality of health care services offered under a network plan by (1) establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide covered benefits to covered	See Table C.

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	AGENCY: NAIC		Date of Subsequent Agency Action, if any:		persons and (2) requiring network plans to have and maintain publicly available access plans consistent with Section 5B of this Act that consist of policies and procedures for assuring the ongoing sufficiency of provider networks. NAIC seeks comments on this draft Act by 1/12/2015. The revisions to this version of the Act reflect changes made from the existing model. Interested parties should submit comments by e-mail only to Jolie Matthews at jmatthews@naic.org. Information regarding the NAIC Network Adequacy Model Review (B) Subgroup, responsible for reviewing and considering revisions to the Act, is available at http://www.naic.org/committees_b_rftf_namr_sg.htm. SUMMARY OF NIHB ANALYSIS: NAIC, rather than CMS, has prepared this draft Act. CMS has indicated (in CMS-9944-P, see 89.h.) that it will look to NAIC model Act prior to revising the Marketplace access standards.	
109.d.	COBRA Coverage Requirements for Group Health Plans ACTION: Request for Comment NOTICE: Continuation Coverage Requirements Application to Group Health Plans AGENCY: IRS	REG-209485-86/TD 8812 (OMB 1545-1581)	Issue Date: 10/8/2014 Due Date: 12/8/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 12/30/2014 Due Date: 1/29/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Continuation Coverage Requirements Application to Group Health Plans; *Use*: The regulations require group health plans to provide notices to individuals entitled to elect COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) continuation coverage of their election rights. Individuals who wish to obtain the benefits provided under the statute must provide plans notices in cases of divorce from the covered employee, a child no longer considered dependent under the terms of the plan, and disability. Most plans will require that elections of COBRA continuation coverage occur in writing. In cases where qualified beneficiaries are short by an insignificant amount in a payment made to the plan, the regulations require the plan to notify the qualified beneficiary if the plan does not wish to treat the tendered payment as full payment. If a health care provider contacts a plan to confirm coverage of a qualified beneficiary, the regulations require that the plan disclose to the qualified beneficiary his or her complete rights to coverage. http://www.gpo.gov/fdsys/pkg/FR-2014-10-08/pdf/2014-24070.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/30/2014 issued an	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-12-30/pdf/2014-30376.pdf	
112.c.	Expanded Access to Non-VA Care Through Veterans Choice ACTION: Proposed Rule NOTICE: Expanded Access to Non-VA Care Through Veterans Choice Program AGENCY: VA	VA RIN 2900-AP24	Issue Date: 11/5/2014 Due Date: 3/5/2015 NIHB File Date: Date of Subsequent Agency Action, if any: Issued start date notice 11/21/2014		SUMMARY OF AGENCY ACTION: VA amends its medical regulations concerning its authority for eligible veterans to receive care from non-VA entities and providers. The Veterans Access, Choice, and Accountability Act of 2014 directs VA to establish a program to furnish hospital care and medical services through non-VA health care providers to veterans who either cannot receive care within the wait-time goals of the Veterans Health Administration or who qualify based on their place of residence (the Veterans Choice Program, or the "Program"). The law also requires VA to publish an interim final rule establishing this program. This interim final rule defines the parameters of the Veterans Choice Program and clarifies aspects affecting veterans and the non-VA providers that will furnish hospital care and medical services through the Veterans Choice Program. http://www.gpo.gov/fdsys/pkg/FR-2014-11-05/pdf/2014-26316.pdf SUMMARY OF NIHB ANALYSIS: Under "eligible entities and providers," the following definition is provided: "Section 17.1530 defines requirements for non-VA entities and health care providers to be eligible to be reimbursed for furnishing hospital care and medical services to eligible veterans under the Program. Paragraph (a) of this section provides that an entity or provider must be accessible to the veteran and be one of the four entities specified in section 101(a)(1)(B) of the Act. These include any health care provider that is participating in the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including any physician furnishing services under such program; any Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)); the Department of Defense; or the Indian Health Service. Outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination and Education Assistance Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act are defined as Federally-qualified health centers in section 1905(l)(2)(B) of the Social Security Act and would be eligible providers under section 101(a)(1)(B)."	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					Under this definition, I/T/Us are included as eligible providers, either as a Medicare participating provider or as an FQHC under SSA 42 U.S.C. 1396d(l)(2)(B). SUMMARY OF SUBSQENT AGENCY ACTION: VA on 11/21/2014 issued a start date notice. In the interim final rule, VA established start dates for participation in the Veterans Choice Program (the "Program") for different groups of veterans depending upon their basis of eligibility to participate. In those regulations, VA stated that veterans eligible based upon their inability to schedule an appointment within the wait-time goals of the Veterans Health Administration can start receiving hospital care and medical services under the Program no later than 12/5/2014. VA also stated that, if these veterans had a start date earlier than 12/5/2014, VA would publish a notice in the FR advising the public of the faster implementation schedule. This notice announces that 11/17/2014 serves as the start date for veterans eligible to participate in the Program.	
112.d.	I/T/U Payment for Physician and Non-Hospital-Based Services ACTION: Proposed Rule NOTICE: Payment for Physician and Other Health Care Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital-Based Care AGENCY: IHS	IHS RIN 0917-AA12	Issue Date: 12/5/2014 Due Date: ~~1/20/2015~~ 2/4/2015 NIHB File Date: Date of Subsequent Agency Action, if any: Issued due date extension 1/14/2015		SUMMARY OF AGENCY ACTION: This proposed rule would amend IHS Purchased and Referred Care (PRC), formally known as Contract Health Services (CHS), regulations to apply Medicare payment methodologies to all physician and other health care professional services and non-hospital based services either authorized under such regulations or purchased by urban Indian organizations (UIOs). Specifically, it proposes that the health programs operated by IHS, Tribes, tribal organizations, or UIOs (collectively, I/T/U programs) will pay the lowest of the amount provided for under the applicable Medicare fee schedule, prospective payment system, or Medicare waiver; the amount negotiated by a repricing agent, if available; or the usual and customary billing rate. IHS might use repricing agents to determine whether it would benefit from savings by utilizing negotiated rates offered through commercial health care networks. This proposed rule seeks comment on how to establish reimbursement that remains consistent across Federal health care programs, aligns payment with inpatient services, and enables IHS to expand beneficiary access to medical care. http://www.gpo.gov/fdsys/pkg/FR-2014-12-05/pdf/2014-28508.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSQENT AGENCY ACTION: IHS on 1/14/2015 issued a document that extends the comment period for the Payment for Physician and Other Health Care	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					Professional Services Purchased by Indian Health Programs and Medical Charges Associated with Non-Hospital-Based Care proposed rule published in 12/5/2014 FR (79 FR 72160). This document extends the comment period for the proposed rule, which would have ended on 1/20/2015, to 2/4/2015. http://www.gpo.gov/fdsys/pkg/FR-2015-01-14/pdf/2015-00400.pdf	
112.e.	Tribal Consultation on VA/IHS Reimbursement Agreements ACTION: Notice NOTICE: Section 102(c) of the Veterans Access, Choice, and Accountability Act of 2014 AGENCY: VA	VA (no reference number)	Issue Date: 12/30/2014 Due Date: 1/14/2015 TSGAC File Date: 1/14/2015 Date of Subsequent Agency Action, if any:	TSGAC response:	SUMMARY OF AGENCY ACTION: As required by section 102(c) of the Veterans Access, Choice, and Accountability Act of 2014, the VA Secretary and the IHS Director will jointly submit to Congress a report on the feasibility and advisability of entering into and expanding certain reimbursement agreements. VA seeks Tribal Consultation on section 102(c). Specifically, VA seeks Tribal Consultation in the form of written comments concerning the feasibility and advisability of IHS and tribal health programs entering into agreements with VA for reimbursement of the costs of direct care services provided to eligible veterans who are not AI/ANs. http://www.gpo.gov/fdsys/pkg/FR-2014-12-30/pdf/2014-30527.pdf See 112.c. for information on the Veterans Choice Program. Summary of Section 102 Section 102, titled, "Enhancement of Collaboration Between Department of Veterans Affairs and Indian Health Service," directs the VA Secretary, in consultation with the IHS Director, to conduct outreach to each medical facility operated by a Tribe or tribal organization through a contract or compact with the IHS under ISDEAA to raise awareness of the ability of such facilities, Tribes, and tribal organizations to enter into agreements under which VA reimburses them for health care provided to veterans who are 1) eligible for health care at such facilities and 2) enrolled in the VA patient enrollment system (or fall under a certain limited exception). Section 102 also requires the VA Secretary to establish metrics for assessing the performance by VA and IHS in increasing access to health care, improving quality and coordination of health care, promoting effective patient-centered collaboration and	See Table C.

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					partnerships between VA and IHS, and ensuring health-promotion and disease-prevention services are appropriately funded and available for beneficiaries under both health care systems. In addition, under section 102, within 180 days of enactment, the VA Secretary and IHS Director of must jointly submit to Congress a report on the feasibility and advisability of the following: • Entering into agreements for the reimbursement by VA of the costs of direct care services provided through organizations receiving amounts pursuant to grants made or contracts entered into under section 503 of the Indian Health Care Improvement Act to veterans who are otherwise eligible to receive health care from such organizations; and • Including the reimbursement of the costs of direct care services provided to veterans who are not AI/ANs in agreements between VA and IHS or a Tribe or tribal organization operating a medical facility through a contract or compact with the IHS under ISDEAA. SUMMARY OF NIHB ANALYSIS:	
112.f.	IHS Reimbursement Rates for CY 2015 ACTION: Notice NOTICE: Reimbursement Rates for Calendar Year 2015 AGENCY: IHS	IHS RIN 0917-ZA29	Issue Date: [Pending at OMB as of 1/17/2015] Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: SUMMARY OF NIHB ANALYSIS:	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 1/31/2015

