

National Indian Health Board



Regulation Review and Impact Analysis Report v. 6.01

as of January 31, 2016

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 reform¹ 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 –

- 7.mmm. Establishment of an Exchange by a State and QHPs (CMS-10593; **comments due 2/1/2016**)
- 7.nnn. Establishment of Exchanges and QHPs--Standards for Employers (CMS-10592; **comments due 2/1/2016**)
- 50.h. Eligibility for Insurance Affordability Programs and Enrollment (CMS-10440; **comments due 2/1/2016**)
- 92.b. Compliance with Individual and Group Market Reforms (CMS-10430; **comments due 2/1/2016**)
- 136.e. Requirements for Reporting Quality Measures (CMS-3323-NC; **comments due 2/1/2016**)
- 25.gg. Inpatient Prospective Payment Systems--0.2 Percent Reduction (CMS-1658-NC; **comments due 2/2/2016**)
- 5.a. PACE Information Request (CMS-R-244; **comments due 2/8/2016**)
- 142.b. Important Message from Medicare (CMS-R-193; **comments due 2/8/2016**)
- 50.f. Eligibility and Enrollment for Employees in SHOP (CMS-10438; **comments due 2/9/2016**)
- 50.g. Eligibility and Enrollment for Small Businesses in SHOP (CMS-10439; **comments due 2/9/2016**)
- 121.n. Medicare Registration Application (CMS-8550; **comments due 2/9/2016**)
- 7.ooo. CMS Healthcare.gov Site Wide Online Survey (CMS-10597; **comments due 2/12/2016**)
- 11.i. PACE Information Request (CMS-R-244; **comments due 2/12/2016**)
- 89.n. Manual for Reconciliation of Advance Payment of CSRs (CCIIO/no ref. #; **comments due 2/15/2016**)
- 67.a. State Consumer Assistance Grants (CMS-10333; **comments due 2/19/2016**)
- 89.g. Cost Sharing Reduction Reconciliation (CMS-10526; **comments due 2/19/2016**)

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, IHCA), and as amended by the Health Care and Education Reconciliation Act (HCERA; Pub. L. 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.

- 129.b.Awarding and Administration of MAC Contracts (CMS-1653-NC; **comments due 2/19/2016**)
- 41.f. New Safe Harbors (OIG-124-N; **comments due 2/22/2016**)
- 194.f. 340B Drug Pricing Program Reporting Requirements (HRSA/OMB 0915-0176; **comments due 2/22/2016**)
- 149. Evaluation of the Graduate Nurse Education Demonstration (CMS-10467; **comments due 2/28/2016**)
- 83.a. Medicaid Statistical Information System (CMS-R-284; **comments due 2/29/2016**)
- 136.c.PQRS and the eRx Incentive Program Data Assessment (CMS-10519; **comments due 2/29/2016**)
- 4.n. CORF Eligibility and Survey Forms (CMS-359/360; **comments due 3/4/2016**)
- 112.n.Catastrophic Health Emergency Fund (CMS-359/360; **comments due 3/11/2016**)
- 95. IHS Forms to Implement the Privacy Rule (IHS-810, -912-1, -912-2, -913, and -917; **comments due 3/22/2016**)
- 175.b.Medicaid Drug Use Review Program (CMS-R-284; **comments due 3/29/2016**)
- 112.I. Expanded Access to Non-VA Care Through Veterans Choice (VA/RIN 2900-AP60; **comments due 3/30/2016**)

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

- 7.III. 2017 Letter to Issuers in FFM (CCIIO/no ref. #; comments submitted 1/17/2016 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)
- 6.i. Pre-Existing Health Insurance Plan Program Updates (CMS-9995-IFC4; sent to OMB 2/3/2015)
- 49.a. Reporting and Returns of Medicare Overpayments (CMS-6037-F; sent to OMB 10/21/2015)
- 188a. Emergency Preparedness Requirements (CMS-3178-F; sent to OMB 11/3/2015)
- 188.b.Fire Safety Requirements for Certain Health Care Facilities (CMS-3277-F; sent to OMB 11/3/2015)
- 112.d.I/T/U Payment for Physician and Non-Hospital-Based Services (IHS/RIN 0917-AA12; sent to OMB 12/14/2015)
- 112.o.IHS Reimbursement Rates for CY 2016 (IHS/RIN 0917-ZA30; sent to OMB 12/31/2015)
- 25.ii. Hospital Changes to Promote Innovation, etc. (CMS-3295-P; sent to OMB 1/4/2016)
- 43. Medicaid Reimbursement for Outpatient Drugs (CMS-2345-F; approved by OMB 1/19/2016)
- 26. Medicaid Home Health (CMS-2348-F; approved by OMB 1/21/2016)
- 60.I. Expansion of the CMS Qualified Entity Program (CMS-5061-P; approved by OMB 1/22/2016)
- 1.p. Health IT Certification Program: Enhanced Oversight (HHS ONC/RIN 0955-AA00; sent to OMB 1/25/2016)
- 5.d. PACE Update (CMS-4168-P; sent to OMB 1/25/2016)
- 10.g. Medicare Shared Savings Program: ACO Benchmarking (CMS-1644-P; approved by OMB 1/27/2016)

Recent (final) rules issued –

- 31.ddd. 2017 Actuarial Value Calculator (CCIIO/no ref. #; issued 1/21/2016)

Contacts: Devin Delrow at DDelrow@nihb.org.

Comments submitted by NIH, TTAG, and other organizations may be accessed at <http://www.nihb.org/tribalhealthreform/mmpc-regulation-comments/>.


**TABLE A: REGULATIONS INCLUDED TO DATE IN RRIAR TABLES B AND C
UPDATED THROUGH 1/31/2016**




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 27	
			SECTION II: MEDICARE	Beginning on page 5 of 27	
			SECTION III: HEALTH REFORM	Beginning on page 16 of 27	
			SECTION IV: OTHER	Beginning on page 25 of 27	
			SECTION I: MEDICAID (AND DUAL MEDICAID AND MEDICARE)		
1.p.	Health IT Certification Program: Enhanced Oversight ACTION: Proposed Rule NOTICE: ONC Health IT Certification Program: Enhanced Oversight and Accountability AGENCY: HHS ONC	HHS ONC RIN 0955-AA00	<u>Issue Date:</u> [Pending at OMB as