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
121.i.	Site Investigation for Diagnostic Testing Facilities ACTION: Request for Comment NOTICE: Site Investigation for Independent Diagnostic Testing Facilities (IDTFs) AGENCY: CMS	CMS-10221	Issue Date: 1/16/2015 Due Date: 3/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Site Investigation for Independent Diagnostic Testing Facilities (IDTFs); *Use*: CMS enrolls Independent Diagnostic Testing Facilities (IDTFs) into the Medicare program via a uniform application, form CMS-855B. Implementation of enhanced procedures for verifying the enrollment information has improved the enrollment process, as well as identified and prevented fraudulent IDTFs from entering the Medicare program. As part of this process, CMS requires verification of compliance with IDTF performance standards. The site investigation form for IDTFs provides a standardized, uniform tool to gather information that tells CMS whether an IDTF meets certain standards (as found in 42 CFR 410.33(g)) and where it practices or renders its services. CMS has used the site investigation form in the past to aid in verifying compliance with the required performance standards found in 42 CFR 410.33(g). CMS has made no revisions to this form since the last submission for OMB approval. http://www.gpo.gov/fdsys/pkg/FR-2015-01-16/pdf/2015-00627.pdf SUMMARY OF NIHB ANALYSIS:	
121.j.	Site Investigation for Suppliers of DMEPOS ACTION: Request for Comment NOTICE: Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) AGENCY: CMS	CMS-R-263	Issue Date: 1/16/2015 Due Date: 3/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); *Use*: CMS enrolls suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) into the Medicare program via a uniform application, form CMS 855S. Implementation of enhanced procedures for verifying the enrollment information has improved the enrollment process, as well as identified and prevented fraudulent DMEPOS suppliers from entering the Medicare program. As part of this process, CMS requires verification of compliance with supplier standards. The site investigation form provided a standardized, uniform tool to gather information from a DMEPOS supplier that tells CMS whether it meets certain qualifications (as found in 42 CFR 424.57(c)) and where it practices or renders its services. CMS has used the site investigation form in the past to aid in verifying compliance with the required supplier standards found in 42 CFR 424.57(c). CMS has made no revisions to this form since the last submission for OMB approval.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					http://www.gpo.gov/fdsys/pkg/FR-2015-01-16/pdf/2015-00627.pdf SUMMARY OF NIHB ANALYSIS:	
121.k.	Verification of Clinic Data--Rural Health Clinic Form ACTION: Request for Comment NOTICE: Verification of Clinic Data--Rural Health Clinic Form and Supporting Regulations AGENCY: CMS	CMS-29	Issue Date: 1/23/2015 Due Date: 3/24/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Verification of Clinic Data--Rural Health Clinic Form and Supporting Regulations; *Use*: The form serves as an application for suppliers of Rural Health Clinic (RHC) services requesting participation in the Medicare program. This form initiates the process of obtaining a decision as to whether applicants meet the conditions for certification as a supplier of RHC services. It also promotes data reduction or introduction to and retrieval from the Automated Survey Process Environment (ASPEN) and related survey and certification databases by the CMS Regional Offices. http://www.gpo.gov/fdsys/pkg/FR-2015-01-23/pdf/2015-01128.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended.	
125.	Interest Rate on Overdue Debts ACTION: Notice NOTICE: Notice of Interest Rate on Overdue Debts AGENCY: HHS	HHS (no reference number)	Issue Date: 12/28/2012 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued revisions		SUMMARY OF AGENCY ACTION: Section 30.18 of HHS claims collection regulations (45 CFR part 30) provides that the Secretary shall charge an annual rate of interest determined and fixed by the Secretary of the Treasury after considering private consumer rates of interest on the date that HHS becomes entitled to recovery. The rate must equal or exceed the current value of funds rate set by the Department of Treasury or the applicable rate determined from the "Schedule of Certified Interest Rates with Range of Maturities," unless the HHS Secretary waives interest in whole or part or a statute, contract, or repayment agreement prescribes a different rate. The Secretary of the Treasury may revise this rate quarterly. HHS publishes this rate in the Fed Reg. The current rate of 10 3⁄8%, as fixed by the Secretary of the Treasury, is certified for the quarter ended September 30, 2012. This interest rate is effective until the Secretary of the Treasury notifies the HHS of any change. SUMMARY OF NIHB ANALYSIS:	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			3/5/2013, 4/23/2013, 7/23/2013, 11/12/2013, 9/2/2014, 10/27/2014, 1/27/2015		SUMMARY OF SUBSEQUENT AGENCY ACTION: Under the 3/5/2013 revision, the current rate of 105/8%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 12/31/2012. This interest rate will remain effective until the Secretary of the Treasury notifies HHS of any change. http://www.gpo.gov/fdsys/pkg/FR-2013-03-05/pdf/2013-04945.pdf Under the 4/23/2013 revision, the current rate of 101/8%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 3/31/2013. This rate is based on the Interest Rates for Specific Legislation, "National Health Services Corps Scholarship Program" and "National Research Service Award Program." This interest rate will apply to overdue debt until HHS publishes a revision. http://www.gpo.gov/fdsys/pkg/FR-2013-04-23/pdf/2013-09578.pdf Under the 7/23/2013 revision, the current rate of 103/8%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 6/30/2013. This rate is based on the Interest Rates for Specific Legislation, "National Health Services Corps Scholarship Program" and "National Research Service Award Program." This interest rate will apply to overdue debt until HHS publishes a revision. http://www.gpo.gov/fdsys/pkg/FR-2013-07-23/pdf/2013-17683.pdf Under the 11/12/2013 revision, the current rate of 101/8%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 9/30/2013. This rate is based on the Interest Rates for Specific Legislation, "National Health Services Corps Scholarship Program" and "National Research Service Award Program." This interest rate will apply to overdue debt until HHS publishes a revision. http://www.gpo.gov/fdsys/pkg/FR-2013-11-12/pdf/2013-26994.pdf Under the 9/2/2014 revision, the current rate of 103/8%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 6/30/2014. This rate is based on the Interest Rates for Specific Legislation, "National Health Services Corps Scholarship Program" and "National Research Service Award Program." This interest rate will apply to overdue debt until HHS publishes a revision. http://www.gpo.gov/fdsys/pkg/FR-2014-09-02/pdf/2014-20773.pdf Under the 10/27/2014 revision, the current rate of 10 3/4%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 9/30/2014. This rate is based on the	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					Interest Rates for Specific Legislation, "National Health Services Corps Scholarship Program" and "National Research Service Award Program." This interest rate will apply to overdue debt until HHS publishes a revision. http://www.gpo.gov/fdsys/pkg/FR-2014-10-27/pdf/2014-25443.pdf Under the 1/27/2015 revision, the current rate of 10 1/2%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 12/31/2014. This rate is based on the Interest Rates for Specific Legislation, "National Health Services Corps Scholarship Program" and "National Research Service Award Program." This interest rate will apply to overdue debt until HHS publishes a revision. http://www.gpo.gov/fdsys/pkg/FR-2015-01-27/pdf/2015-01429.pdf	
132.e.	Outpatient/Ambulatory Surgery Experience of Care Survey ACTION: Request for Comment NOTICE: Outpatient and Ambulatory Surgery Experience of Care Survey AGENCY: CMS	CMS-10500	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: None Date of Subsequent Agency Action: Issued new request 12/27/2013; issued revision 1/16/2015 Due Date: 1/27/2014; 3/17/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: *Outpatient and Ambulatory Surgery Experience of Care Survey*; *Use*: CMS will use the information collected through the field test to inform the development of a larger national survey effort, including development of the final survey instrument and data collection procedures. CMS will use the data collected in this survey effort to conduct a rigorous psychometric analysis of the survey content. Such an analysis seeks to assess the measurement properties of the proposed instrument and sub-domain composites created from item subsets to assure the definition of information reported from any future administrations of the survey. This field test also will serve to refine data collection procedures. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/27/2013 issued a new version of this PRA request. CMS has revised this PRA request since the publication of the 60-day notice in the 10/4/2013 FR (78 FR 61848). http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-31015.pdf CMS on 1/16/2015 issued a revision of this PRA request.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					http://www.gpo.gov/fdsys/pkg/FR-2015-01-16/pdf/2015-00627.pdf	
132.g.	HCAHPS Survey Mode Experiment ACTION: Request for Comment NOTICE: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Mode Experiment AGENCY: CMS	CMS-10542	Issue Date: 11/28/2014 Due Date: 1/27/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey Mode Experiment; *Use*: CMS publicly reports hospital-level scores derived from national implementation of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey on its Hospital Compare Web site. The HCAHPS initiative allows vendors to select one mode of survey administration from four approved administration protocols (mail only, telephone only, mail-telephone mixed mode, and touch-tone IVR only). Before public reporting, CMS adjusts HCAHPS scores for the selected mode of administration, using mail administration as the comparison mode, to correct for any inflation or deflation of scores that result from mode. The current mode adjustments employed for HCAHPS are the product of two separate mode experiments conducted using different versions of the survey and different sample. The planned HCAHPS mode experiment seeks to conduct a mode experiment of sufficient sample and scale to determine if the mode adjustments currently employed for the 32-item HCAHPS core survey need revision. An additional goal involves collecting empirical evidence on the effect of the number of additional supplemental items on survey response rate and patterns of response to the HCAHPS core demographic items (known as "About You" items). http://www.gpo.gov/fdsys/pkg/FR-2014-11-28/pdf/2014-28137.pdf SUMMARY OF NIHB ANALYSIS:	
132.h.	EDPEC Survey Mode Experiment ACTION: Request for Comment NOTICE: Emergency Department Patient	CMS-10543	Issue Date: 11/28/2014 Due Date: 1/27/2015 NIHB File Date: None		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Emergency Department Patient Experience of Care (EDPEC) Survey Mode Experiment; *Use*: This survey supports the six national priorities for improving care from the National Quality Strategy developed by HHS as directed under ACA to create national aims and priorities to guide local, state, and national efforts to improve the quality of health care. The six priorities include: making care safer by reducing harm caused by the delivery of care; ensuring the engagement of each individual and family as partners in their care; promoting effective communication and coordination of care;	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Experience of Care (EDPEC) Survey Mode Experiment AGENCY: CMS		Date of Subsequent Agency Action, if any:		promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models. In 2012, CMS launched the development of the Emergency Department Patient Experience of Care Survey (EDPEC) to measure the experiences of patients (18 and older) with emergency department care. This survey will provide patient experience with care data that enables comparisons of emergency department and support for improving the quality of patient experience in the emergency department. http://www.gpo.gov/fdsys/pkg/FR-2014-11-28/pdf/2014-28137.pdf SUMMARY OF NIHB ANALYSIS:	
134.I.	Federally Qualified Health Center Cost Report Form ACTION: Request for Comment NOTICE: Federally Qualified Health Center Cost Report Form AGENCY: CMS	CMS-224-14	Issue Date: 12/19/2014 Due Date: 2/17/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Federally Qualified Health Center Cost Report Form; *Use*: Providers of services participating in the Medicare program must, under sections 1815(a) and 1861(v)(1)(A) of the Social Security Act, submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. In addition, regulations at 42 CFR 413.20 and 413.24 require adequate cost data and cost reports from providers on an annual basis. CMS requires the CMS-224-14 cost report to determine reasonable costs incurred by a provider in furnishing medical services to Medicare beneficiaries and reimbursement due to or from a provider. http://www.gpo.gov/fdsys/pkg/FR-2014-12-19/pdf/2014-29741.pdf SUMMARY OF NIHB ANALYSIS:	
137.c.	Transcatheter Mitral Valve Repair National Coverage Decision ACTION: Request for Comment	CMS-10531	Issue Date: 12/12/2014 Due Date: 2/10/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Transcatheter Mitral Valve Repair (TMVR) National Coverage Decision (NCD); *Use*: The CMS National Coverage Determination (NCD) titled, "Transcatheter Mitral Valve Repair (TMVR)," requires this data collection. Medicare covers the TMVR device only when specific conditions are met, including that the heart team and hospital submit data in a prospective, national, audited registry. The data includes patient-,	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Transcatheter Mitral Valve Repair (TMVR) National Coverage Decision (NCD) AGENCY: CMS		NIHB File Date: Date of Subsequent Agency Action, if any:		practitioner-, and facility-level variables that predict outcomes such as all-cause mortality and quality of life. The Society of Thoracic Surgery/American College of Cardiology Transcatheter Valve Therapy (STS/ACC TVT) Registry, one registry overseen by the National Cardiovascular Data Registry, meets the requirements specified in the NCD on TMVR. The TVT Registry will support a national surveillance system to monitor the safety and efficacy of the TMVR technologies for the treatment of mitral regurgitation (MR). The data also will include the variables on the eight item Kansas City Cardiomyopathy Questionnaire (KCCQ-10) to assess heath status, functioning, and quality of life. The KCCQ allows the derivation of an overall summary score from the physical function, symptoms (frequency and severity), social function, and quality of life domains. The data collected and analyzed in the TVT Registry will help determine if TMVR is reasonable and necessary (e.g., improves health outcomes) for Medicare beneficiaries under Section 1862(a)(1)(A) of the Social Security Act. Furthermore, data from the Registry will assist the medical device industry and the FDA in surveillance of the quality, safety, and efficacy of new medical devices to treat mitral regurgitation. For purposes of the TMVR NCD, the TVT Registry has contracted with the Data Analytic Centers to conduct the analyses. In addition, CMS will make data available for research purposes under the terms of a data use agreement that only provides de-identified datasets. http://www.gpo.gov/fdsys/pkg/FR-2014-12-12/pdf/2014-29172.pdf SUMMARY OF NIHB ANALYSIS:	
164.b.	Medicare Secondary Payer and "Future Medicals" ACTION: Proposed Rule NOTICE: Medicare Secondary Payer and "Future Medicals" AGENCY: CMS	CMS-6047	Issue Date: [Approved by OMB 10/9/2014] Due Date: NIHB File Date:		SUMMARY OF AGENCY ACTION: This proposed rule would announce the intention of CMS regarding means beneficiaries or their representatives can use to protect the interest of Medicare with respect to Medicare Secondary Payer (MSP) claims involving automobile and liability insurance (including self-insurance), no-fault insurance, and workers' compensation where future medical care is claimed or the settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care. SUMMARY OF NIHB ANALYSIS:	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Date of Subsequent Agency Action, if any:			
172.b.	Testing and Research for Medicare Beneficiary Survey ACTION: Request for Comment NOTICE: Generic Clearance for Questionnaire Testing and Methodological Research for the Medicare Current Beneficiary Survey (MCBS) AGENCY: CMS	CMS-10549	Issue Date: 1/30/2015 Due Date: 3/31/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: Generic Clearance for Questionnaire Testing and Methodological Research for the Medicare Current Beneficiary Survey (MCBS); *Use*: This OMB clearance package seeks to clear a Generic Clearance to support an effort to evaluate the operations and content of the Medicare Current Beneficiary Survey (MCBS). MCBS--a continuous, multipurpose survey of a nationally representative sample of aged, disabled, and institutionalized Medicare beneficiaries sponsored by CMS--serves as the only comprehensive source of information on the health status, health care use and expenditures, health insurance coverage, and socioeconomic and demographic characteristics of the entire spectrum of Medicare beneficiaries. The core of the MCBS includes a series of interviews with a stratified random sample of the Medicare population, including aged and disabled enrollees, residing in the community or in institutions. Questions involve enrollee patterns of health care use, charges, insurance coverage, and payments over time. Respondents are asked about their sources of health care coverage and payment, their demographic characteristics, their health and work history, and their family living circumstances. In addition to collecting information through the core questionnaire, MCBS collects information on special topics through supplements. http://www.gpo.gov/fdsys/pkg/FR-2015-01-30/pdf/2015-01790.pdf SUMMARY OF NIHB ANALYSIS:	
174.f.	FEHBP: Rate Setting for Community-Rated Plans ACTION: Proposed Rule	OPM (RIN 3206-AN00)	Issue Date: 1/17/2015 Due Date: 3/9/2015		SUMMARY OF AGENCY ACTION: This proposed rule would make changes to the Federal Employees Health Benefits Acquisition Regulation (FEHBAR). These changes would: Define which subscriber groups might qualify as similarly sized subscriber groups (SSSGs); require SSSGs to use a traditional community rating; establish that traditional community-rated Federal Employees Health Benefits Program (FEHBP) plans must	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Federal Employees Health Benefits Program; Rate Setting for Community-Rated Plans AGENCY: OPM		NIHB File Date: Date of Subsequent Agency Action, if any:		select only one, rather than two, SSSGs; and make conforming changes to FEHBP contract language to account for the new medical loss ratio (MLR) standard for most community-rated FEHBP plans. http://www.gpo.gov/fdsys/pkg/FR-2015-01-07/pdf/2014-30633.pdf SUMMARY OF NIHB ANALYSIS:	
180.	Flu Vaccination Standard for Certain Providers and Suppliers ACTION: Request for Comment NOTICE: Influenza Vaccination Standard for Certain Participating Providers and Suppliers AGENCY: CMS	CMS-3213-F	Issue Date: [Approved by OMB on 4/18/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This final rule requires certain Medicare and Medicaid providers and suppliers to offer all patients an annual influenza vaccination, unless medically contraindicated or unless the patient or his or her representative or surrogate declined vaccination. This final rule seeks to increase the number of patients receiving annual vaccination against seasonal influenza and decrease the morbidity and mortality rate from influenza. This final rule also requires certain providers and suppliers to develop policies and procedures that will allow them to offer vaccinations for pandemic influenza in case of a future pandemic influenza event. SUMMARY OF NIHB ANALYSIS:	
184.e.	Fecal Occult Blood Testing Under CLIA ACTION: Proposed Rule NOTICE: Clinical Laboratory Improvement Amendments (CLIA); Fecal Occult Blood (FOB) Testing AGENCY: CMS	CMS-3271-P	Issue Date: 11/7/2014 Due Date: 1/6/2015 NIHB File Date: None Date of Subsequent		SUMMARY OF AGENCY ACTION: This proposed rule would amend the Clinical Laboratory Improvement Amendments (CLIA) regulations to clarify that the waived test categorization applies to only non-automated fecal occult blood tests. In addition, the proposed rule would remove the hemoglobin by copper sulfate method from the list of waived tests if commenters confirm that laboratories no longer use the method. http://www.gpo.gov/fdsys/pkg/FR-2014-11-07/pdf/2014-26559.pdf SUMMARY OF NIHB ANALYSIS:	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Agency Action, if any:			
184.f.	Laboratory Personnel Report ACTION: Request for Comment NOTICE: Laboratory Personnel Report (CLIA) and Supporting Regulations AGENCY: CMS	CMS-209	Issue Date: 11/28/2014 Due Date: 1/27/2015 NIHB File Date: None Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension without change of a currently approved collection; *Title*: Laboratory Personnel Report (CLIA) and Supporting Regulations; *Use*: The information collected on this survey form serves the administrative pursuit of the congressionally mandated program with regard to regulation of laboratories participating in CLIA. The surveyor will provide the laboratory with CMS-209. While the surveyor performs other aspects of the survey, the laboratory will complete CMS-209 by recording the personnel data needed to support their compliance with the personnel requirements of CLIA. The surveyor will then use this information in choosing a sample of personnel to verify compliance with the personnel requirements. Information on personnel qualifications of all technical personnel ensures that the sample is representative of the entire laboratory. http://www.gpo.gov/fdsys/pkg/FR-2014-11-28/pdf/2014-28137.pdf SUMMARY OF NIHB ANALYSIS:	
184.g.	Survey Report Form for CLIA ACTION: Request for Comment NOTICE: Survey Report Form for Clinical Laboratory Improvement Amendments (CLIA) and Supporting Regulations AGENCY: CMS	CMS-1557	Issue Date: 12/24/2014 Due Date: 2/23/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Survey Report Form for Clinical Laboratory Improvement Amendments (CLIA) and Supporting Regulations; *Use*: Surveyors use the form to report findings during a CLIA survey. For each type of survey conducted (i.e., initial certification, recertification, validation, complaint, addition/deletion of specialty/subspecialty, transfusion fatality investigation, or revisit inspections) the Survey Report Form incorporates the requirements specified in the CLIA regulations. http://www.gpo.gov/fdsys/pkg/FR-2014-12-24/pdf/2014-30027.pdf SUMMARY OF NIHB ANALYSIS:	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 1/31/2015

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
185.g.	Safe Harbor for FQHC Arrangements ACTION: Request for Comment NOTICE: Safe Harbor for Federally Qualified Health Centers Arrangements AGENCY: HHS OIG	HHS-OS-0990-0322-60D HHS-OS-0990-0322-30D	Issue Date: 10/1/2014 Due Date: 12/1/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued reinstatement 1/23/2015 Due Date: 2/23/2015		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Safe Harbor for Federally Qualified Health Centers Arrangements; *Use*: HHS OIG seeks an approval by OMB on an extension for data collection 0990-0322, which involves requirements associated with a voluntary safe harbor for Federally Qualified Health Centers under the Federal anti-kickback statute. The safe harbor protects certain arrangements involving goods, items, services, donations, and loans provided by individuals and entities to certain health centers funded under section 330 of the Public Health Service Act. http://www.gpo.gov/fdsys/pkg/FR-2014-10-01/pdf/2014-23322.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 1/23/2015 issued a reinstatement of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-01-23/pdf/2015-01098.pdf No comments recommended.	
189.b.	Annual Update of the HHS Poverty Guidelines ACTION: Notice NOTICE: Annual Update of the HHS Poverty Guidelines AGENCY: HHS	HHS (no reference number)	Issue Date: 1/22/2015 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This notice provides an update of the HHS poverty guidelines to account for the increase in prices as measured by the Consumer Price Index for the last calendar year. http://www.gpo.gov/fdsys/pkg/FR-2015-01-22/pdf/2015-01120.pdf SUMMARY OF NIHB ANALYSIS: A table comparing the 2015 HHS poverty guidelines with the 2014 guidelines is embedded below.  HHS Poverty Guidelines 2014-2015 Medicaid will use the 2015 poverty guidelines for eligibility determinations for the	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					remainder of 2015 and until HHS issues revised guidelines in 2016. (The Marketplace will continue to use the 2014 poverty guidelines for 2015 QHP enrollment.) A TSGAC handout on the use of these poverty guidelines is embedded below.  TSGAC Revised- 2015 FPL Handout - Medica	
196.	Patient Rights CoPs and Conditions for Coverage ACTION: Proposed Rule NOTICE: Medicare and Medicaid Program; Revisions to Certain Patient's Rights Conditions of Participation and Conditions for Coverage AGENCY: CMS	CMS-3302-P	Issue Date: 12/12/2014 Due Date: 2/10/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This proposed rule would revise the applicable conditions of participation (CoPs) for providers, conditions for coverage (CfCs) for suppliers, and requirements for long-term care facilities to ensure that certain requirements conform with the Supreme Court decision in *United States v. Windsor*, 570 U.S.12, 133 S.Ct. 2675 (2013), and HHS policy. Specifically, CMS proposes to revise certain definitions and patients' rights provisions to ensure that same-sex spouses in legally valid marriages receive equal rights in Medicare and Medicaid participating facilities. http://www.gpo.gov/fdsys/pkg/FR-2014-12-12/pdf/2014-28268.pdf SUMMARY OF NIHB ANALYSIS:	
199.a.	National CLAS Standards in Health and Health Care ACTION: Request for Comment NOTICE: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: Evaluation of Awareness, Adoption, and Implementation	HHS-OS-0990-New-60D HHS-OS-0990-New-30D	Issue Date: 9/26/2014 Due Date: 11/25/2014 NIHB File Date: None Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: New collection; *Title*: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: Evaluation of Awareness, Adoption, and Implementation; *Use*: The HHS Office of Minority Health (OMH) seeks new OMB approval for data collection on an evaluation project titled "National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: Evaluation of Awareness, Adoption, and Implementation." This assessment seeks to describe and examine systematically the awareness, knowledge, adoption, and implementation of the HHS OMH National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) in a sample of health and health care organizations and to use the resultant data to develop a preliminary model of implementation to guide organizational adoption and implementation of the National CLAS Standards.	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 1/31/2015

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	AGENCY: HHS		Issued new request 12/19/2014 Due Date: 1/20/2015		Originally released in 2001, the HHS OMH National CLAS Standards include recommended action steps intended to advance health equity, improve quality, and help eliminate health care disparities. The National CLAS Standards, revised in 2013, include 15 Standards that provide health and health care organizations with a blueprint for successfully implementing and maintaining culturally and linguistically appropriate services. Despite increased recognition of the National CLAS Standards as a fundamental tool for health and health care organizations to use in their efforts to become more culturally and linguistically competent, neither the original nor the enhanced National CLAS Standards have undergone systematic evaluation in terms of public awareness, organizational adoption and implementation, or impact on health services outcomes. A need exists to collect information from health and health care organizations to understand how and to what extent the intended audiences have utilized the National CLAS Standards. http://www.gpo.gov/fdsys/pkg/FR-2014-09-26/pdf/2014-23000.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: HHS on 12/19/2014 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-12-19/pdf/2014-29740.pdf	
199.b.	CLAS County Data ACTION: Guidance NOTICE: CLAS County Data AGENCY: CCIIO	CCIIO (no reference number)	Issue Date: 12/12/2014 Due Date: None NIHB File Date: Date of		SUMMARY OF AGENCY ACTION: Public Health Service Act (PHS Act) section 2719 requires non-grandfathered group health plans and health insurance issuers offering non-grandfathered health insurance coverage to provide relevant notices in a culturally and linguistically appropriate manner. The regulations implementing section 2719 require these plans and issuers to make certain accommodations for notices sent to an address in a county meeting a threshold percentage of people literate only in the same non-English language (10 percent or more of the population residing, as determined based on American Community Survey (ACS)). Section 2715 of the PHS Act requires group health plans and health insurance	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Subsequent Agency Action, if any: Issued revised Guidance 1/7/2015		issuers offering group and individual coverage to provide the summary of benefits and coverage (SBC) and uniform glossary in a culturally and linguistically appropriate manner. The regulations implementing section 2715 adopt the ten percent threshold set forth in the section 2719 implementing regulations. This guidance includes all counties that meet or exceed the 10 percent threshold (rounded to the nearest percent) for the 2009-2013 ACS data and applies until the next edition. CMS will update this list annually following the release of the applicable ACS data. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data_12-05-14_clean_508.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CCIIO on 1/7/2015 issued a revised version of this guidance http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data-01-07-15-508.pdf.	
200.	Mental Health Parity Rules for Medicaid and CHIP ACTION: Proposed Rule NOTICE: Mental Health Parity and Addiction Equity Act of 2008; the Application to Medicaid Managed Care, CHIP, and Alternative Benefit Plans AGENCY: CMS	CMS-2333-P	Issue Date: [Pending at OMB as of 1/7/2015] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: This proposed rule would address the requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicaid Alternative Benefit Plans (ABPs), CHIP, and Medicaid managed care organizations (MCOs). SUMMARY OF NIHB ANALYSIS:	

National Indian Health Board

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 1/31/2015

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
201.	Use of Restraint and Seclusion in Psychiatric Facilities ACTION: Request for Comment NOTICE: Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities (PRTFs) for Individuals Under Age 21 and Supporting Regulations AGENCY: CMS	CMS-R-306	Issue Date: 1/30/2015 Due Date: 3/31/2015 NIHB File Date: Date of Subsequent Agency Action, if any:		SUMMARY OF AGENCY ACTION: *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities (PRTFs) for Individuals Under Age 21 and Supporting Regulations; *Use*: Psychiatric residential treatment facilities must report deaths, serious injuries, and attempted suicides to the State Medicaid Agency and the Protection and Advocacy Organization. They also must provide residents the restraint and seclusion policy in writing and document in resident records all activities involving the use of restraint and seclusion. http://www.gpo.gov/fdsys/pkg/FR-2015-01-30/pdf/2015-01790.pdf SUMMARY OF NIHB ANALYSIS:	

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 1/31/2015

RRIAR Ref. #	Short Title/Current Status of Regulation/ Title/Agency	File Code & Dates	Summary of NIHB and/or TTAG Recommendations	Evaluation of Subsequent Rule Issued/ Action Taken by Agency
7.vv.	2016 Letter to Issuers in FFMs ACTION: Guidance NOTICE: Draft 2016 Letter to Issuers in the Federally-Facilitated Marketplaces AGENCY: CCIIO	CCIIO (no reference number) Issue Date: 12/19/2014 Due Date: 1/12/2015 TTAG File Date: 1/12/2015 Date of Subsequent Agency Action, if any:	TTAG recommendations-- 1. Application of Requirements Related to Indian Health Providers (IHPs): The requirements in the 2016 Issuer Letter apply solely to issuers when offering qualified health plans (QHPs) through the Federally-Facilitated Marketplace (FFM); CMS should extend these requirements to issuers when offering QHPs in State-Based Marketplaces. 2. Requirement for Issuers to Offer Contracts to IHCPs: The draft 2016 Issuer Letter does not retain a provision in the 2015 Issuer Letter (page 20) requiring issuers--in cases in which they fail to meet the 30 percent essential community provider (ECP) guideline--to attest in a narrative justification to having made good faith contract offers to all IHCPs in a QHP service area and instead states on page 26, "If an issuer's application does not satisfy the 30 percent ECP standard *as well as the requirement to offer contracts in good faith to all available Indian health providers in the service area*," the issuer must provide a narrative justification (emphasis added); CMS should delete the italicized phrase, as it would allow an issuer to offer a QHP through the FFM without having made good faith contract offers to all available IHPs. TTAG made additional recommendations regarding issues addressed in the 2016 Issuer Letter in comments submitted separately in response to CMS-9944-P (see 89.h.)	No subsequent Agency action taken (as of 1/31/2015).

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RRIAR Ref. #	Short Title/Current Status of Regulation/ Title/Agency	File Code & Dates	Summary of NIHB and/or TTAG Recommendations	Evaluation of Subsequent Rule Issued/ Action Taken by Agency
89.h.	Notice of Benefit and Payment Parameters for 2016 ACTION: ~~Proposed~~ Final Rule NOTICE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 AGENCY: CMS	CMS-9944-~~P~~F Issue Date: 11/26/2014 Due Date: 12/22/2014 TTAG File Date: 12/22/2014 Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 1/29/2015	TTAG recommendations-- 1. Requirement on Summary of Benefits and Coverage (SBC): The proposed rule would establish a requirement that QHP issuers prepare an SBC for each plan variation, such as the "zero cost-sharing variation" and the "limited cost-sharing variation"; in regard to this requirement, CMS should: • a. Retention: Retain this requirement, as to date, information on Indian-specific cost-sharing protections provided by issuers to consumers, if any, often proves confusing or incorrect, prompting some AI/ANs to decide not to enroll in coverage through a Marketplace; • b. Encouraging Issuer Compliance: Encourage issuers to prepare SBCs for use during the 2015 benefit year but no later than the first day of the Marketplace open enrollment period for the 2016 benefit year; • c. Regulatory Cross-Reference: Add a cross-reference to the requirement to prepare an SBC in the regulation on SBCs (45 § 147.200) by inserting in §147.200 the following language (in brackets and bold): "*§147.200 Summary of benefits and coverage and uniform glossary. (a) Summary of benefits and coverage--(1) In general. A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group or individual health insurance coverage, is required to provide a written summary of benefits and coverage (SBC) for* ***[each plan variation of]*** *each benefit*	No subsequent Agency action taken (as of 12/31/2014).

RRIAR Ref. #	Short Title/Current Status of Regulation/ Title/Agency	File Code & Dates	Summary of NIHB and/or TTAG Recommendations	Evaluation of Subsequent Rule Issued/ Action Taken by Agency
			package [, as indicated in §156.420(h)] without charge to entities and individuals described in this paragraph (a)(1) in accordance with the rules of this section"; and • d. Examples Regarding Compliance: In the preamble to the final rule, and in subsequent guidance documents, provide examples of when QHP issuers must provide SBCs to comply with the requirements set forth in § 147.200 and § 156.420(h) and the circumstances, if any, under which a single SBC can satisfy the requirement for multiple plans. 2. Hardship Exemption: The proposed rule includes a provision that would codify the newly established process for obtaining the hardship exemption from the tax penalty for IHS-eligible individuals; in regard to this provision, CMS should: • a. Retention: Retain this provision (§ 155.605(g)(6)(iii)), which would make agency regulations consistent with revised IRS regulations; and • b. Paper-Based Application Process: Refocus attention on fixing the paper-based exemption application process through Federally-Facilitated Marketplaces by allocating sufficient resources and making the current status of individual applications--as well as applications in the aggregate--more transparent. 3. Code Citation to Definition of Indian Under Medicaid: The proposed rule includes a provision that would amend § 155.605(g)(6)(i) by changing the citation to 42 § 447.50 to 42	

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RRIAR Ref. #	Short Title/Current Status of Regulation/ Title/Agency	File Code & Dates	Summary of NIHB and/or TTAG Recommendations	Evaluation of Subsequent Rule Issued/ Action Taken by Agency
			§ 447.51, which cross-references the definition of Indian used for Medicaid purposes; CMS should retain this provision. 4. Network Adequacy and Essential Community Provider Provisions: The proposed rule would codify some of the network adequacy and essential community provider (ECP) provisions that appear in the CCIIO 2015 Issuer Letter and apply solely under the FFM, including 1) codifying the requirement that QHP issuers offer contracts to all Indian health care providers (IHCPs), 2) requiring/encouraging "good faith" offers pertaining to payment rates, 3) adding a requirement that QHP-IHCP contracts apply the special terms and conditions under Federal law pertaining to IHCPs (contained in the QHP Addendum), and 4) applying the requirement that QHP issuers offer contracts to IHCPs; in regard to these provisions, CMS should: • a. Retention: Retain the requirement that QHP issuers offer contracts to all IHCPs in the QHP service area; • b. 30 Percent ECP Standard: At a minimum, maintain the minimum standard of contracting with at least 30 percent of available ECPs until such time as quantitative evidence indicates that enrollees have reasonable and timely access to health care services; • c. "Good Faith" Contract Offers: Retain the provision requiring "good faith" contract offers to IHCPs, but 1) clarify that the minimum payment rate provision exists as a requirement rather than an "expectation" and 2) include the minimum payment rate requirement in the final regulations, rather than limiting it to the preamble;	

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RRIAR Ref. #	Short Title/Current Status of Regulation/ Title/Agency	File Code & Dates	Summary of NIHB and/or TTAG Recommendations	Evaluation of Subsequent Rule Issued/ Action Taken by Agency
			• d. QHP Addendum Language: Modify the language referencing the QHP Addendum to make it consistent with the wording of the CCIIO 2015 Issuer Letter, as the proposed rule appears to require application of the Indian-specific provisions in Federal law but not (as required in the CCIIO 2015 Issuer Letter) actual use of the Addendum; • e. "Alternative Standard" for Issuers: Strengthen the "alternative standard" for QHP issuers to comply with ACA requirements by 1) adding a requirement that they indicate efforts taken to date to meet the ECP standard and 2) making publicly available their narrative description of efforts taken to date, as well as their plan on "how the plan's provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year"; and • f. State-Based Marketplace (SBM) Standards: Add language to the preamble of the final rule "urging" SBMs to apply the IHCP contracting standards to QHPs offered through SBMs. 5. Application of Cost-Sharing Protections for AI/AN Families: Responses from CMS to earlier comments from tribal organizations indicated a willingness to address problems with the application of cost-sharing protections for families with AI/AN and non-AI/AN members beginning with the 2016 benefit year, but the proposed rule does not address this issue; in regard to this concern, CMS should 1) implement tribal recommendations (made on CMS-9964-P in December 2012) to eliminate the potential for an increase in	

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			the aggregate premiums and to prevent shifting of out-of-pocket (OOP) liabilities to non-Indian family members or 2) provide as an administrative convenience the ability of other IHS-eligible family members to enroll in the same zero cost-sharing variation or limited cost-sharing variation in which Indian members of the family qualify. 6. AI/AN Family Tag-Along Policy: At the request of tribal organizations, CCIIO issued guidance to enrollment assisters on November 15, 2014, indicating that family members of individuals eligible for the Monthly Special Enrollment Period (SEP) for Indians can enroll in Marketplace coverage with the eligible individuals, and although the proposed rule would make several modifications to SEP regulations (§155.420), it would not codify this provision; in regard to this provision, CMS should add this provision to the final rule by inserting in §155.420(d)(8) the following language (in bold): "(8) The qualified individual who is an Indian, as defined by section 4 of the Indian Health Care Improvement Act, **or his or her dependent**, may enroll in a QHP or change from one QHP to another one time per month." 7. Maximum Out-of-Pocket Costs for Individuals: The proposed rule includes language clarifying (for the 2016 benefit year and beyond) that the annual limitation on cost-sharing for self-only coverage applies to all individuals, regardless of whether the individual is covered by a self-only plan or a family plan, with the limit let at $6,850 in 2016; CMS should retain this provision.	

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92.II.	Health Benefit Plan Network Access and Adequacy Model Act ACTION: Request for Comment NOTICE: Health Benefit Plan Network Access and Adequacy Model Act (Draft) AGENCY: NAIC	NAIC (no reference number) Issue Date: 11/12/2014 Due Date: 1/12/2015 TTAG File Date: 1/12/2015 Date of Subsequent Agency Action, if any:	TTAG recommendations-- 1. Inclusion of Indian Health Providers (IHPs) in Networks: The most geographically accessible and culturally appropriate primary care providers often work in clinics and hospitals operated by IHS, Tribes, and tribal organizations, and although it would make sense for health carriers to include IHPs in their networks, barriers to this practice exist; to reduce these barriers, NAIC should: • Include in the Model Act a section specific to IHPs that the 34 states with federally-recognized Tribes could adopt and other states could choose to omit; and/or • Amend the language throughout the Model Act to accommodate the distinctive characteristics of IHPs. 2. Definition of Essential Community Provider (ECP): The Model Act does not include a definition of ECP, although one exists; NAIC should add the following language: "Essential community provider" means a provider that serves predominantly low income, medically underserved individuals, including a provider defined in Section 340B(a)(4) of the PHSA and a tax exempt entity that meets the requirements of that standard except that it does not receive funding under that section. Drafting Note: The term "essential community provider" is not used in this Act. However, the term is defined in this section	No subsequent Agency action taken (as of 1/31/2015).

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			to alert states that having a certain number or percentage of essential community providers in a provider network is a requirement that a qualified health plan (QHP) must satisfy in order to be offered on a health insurance exchange under the federal Affordable Care Act (ACA) and implementing regulations. 3. Definition of Health Care Professional: The Model Act defines a health care professional as "a physician or other health care practitioner licensed, accredited or certified to perform specified health services *consistent with state law*" (emphasis added); the phrase "consistent with state law" might prove problematic for IHPs because federal law allows professionals licensed in a different state to practice in IHS and tribal facilities, and as such, NAIC should revise this definition. 4. Definition of IHP: The Model Act includes no definitions related to Indian health care; NAIC should add the following definition of IHP: A facility or program that is funded in part by the federal government or a federally-recognized Tribe to serve primarily American Indians and Alaska Natives, including the federal Indian Health Service, facilities and programs that are operated by Tribes and Tribal Organizations, and urban Indian clinics (also called "I/T/U"). 5. Geographic Accessibility: Section 5, Part A of the Model Act creates the standard of network adequacy with regard to types of providers, and Part B allows health carriers to use	

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			any of eight reasonable criteria, which include (3) Geographic accessibility and (4) Geographic population dispersion; the concept of geographic population dispersion might prove contradictory, providing an exception to geographic accessibility, and as such, NAIC should seek to ensure that, if IHPs (or other types of providers) already operate in remote areas or areas with low population density, health carriers offer networks that include these providers. 6. Obtaining Covered Benefits from Out-of-Network Providers: Section 5, Part C of the Model Act addresses the two cases in which health carriers must allow covered individuals to obtain covered benefits from out-of-network providers; NAIC should add a third case to specify that AI/ANs can access services from geographically accessible IHPs, a provision that already exists in current law and Medicaid and qualified health plan (QHP) regulations. 7. Access Plans: The Model Act requires health carriers to submit access plans that describe or contain 11 items; NAIC should add to item (2), "The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable," details about how plans in states with IHPs will coordinate with Indian health facilities for referrals, as well as add an additional item that requires carriers in states with federally-recognized Tribes to document their good faith efforts to include IHPs in their networks. 8. Anti-Discrimination Provisions: Section 6, F(3) of the Model Act includes provisions to prevent discrimination against providers in the establishment of health carrier	

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			networks; to prevent discrimination against IHPs, NAIC should include, either in a special Indian health section or in the section related to anti-discrimination, a requirement that carriers make a good faith effort to offer provider contracts to all IHPs.	
112.e.	Tribal Consultation on VA/IHS Reimbursement Agreements ACTION: Notice NOTICE: Section 102(c) of the Veterans Access, Choice, and Accountability Act of 2014 AGENCY: VA	VA (no reference number) Issue Date: 12/30/2014 Due Date: 1/14/2015 TSGAC File Date: 1/14/2015 Date of Subsequent Agency Action, if any:	TSGAC recommendations-- 1. Direct Communication with Tribal Health Programs: VA should establish communication with tribal and urban health programs regarding all aspects of its implementation of the Veterans Access, Choice and Accountability Act of 2014 and other department initiatives, as IHS cannot speak for these programs. 2. Inclusion of Tribal Health Programs in New Agreement Negotiations: To the extent that VA considers new model language or agreements to streamline contracting with I/T/Us to provide services to AI/ANs, in addition to IHS representatives, any negotiations or discussions should include tribal and urban health program representatives to ensure recognition of the differences between IHS and tribal and urban health programs. 3. Inclusion of Tribal Health Programs in Development of Performance Metrics: Tribal and urban Indian health program representatives should serve as participants in satisfying the requirement of section 102(b) of identifying and	No subsequent Agency action taken (as of 1/31/2015).

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			developing the performance metrics for both VA and IHS under their Memorandum of Understanding regarding increasing access to health care, improving quality and coordination of health care, promoting effective patient-centered collaboration and partnerships between VA and IHS, and ensuring funding and availability of health-promotion and disease-prevention services for beneficiaries under both health care systems. 4. Recommendation for Entering and Expanding Agreements with I/T/Us: In its report to Congress, VA should recommend entering agreements with I/T/Us for reimbursement of the costs of services provided to eligible non-AI/AN veterans and, when possible, using and expanding these agreements to accelerate the implementation of all aspects of the efforts by VA to expand access to health care to eligible veterans.	

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RRIAR INDEX: HEALTH REFORM
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RRIAR Index: Health Reform[1]					
From left-to-right in the table, the term is listed (*e.g.*, "Indian-specific ACA provisions"); the subtopic is listed (*e.g.*, "Cost-sharing reductions"); the RRIAR entry number is shown (*e.g.*, "7.a"); in parenthesis, the page number in Table B is shown first in red (*e.g.,* "(18)") and the page number in Table C is shown second in blue, underlined (*e.g.*, "(16)"). The RRIAR entry numbers and page numbers are listed in the column associated with the most recent edition of the RRIAR in which they appear.					
Terms	RRIAR Entry Numbers (Page Numbers)[3] Red = Table B Blue = Table C				Other Citations
	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
Indian-specific ACA provisions					
Cost-sharing reductions	7.a. (18/16), 7.c. (24/67), 7.g. (29/76), 29.a. (70/112)	7.u. (32/12), 50.d. (136/61), 50.h. (140/68), 89.a. (194/79), 89.b. (195/87), 111.b. (238/96), 111.c. (240/102)	31.w. (133/14), 31.x. (135/16), 89.a. (/43)	7.ww. (10), 7.xx. (10)	
Definition of Indian	7.a. (18/16), 7.b. (21/22),	7.u. (32/12), 31.e. (94/40),			

[1] "Health reform" is inclusive of (1) the Patient Protection and Affordable Care Act (Pub. L. 111-148), incorporating by reference S. 1790 as reported by the Committee on Indian Affairs of the Senate in December 2009 (containing amendments to the Indian Health Care Improvement Act, IHCIA), and as amended by the Health Care and Education Reconciliation Act (HCERA; Public Law 111–152) (collectively referred to as "ACA") and (2) the American Recovery and Reinvestment Act of 2009 (ARRA, Pub. L. 111-5).

[3] The purpose of the Regulation Review and Impact Analysis Report (RRIAR) is to identify and summarize key regulations issued by the Centers for Medicare and Medicaid Services (CMS) pertaining to Medicare, Medicaid, CHIP, and health reform that affect (a) American Indians and Alaska Natives and/or (b) Indian Health Service, Indian Tribe and tribal organization, and urban Indian organization providers. Further, the RRIAR includes summaries of the regulatory analyses prepared by NIHB and the recommendations to CMS (and other agencies) made by the Tribal Technical Advisory Group, NIHB, and/or other tribal organizations (if any). The RRIAR also indicates the extent to which these recommendations were incorporated into any subsequent CMS actions.

This Index lists key terms found in regulations implementing "health reform," which is inclusive of (1) the Patient Protection and Affordable Care Act (Pub. L. 111-148), incorporating by reference S. 1790 as reported by the Committee on Indian Affairs of the Senate in December 2009 (containing amendments to the Indian Health Care Improvement Act, IHCIA), and as amended by the Health Care and Education Reconciliation Act (HCERA; Public Law 111–152) (collectively referred to as "ACA") and (2) the American Recovery and Reinvestment Act of 2009 (ARRA, Pub. L. 111-5). The terms, when applicable, are further sorted by subtopic, with the corresponding RRIAR entry numbers and page numbers shown.

See the accompanying "RRIAR Number Reference Guide: Health Reform" for a listing, by RRIAR entry number, of the notice type, short title, and issuing agency or agencies for each entry.

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
	7.c. (24/67), 7.d. (26/75)	50.d. (136/61), 50.f. (138/64), 50.h. (140/68), 89.a. (194/79), 111.b. (238/96)			
Essential community providers	7.a. (18/16), 7.b. (21/22)	7.i. (XX), 7.n. (23/1), 50.c. (135/54), 111.b. (238/96)	7.ee. (29/4), 50.e. (171), 92.cc. (255)	7.vv. (8/1), 92.ll. (41/6)	
Exemption from tax penalty		31.e. (94/40), 31.g. (103/44), 31.q. (114/47)	7.mm. (42), 31.v. (133/13)	7.ww. (10)	
Implementation of section 402 of IHCIA			50.q. (173), 50.r. (175), 50.x. (179/30)		
Indian addendum	7.b. (21/22)	50.c. (135/54), 111.a. (237/94), 111.b. (238/96)	7.ee. (29/4)	7.vv. (8/1)	
Issuer regulations (Indian-specific concerns)	7.a. (18/16), 7.b. (21/22), 7.g. (29/76)	7.n. (23/1), 89.a. (194/79), 89.b. (195/87), 111.a. (237/94), 168. (318/106)	7.ee. (29/4), 50.t. (176/29), 65. (199/36), 92.u. (242/49), 92.cc. (255)	7.vv. (8/1), 92.ll. (41/6)	
Premium sponsorship	7.a. (18/16), 7.b. (21/22), 7.g. (29/76), 29.a. (70/112)	50.d. (136/61), 111.a. (237/94), 111.b. (238/96)	7.b. (3), 7.ee. (29/4), 50.q. (173), 50.r. (175), 50.x. (179/30),	7.vv. (8/1)	

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
Tribal consultation Tribal Employer Participation in FEHBP Tobacco use (ceremonial)		50.d. (136/61), 50.f. (138/64), 50.h. (140/68), 92.a. (202/91)	65. (199/36) 64.a. (196/31), 64.b (198/33) 174.d. (317)	64.c. (34)	
1311 Funding for Change orders		67.c. (164)	67.d. (202), 67.f. (203)		
Basic Health Program	39.a. (80/123)		39.b. (155/19), 39.c. (157/23), 39.d. (159)	39.e. (27)	
Consumer assistance grants		67.a. (162)			
Consumer Operated and Oriented Plan (CO-OP) Program	12.a. (44), 12.b. (46/94)	12.c. (58)		12.d. (15)	
Cost-sharing reductions	7.a. (18/16), 45. (87)	29.f. (89), 50.d. (136/61), 50.h. (140/68), 50.n. (146), 89.a. (194/79), 89.b. (195/87), 89.d. (198), 89.f. (201), 111.c. (240/102)	29.g. (107/12), 29.h. (108), 31.w. (133/14), 50.w (178), 89.g. (226)		
Early retiree reinsurance program		88.a. (193),			

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		88.b. (194)			
Electronic funds transfers	63.a. (113)	63.b. (159)			
Employer requirements (see also Shared responsibility)					
Coverage		29.d. (88), 31.i. (107), 92.l. (211), 92.m. (212)	92.bb. (254), 92.jj. (266)		
Notices		7.x. (34), 7.z. (36)			
Reporting		31.k. (108)	31.o. (129), 31.p. (130), 31.z. (137), 31.cc. (142), 31.jj. (148)		
Self-funded, non-federal governmental plans			92.ee. (259)		
Employer tax credits			31.m. (127), 31.n. (128)		
Essential health benefits					
Excepted benefits		31.i. (107)	31.t. (131)	31.oo. (24)	
Preventive services	31.a. (74/115), 31.b. (77)	31.c. (91), 31.j. (108)	31.y. (136), 31.dd. (142), 31.ee. (144), 31.ff. (145), 31.ll. (149)	31.gg. (20)	
Standards	7.g. (29/76), 31.a. (74/115),	31.d. (93)	92.aa. (253)		

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
	45. (87), 50.b. (98)				
Exchanges					
Federally-facilitated and state-partnership					
Benefit and payment parameters (see Notice of Benefit and Payment Parameters)					
Blueprint for approval	7.f. (29)		7.y. (27)		
Certified application counselors		7.o. (26/3), 7.u. (32/12), 28.c. (84/30)	92.u. (242/49), 7.oo. (44)		
Eligibility and enrollment	7.c. (24/67), 7.g. (29/76)	7.s. (30/11), 7.w. (34), 7.aa. (37), 7.cc. (39), 7.dd. (40), 50.d. (136/61), 50.h. (140/68), 50.k. (143/73)	7.ff. (33), 7.qq. (47), 7.rr. (48), 7.uu. (51), 67.e. (202), 92.dd. (257/52)	92.hh. (39)	
Enrollee satisfaction	7.a. (18/16)	168. (318/106)			
General	7.a. (18/16), 7.b. (21/22), 7.e. (27)	7.i. (19), 89.c. (198/89)	7.b. (3), 7.ss. (50) 92.u. (242/49)		
Guidance (other)					
Agent/broker		7.r. (29)			
General	7.g. (29/76)		31.u. (132)		
Issuer		7.n. (23/1)	7.ee. (29/4),	7.vv. (8/1)	

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
Health insurance affordability programs (see Cost-sharing reductions and Premium tax credits)			7.gg. (35), 7.hh. (36)		
Information collection/reporting/ security/transactions		7.j. (20), 7.k. (21), 7.m. (22), 29.e. (89/39), 68. (164)	29.o. (117), 29.p. (118), 31.cc. (142), 50.e. (171)		
Navigators and non-Navigator assistance personnel	7.a. (18/16)	7.o. (26/3), 7.p. (27)	7.q. (23), 7.oo. (44)	7.v. (7), 7.kk. (8)	
Outreach	7.a. (18/16), 7.g. (29/76)	67.b. (163)	7.pp. (46)		
Program integrity		7.s. (30/11)			
Quality	100.a. (144)		100.b. (271)		
Special enrollment periods		31.h. (105)	6.h. (22), 7.ii. (38), 7.jj. (38), 29.i. (108)		
Stand-alone dental plans		7.u. (32/12)	7.l. (23)		
Web portal	7.g. (29/76)		65. (199/36)		
State-based					
General		7.dd. (40), 50.u. (150)	50.o. (172), 50.s. (175)	7.t. (5)	
State alternative applications		50.k. (143/73), 50.l. (144)			

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
Federal Employees Health Benefits Program (FEHBP)		174.a. (323), 174.b. (325)	174.c. (315), 174.d. (317), 174.e. (318)	174.f. (55)	
Health insurance market rules					
Regulations					
90-day waiting period	91.a. (138)		91.b. (231), 91.c. (231)		
Age curves		92.c. (205)			
Appeals and external review	90. (138)	128.a. (259), 128.b. (261), 128.c. (261), 128.d. (262)			
Contraceptive services		31.i. (107)	31.y. (136), 31.dd. (142), 31.ee. (144), 31.ff. (145), 31.ll. (149)	31.gg. (20), 31.nn. (23)	
Employer-sponsored insurance verification				54. (33)	
General		92.a. (202/91)	92.u. (242/49), 92.dd. (257/52) 92.ff. (260)		
Geographic rating areas		92.c. (205)			
Grandfathered health plans		92.e. (206)	92.h. (234), 92.n. (237)		
Information reporting		31.k. (108), 31.l. (110), 92.b. (203),	31.aa. (138), 31.cc. (142), 31.ii. (147),		

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		92.c. (205)	31.kk. (149), 92.g. (232), 145.b. (302),		
Mental health services	31.a. (74/115)		92.t. (241)		
Network/provider issues			92.w. (249/51), 92.cc. (255), 145.a. (301)	92.ll. (41/6)	
Preventive services (see Essential health benefits)					
Rate review		92.o. (213)	92.g. (232), 92.s. (240)		
Reference pricing			92.gg. (261)		
Same-sex spouses			92.z. (252)		
Stop-loss insurance	56. (106)				
Student insurance	51. (101)				
Transitional policy			92.x. (250), 92.aa. (253)		
Unique plan identifiers	77. (125)				
Notices					
Annual/lifetime limits		92.d. (205), 92.j. (210)			
Coverage (Summary of Benefits and Coverage)		122.c. (254)		31.pp. (25), 92.kk. (41)	
Enrollment opportunity		92.j. (210)		92.v. (39)	
Market renewal		92.f. (207)	92.y. (251)		

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
Patient protection		92.d. (205), 92.j. (210)	92.k. (236), 92.r. (238)		
Pre-existing condition exclusion		122.b. (254)			
Rescission		92.d. (205), 92.j. (210)	92.i. (235), 92.q. (237)		
Special enrollment rights		122.a. (253)			
Transition		92.p. (214)			
High-risk pools (see Pre-Existing Condition Insurance Plan)					
Issuer Letters (CCIIO)					
2014 Issuer Letter		7.n. (23/1)			
2015 Issuer Letter			7.ee. (29/4)		
2016 Issuer Letter				7.vv. (8/1)	
Marketplaces (see Exchanges)					
Medical loss ratio					
General requirements	48.a. (96)	48.d. (131), 48.g. (133), 89.a. (194/79)	48.e. (169)	48.b. (29)	
Medicare Parts C and D		48.c. (131), 48.f. (132)			
Medicaid/CHIP					
Application of essential health benefits	31.a. (74/115)				
Community First Choice Option	16.a. (49/100)				
Eligibility/enrollment under ACA	7.a. (18/16), 7.c. (24/67),	28.a. (82/24), 28.c. (84/30)	28.e. (104)		

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
Federal Medical Assistance Percentage rates	7.g. (29/76)	28.d. (85/38)			
Medicare					
Accountable Care Organization standards	10.b. (138/82)				
Federally Qualified Health Center payments			159.b. (310/60)		
Minimal essential coverage		31.e. (94/40), 31.q. (114/47), 31.s. (117)	29.m. (113), 31.p. (130), 31.x. (135/16), 92.aa. (253)		
Multi-State Plan Program		111.a. (237/94), 111.b. (238/96), 111.c. (240/102), 111.d. (241)	111.e. (280)		
Nondiscrimination		99.b. (221/94), 111.b. (238/96)			
Notice of Benefit and Payment Parameters					
2014		89.a. (194/79), 89.b. (195/87)	7.bb.(28)		
2015			89.e. (225)		
2016				89.h. (36/1)	
Patient-Centered Outcomes Research Trust Fund	116. (154)				
Pre-Existing Condition Insurance Plan	6.a. (16/15), 6.b. (17)	6.c., (17), 6.d. (18), 6.e. (18),	6.g. (22), 6.h. (22)		

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
		6.f. (19)			
Premium tax credits					
General	29.a. (70/112)	29.b. (86), 29.c. (87), 29.d. (88), 29.f. (89), 50.d. (136/61), 50.h. (140/68), 50.n. (146)	29.g. (107/12), 29.h. (108), 29.j. (109), 29.k. (110), 29.l. (113), 29.m. (113), 29.n. (115), 50.w. (178)	29.q. (19)	
Relation to cost-sharing reduction eligibility			89.a. (43)		
Prescription drug fee			198.a. (347), 198.b. (347)		
Qualified health plans					
Accreditation	50.b. (98)	31.d. (93), 50.j. (142)			
Actuarial value	45. (87)	31.d. (93), 89.a. (194/79), 89.b. (195/87)	31.hh. (147), 92.aa. (253), 92.ii. (264)	31.mm. (21)	
Enrollee satisfaction		168. (318/106)			
Essential community providers	7.a. (18/16), 7.b. (21/22)	7.i. (XX), 7.n. (23/1), 50.c. (135/54), 111.b. (238/96)	7.ee. (29/4), 50.e. (171), 92.cc. (255)		
General	7.b. (21/22)	50.p. (147), 89.c. (198/89)	7.b. (3)		

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
Guaranteed availability			92.aa. (253)		
Quality rating system			50.t. (176/29)		
State evaluation		50.i. (142)			
Third-party payments	7.a. (18/16), 7.b. (21/22), 7.g. (29/76), 29.a. (70/112)		50.q. (173), 50.x. (179/30), 50.y. (182)		
Reinsurance, risk corridors, and risk adjustment	7.a. (18/16), 27.a. (65/104)	27.b. (77), 27.d. (79), 27.e. (80)	27.c. (100), 27.f. (101), 27.g. (102), 27.h. (102), 27.j. (104)	27.i. (18)	
Shared responsibility payments					
Employers		31.k. (108)	31.f. (120)		
Exemptions		31.e. (94/40), 31.h. (105), 31.q. (114/47)	7.jj. (38), 7.ll. (41), 7.mm. (42), 29.m. (113), 31.v. (133/13), 31.bb. (139/18), 7.nn. (43), 7.tt. (51)		
Individuals		31.g. (103/44), 31.r. (116)	31.x. (135/16)		
Small Business Health Options Program (SHOP)					

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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.01)	
Aggregation of premiums			50.z. (183)		
General	7.c. (24/67)	7.s. (30/11), 7.dd. (40), 50.f. (138/64), 50.g. (139/66), 89.c. (198/89)	7.ee. (29/4), 50.z. (183)	7.vv. (8/1)	
State alternative applications		50.m. (145)			
Waivers for state innovation	14. (49/98)				
Wellness programs		99.a. (220)	99.c. (269)		

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RRIAR Number	Action	Short Title	Agency
6.a.	Interim Final Rule	High-Risk Pool Eligibility	CCIIO (OCIIO)
6.b.	Interim Final Rule	Pre-Existing Condition Insurance Plan Program	CMS
6.c.	Request for Comment	Pre-Existing Condition Insurance Plan Authorization	CMS
6.d.	Request for Comment	Matching Grants to States for the Operation of High Risk Pools	CMS
6.e.	Request for Comment	Pre-Existing Health Insurance Plan	CMS
6.f.	Interim Final Rule	Pre-Existing Health Insurance Plan Program (Payment Rates)	CMS
6.g.	Guidance	Policy Sales to Medicare Beneficiaries Losing Coverage Due to High Risk Pool Closures	CMS
6.h.	Guidance	Special Enrollment Period for PCIP Enrollees	CCIIO
7.a.	Request for Comment	ACA Exchange Rules	CCIIO (OCIIO)
7.b.	Final/Interim Final Rule	Establishment of Exchange/QHP	CMS
7.c.	Final Rule	Exchange: Eligibility Determinations	CMS
7.d.	N/A	Definition of Indian (Response to CMS/IRS Regulations)	N/A
7.e.	Request for Comment	Exchange: Cooperative Agreements	CMS
7.f.	Request for Comment	Exchange: Blueprint Application	CMS
7.g.	Request for Comment	Exchange: General Guidelines	CMS
7.i.	Guidance	Guidance on the State Partnership Exchange	CCIIO
7.j.	Notice	New System of Records: Exchanges	CMS
7.k.	Request for Comment	Agent/Broker Data Collection in Federally-Facilitated Exchanges	CMS
7.l.	Guidance	Stand-Alone Dental Plans in Federally-Facilitated Exchanges	HHS
7.m.	Guidance	Data Transactions in Federally-Facilitated Exchanges	CMS
7.n.	Guidance	Federally-Facilitated and State Partnership Exchanges	CCIIO
7.o.	Final Rule	Standards for FFE Navigators and Assistance Personnel	CMS
7.p.	Notice	Cooperative Agreement to Support Navigators in FFE	CCIIO
7.q.	Request for Comment	Cooperative Agreement to Support Navigators in FFE	CMS
7.r.	Guidance	Role of Agents, Brokers, and Web-Brokers in Marketplaces	CCIIO
7.s.	Final Rule	Program Integrity: Exchange, SHOP, and Eligibility Appeals	CMS
7.t.	Request for Comment	Cooperative Agreement to Support State Exchanges	CMS
7.u.	Guidance	Certified Application Counselor Program for FFE	CCIIO
7.v.	Request for Comment	Consumer Assistance Tools and Programs of Exchanges	CMS
7.w.	Request for Comment	Enrollment Assistance Program	CMS
7.x.	Request for Comment	Notice to Employees of Coverage Options	DoL
7.y.	Request for Comment	Blueprint for Approval of Health Insurance Marketplaces	CMS
7.z.	Guidance	Employer Notification Requirements Under ACA	DoL
7.aa.	Guidance	Federally Facilitated Marketplace Enrollment Operational Policy	CCIIO

RRIAR Number	Action	Short Title	Agency
7.bb.	Final Rule	Program Integrity; Amendments to the HHS Notice of Benefit and Payment Parameters	CMS
7.cc.	Guidance	Using Account Transfer Flat Files to Enroll Individuals	CCIIO
7.dd.	Final Rule	Maximizing Coverage Under ACA	CMS
7.ee.	Guidance	2015 Letter to Issuers in FFMs	CCIIO
7.ff.	Guidance	Enrollment and Termination Policies for Marketplace Issuers	CCIIO
7.gg.	Guidance	Casework Guidance for Issuers in FFMs	CCIIO
7.hh.	Guidance	Guidance on Individuals "In Line" for FFM	CCIIO
7.ii.	Guidance	Guidance on Special Enrollment Periods for Complex Cases	CCIIO
7.jj.	Guidance	SEPs and Hardship Exemptions for Certain Individuals	CCIIO
7.kk.	Request for Comment	Standards for Navigators and Non-Navigator Personnel	CMS
7.ll.	Guidance	Filing Threshold Hardship Exemption	CCIIO
7.mm.	Guidance	Exemption for Individuals Eligible for Indian Provider Services	CCIIO
7.nn.	Guidance	Hardship Exemptions, Age Offs, and Catastrophic Coverage	CCIIO
7.oo.	Guidance	Information and Tips for Assisters: Working with AI/ANs	CCIIO
7.pp.	Guidance	Effort to Help Marketplace Enrollees Stay Covered	CCIIO
7.qq.	Guidance	Options for Paper-Based Marketplace Eligibility Appeals	CCIIO
7.rr.	Guidance	Termination of Enrollment in FFM Due to Death	CCIIO
7.ss.	Notice	Health Insurance Marketplace Public Use Files	CCIIO
7.tt.	Guidance	Hardship Exemptions for Persons Meeting Certain Criteria	CCIIO
7.uu.	Guidance	Guidance for Issuers on 2015 Reenrollment in the FFM	CCIIO
7.vv.	Guidance	2016 Letter to Issuers in FFMs	CCIIO
7.ww.	Guidance	Special Protections for AI/ANs	CMS
7.xx.	Guidance	AI/AN Trust Income and MAGI	CMS
10.b.	Final Rule	ACO Standards	CMS
12.a.	Request for Comment	Co-Op Plans (Section 1322 of ACA)	CCIIO (OCIIO)
12.b.	Final Rule	Co-Op Plans (Section 1322 of ACA)	CMS
12.c.	Guidance	CO-OP Program Contingency Fund	CCIIO
12.d.	Request for Comment	Consumer Operated and Oriented Program	CMS
14.	Final Rule	ACA Waivers for State Innovation	Treasury/CMS
16.a.	Final Rule	New Medicaid Community First Choice Option	CMS
27.a.	Final Rule	Risk Adjustment Standards in ACA	CMS
27.b.	Guidance	HHS Risk Adjustment Model Algorithm	CCIIO
27.c.	Request for Comment	Reinsurance, Risk Corridors, and Risk Adjustment Standards	CMS
27.d.	Guidance	HHS-Developed Risk Adjustment Model Algorithm	CCIIO

RRIAR Number	Action	Short Title	Agency
27.e.	Guidance	Reinsurance Enrollment Count	CCIIO
27.f.	Guidance	Risk Corridors and Budget Neutrality	CCIIO
27.g.	Guidance	Reinsurance Contributions Process	CCIIO
27.h.	Guidance	HHS-Developed Risk Adjustment Model Algorithm	CMS
27.i.	Request for Comment	Risk Corridors Transitional Policy	CMS
27.j.	Guidance	Transitional Reinsurance Program Annual Form	CCIIO
28.a.	Final Rule	Medicaid Eligibility Under ACA	CMS
28.c.	Final Rule	Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, etc.	CMS
28.d.	Final Rule	Increased FMAP Changes Under ACA	CMS
28.e.	Request for Comment	Medicaid Implementation Advanced Planning Document	CMS
29.a.	Final Rule	Premium Subsidies and Tax Credits	IRS
29.b.	Final Rule	Health Insurance Premium Tax Credit	Treasury
29.c.	Request for Comment	Health Insurance Premium Tax Credit	IRS
29.d.	Proposed Rule	Minimum Value of Eligible Employer-Sponsored Plans	IRS
29.e.	Final Rule	Information Reporting for Exchanges	IRS
29.f.	Guidance	IRS Ruling 2013-17 and Advance Premium Tax Credits	CCIIO
29.g.	Request for Comment	Payment Collections Operations Contingency Plan	CMS
29.h.	Guidance	Verification of Income for Tax Credits and Cost Sharing	HHS
29.i.	Guidance	Victims of Domestic Abuse	CCIIO
29.j.	Final/Temporary Rule	Rules Regarding the Health Insurance Premium Tax Credit	IRS
29.k.	Proposed Rule	Rules Regarding the Health Insurance Premium Tax Credit	IRS
29.l.	Guidance	Determining the Deduction for the Premium Tax Credit	IRS
29.m.	Guidance	Revisions to Calculating the Premium Tax Credit, et al.	IRS
29.n.	Notice	Premium Tax Credit	IRS
29.o.	Notice	Health Insurance Marketplace Statement	IRS
29.p.	Request for Comment	Health Insurance Premium Tax Credit	IRS
29.q.	Guidance	Penalty Relief Related to Advance Payments of PTC	IRS
31.a.	Guidance	Essential Health Benefits Bulletin	CCIIO
31.b.	Interim Final Rule	Preventive Health Services	IRS/DoL/CMS
31.c.	Final Rule	Coverage of Certain Preventive Services Under ACA	IRS/DoL/CMS
31.d.	Final Rule	Standards on EHB, Actuarial Value, and Accreditation	CMS
31.e.	Final Rule	Exchanges: Eligibility for Exemptions and Minimum Essential Coverage Provisions	CMS
31.f.	Final Rule	Employer Shared Responsibility	IRS
31.g.	Final Rule	Shared Responsibility for Not Maintaining Essential Coverage	IRS

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31.h.	Guidance	Hardship Exemption Criteria and Special Enrollment Periods	CCIIO
31.i.	Guidance	Safe Harbor for Coverage of Contraceptive Services	CCIIO
31.j.	Guidance	Women's Preventive Services Guidelines	HRSA
31.k.	Guidance	Employer and Insurer Reporting and Shared Responsibility	IRS
31.l.	Request for Comment	Data Submission for the FFE User Fee Adjustment	CMS
31.m.	Final Rule	Tax Credit for Health Insurance Expenses of Small Employers	IRS
31.n.	Request for Comment	Credit for Small Employer Health Insurance Premiums	IRS
31.o.	Final Rule	Health Insurance Coverage Reporting by Large Employers	IRS
31.p.	Final Rule	Minimum Essential Coverage Reporting	IRS
31.q.	Request for Comment	Exchange Functions: Eligibility for Exemptions	CMS
31.r.	Guidance	Shared Responsibility Provision	CCIIO
31.s.	Guidance	Obtaining Recognition as Minimum Essential Coverage	CCIIO
31.t.	Final Rule	Amendments to Excepted Benefits	IRS/DoL/CMS
31.u.	Guidance	Options Available for Consumers with Cancelled Policies	CCIIO
31.v.	Guidance	Instructions for the Application for Indian-Specific Exemptions	CMS
31.w.	Guidance	Q&A on Cost-Sharing Reductions for Contract Health Services	CCIIO
31.x.	Final Rule	MEC and Other Rules on the Shared Responsibility Payment	IRS
31.y.	Guidance	Disclosure with Respect to Preventive Services	CCIIO
31.z.	Notice	Reporting on Employer Health Insurance Offer and Coverage	IRS
31.aa.	Notice	Reporting on Health Coverage by Insurers	IRS
31.bb.	Notice	Health Coverage Exemptions	IRS
31.cc.	Request for Comment	Application for Filing ACA Information Returns	IRS
31.dd.	Proposed Rule	Coverage of Certain Preventive Services Under ACA	IRS/DoL/CMS
31.ee.	Interim Final Rule	Coverage of Certain Preventive Services Under ACA	IRS/DoL/CMS
31.ff.	Proposed Rule	Coverage of Certain Preventive Services Under ACA	IRS
31.gg.	Request for Comment	EBSA Form 700--Certification	DoL
31.hh.	Guidance	State-Specific Data for the Actuarial Value Calculator	CCIIO
31.ii.	Request for Comment	Reporting of Minimum Essential Coverage	IRS
31.jj.	Request for Comment	Information Reporting by Employers on Health Coverage	IRS
31.kk.	Request for Comment	ACA Uniform Explanation of Coverage Documents	IRS
31.ll.	Request for Comment	Data Submission for the FFE User Fee Adjustment	CMS
31.mm.	Guidance	2016 Actuarial Value Calculator	CCIIO
31.nn.	Request for Comment	Notification of Objection to Covering Contraceptive Services	CMS
31.oo.	Proposed Rule	Amendments to Excepted Benefits	IRS/DoL/CMS

RRIAR Number	Action	Short Title	Agency
31.pp.	Proposed Rule	Summary of Benefits and Coverage and Uniform Glossary	IRS/DoL/CMS
39.a.	Request for Information	Basic Health Program	CMS
39.b.	Final Rule	Basic Health Program	CMS
39.c.	Final Methodology	Basic Health Program: Federal Funding Methodology for 2015	CMS
39.d.	Request for Comment	Basic Health Program Report for Exchange Premium	CMS
39.e.	Proposed Methodology	Basic Health Program: Federal Funding Methodology for 2016	CMS
45.	Guidance	Actuarial Value and Cost-Sharing	CMS
48.a.	Final Rule	Medical Loss Ratio Requirements	CMS
48.b.	Request for Comment	Medical Loss Ratio Rebate Calculation Report and Notices	CMS
48.c.	Final Rule	MLR Requirements for Medicare Part C and Part D	CMS
48.d.	Guidance	Medical Loss Ratio Reporting and Rebate Requirements	CCIIO
48.e.	Final Rule	Computation of MLR	IRS
48.f.	Request for Comment	Medical Loss Ratio Report for MA Plans and PDPs	CMS
48.g.	Guidance	Medical Loss Ratio Reporting and Rebate Requirements	CCIIO
50.b.	Final Rule	EHB and QHP Standards	CMS
50.c.	Guidance	Model Qualified Health Plan Addendum (Indian Addendum)	CMS/IHS
50.d.	Request for Comment	Data Elements for Exchange Application	CMS
50.e.	Request for Comment	Initial Plan Data Collection to Support QHP Certification	CMS
50.f.	Request for Comment	Eligibility and Enrollment for Employees in SHOP	CMS
50.g.	Request for Comment	Eligibility and Enrollment for Small Businesses in SHOP	CMS
50.h.	Request for Comment	Eligibility for Insurance Affordability Programs and Enrollment	CMS
50.i.	Guidance	State Evaluation of Plan Management Activities	CCIIO
50.j.	Request for Comment	Recognized Accrediting Entities Data Collection	CMS
50.k.	Guidance	Model Eligibility Application	CCIIO
50.l.	Guidance	State Alternative Applications for Health Coverage	CCIIO
50.m.	Guidance	State Alternative Applications for Health Coverage Through SHOP	CCIIO
50.n.	Final Rule	Disclosures for Health Insurance Affordability Program Eligibility	Treasury
50.o.	Request for Comment	State Health Insurance Exchange Incident Report	CMS
50.p.	Guidance	QHP Webinar Series FAQs	CMS
50.q.	Guidance	Third Party Payments of Premiums for QHPs	CCIIO
50.r.	Guidance	Implementation of Section 402 of IHCIA	IHS
50.s.	Request for Comment	State-Based Marketplace Annual Report	CMS
50.t.	Request for Comment	QHP Quality Rating System Measures and Methodology	CMS
50.u.	Guidance	State-Based Marketplace Annual Reporting Tool	CCIIO

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50.w.	Guidance	Retroactive Advance Payments of PTCs and CSRs Due to Exceptional Circumstances	CCIIO
50.x.	Interim Final Rule	Third Party Payment of QHP Premiums	CMS
50.y.	Final Rule	Tax Treatment of Retirement Plan Payment of Premiums	IRS
50.z.	Guidance	Implementation of Employee Choice in SHOP in 2015	CCIIO
51.	Final Rule	Student Insurance Coverage	CMS
54.	Notice	ESI Coverage Verification	CMS
56.	Request for Information	Stop-Loss Insurance	IRS/DoL/CMS
63.a.	Interim Final Rule	Health Care EFT Standards	HHS
63.b.	Request for Comment	Electronic Funds Transfers Authorization Agreement	CMS
64.a.	Notice	Policy on Conferring with Urban Indian Organizations	IHS
64.b.	Notice	CMS Tribal Consultation Policy	CMS
64.c.	Notice	Tribal Consultation Policy	Treasury
65.	Request for Comment	Health Care Reform Insurance Web Portal Requirements	CMS
67.a.	Request for Comment	State Consumer Assistance Grants	CMS
67.b.	Request for Comment	Research on Outreach for Health Insurance Marketplace	CMS
67.c.	Guidance	Use of 1311 Funding for Change Orders	CCIIO
67.d.	Guidance	Use of 1311 Funds and No Cost Extensions	CCIIO
67.e.	Guidance	Consumer Assistance for Marketplace Enrollment	CCIIO
67.f.	Guidance	Use of 1311 Funds, et al.	CCIIO
68.	Request for Comment	Security of Electronic Health Information	CMS
77.	Final Rule	Unique Plan Identifiers	CMS
88.a.	Request for Comment	Early Retiree Reinsurance Program Survey	CMS
88.b.	Notice	Early Retiree Reinsurance Program	CMS
89.a.	Final Rule	Notice of Benefit and Payment Parameters for 2014	CMS
89.b.	Interim Final Rule	Amendments to the Notice of Benefit and Payment Parameters	CMS
89.c.	Final Rule	Small Business Health Options Program	CMS
89.d.	Request for Comment	Cost-Sharing Reductions Reconciliation Methodology	CMS
89.e.	Final Rule	Notice of Benefit and Payment Parameters for 2015	CMS
89.f.	Guidance	Choice of Methodology for Cost-Sharing Reduction Reconciliation	CCIIO
89.g.	Request for Comment	Cost Sharing Reduction Reconciliation	CMS
89.h.	Proposed Rule	Notice of Benefit and Payment Parameters for 2016	CMS
90.	Guidance	Adverse Benefit Determinations	CCIIO
91.a.	Guidance	Waiting Period Limitation Under Public Health Service Act	CCIIO
91.b.	Final Rule	Waiting Period Limitation and Coverage Requirements	IRS/DoL/CMS

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91.c.	Final Rule	Waiting Period Limitation	IRS/DoL/CMS
92.a.	Final Rule	Health Insurance Market Rules	CMS
92.b.	Request for Comment	Compliance with Individual and Group Market Reforms	CMS
92.c.	Guidance	Age Curves, Geographical Rating Areas, and State Reporting	CMS
92.d.	Request for Comment	Patient Protection Notices and Disclosure Requirements	CMS
92.e.	Request for Comment	Disclosure and Recordkeeping for Grandfathered Health Plans	CMS
92.f.	Guidance	Model Language for Individual Market Renewal Notices	CMS
92.g.	Request for Comment	Reporting for Grants to Support Health Insurance Rate Review	CMS
92.h.	Request for Comment	Disclosure and Recordkeeping for Grandfathered Health Plans	DoL
92.i.	Request for Comment	ACA Notice of Rescission	Treasury
92.j.	Request for Comment	Enrollment Opportunity Notice Relating to Lifetime Limits	Treasury
92.k.	Request for Comment	ACA Notice of Patient Protection	IRS
92.l.	Guidance	Application of ACA Provisions to HRAs, Health FSAs, et al.	IRS/DoL
92.m.	Guidance	Application of ACA Provisions to Certain Healthcare Arrangements	CCIIO
92.n.	Request for Comment	Rules for Group Health Plans Related to Grandfather Status	IRS
92.o.	Guidance	State Reporting for Plan or Policy Years Beginning in 2015	CCIIO
92.p.	Guidance	Standard Notices for Transition to ACA Compliant Policies	CCIIO
92.q.	Request for Comment	ACA Advance Notice of Rescission	DoL
92.r.	Request for Comment	ACA Patient Protection Notice	DoL
92.s.	Request for Comment	Rate Increase Disclosure and Review Reporting Requirements	CMS
92.t.	Guidance	ACA Implementation: Market Reform and Mental Health Parity	CCIIO
92.u.	Final Rule	Exchange and Insurance Market Standards for 2015 and Beyond	CMS
92.v.	Guidance	Q&A on Outreach by Medicaid MCOs to Former Enrollees	CCIIO
92.w.	Request for Information	Provider Non-Discrimination	CMS/IRS/DoL
92.x.	Guidance	Extension of Transitional Policy for Non-Grandfathered Coverage	CCIIO
92.y.	Guidance	Draft Notices When Discontinuing or Renewing a Product	CCIIO
92.z.	Guidance	Coverage of Same-Sex Spouses	CCIIO
92.aa.	Guidance	Health Insurance Market Reforms and Marketplace Standards	CCIIO
92.bb.	Guidance	Employer Health Care Arrangements (Q&A)	IRS
92.cc.	Guidance	FAQs on Essential Community Providers	CCIIO
92.dd.	Final Rule	Eligibility Determinations for Exchange Participation	CMS
92.ee.	Guidance	Self-Funded, Non-Federal Governmental Plans	CCIIO
92.ff.	Final Rule	Deduction Limitation for Remuneration by Insurers	IRS
92.gg.	Guidance	FAQs About ACA Implementation (Reference Pricing)	CCIIO

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92.hh.	Request for Comment	Annual Eligibility Redetermination Notices, et al.	CMS
92.ii.	Guidance	Group Plans that Fail to Cover In-Patient Hospitalization Services	CCIIO
92.jj.	Guidance	ACA Implementation (Premium Reimbursement Arrangements)	CCIIO
92.kk.	Request for Comment	Summary of Benefits and Coverage and Uniform Glossary	CMS
92.ll.	Request for Comment	Health Benefit Plan Network Access and Adequacy Model Act	NAIC
99.a.	Final Rule	Wellness Programs	IRS/DoL/CMS
99.b.	Request for Information	Nondiscrimination in Certain Health Programs or Activities	HHS OCR
99.c.	Request for Comment	Evaluation of Wellness and Prevention Programs	CMS
100.a.	Request for Information	Health Care Quality for Exchanges	CMS
100.b.	Request for Comment	Marketplace Quality Standards	CMS
111.a.	Request for Comment	Multi-State Plan Application	OPM
111.b.	Final Rule	Multi-State Plan Program for Exchanges	OPM
111.c.	Request for Comment	Request for External Review	OPM
111.d.	Notice	New System of Records (MSP Program)	OPM
111.e.	Proposed Rule	Establishment of Multi-State Plan Program for Exchanges	OPM
116.	Final Rule	Fees for the Patient-Centered Outcomes Research Trust Fund	Treasury
122.a.	Request for Comment	Special Enrollment Rights Under Group Health Plans	DoL
122.b.	Request for Comment	Pre-Existing Condition Exclusion Under Group Health Plans	DoL
122.c.	Request for Comment	Creditable Coverage Under Group Health Plans	DoL
128.a.	Request for Comment	ACA Internal Claims and Appeals and External Review Procedures	CMS
128.b.	Guidance	State External Review Process for Health Plans	CCIIO
128.c.	Guidance	County Level Estimates Related to CLAS Standards Under ACA	CCIIO
128.d.	Request for Comment	ACA Internal Claims and Appeals and External Review Disclosures	IRS
145.a.	Final Rule	Health Insurance Providers Fee	IRS
145.b.	Request for Comment	Report of Health Insurance Provider Information	IRS
159.b.	Final Rule	Medicare PPS for Federally Qualified Health Centers, et al.	CMS
168.	Request for Comment	Enrollee Satisfaction Survey Data Collection	CMS
169.	Request for Comment	Health Care Sharing Ministries	CMS
174.a.	Final Rule	FEHBP: Members of Congress and Congressional Staff	OPM
174.b.	Final Rule	FEHBP: Coverage of Children	OPM
174.c.	Final Rule	FEHBP: Eligibility for Temporary and Seasonal Employees	OPM
174.d.	Guidance	New Flexibility for Tribal Employer Participation in FEHBP	OPM
174.e.	Final Rule	FEHBP Miscellaneous Changes: Medically Underserved Areas	OPM
174.f.	Proposed Rule	FEHBP: Rate Setting for Community-Rated Plans	OPM

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198.a.	Final/Temporary Rule	Branded Prescription Drug Fee	IRS
198.b.	Proposed Rule	Branded Prescription Drug Fee	IRS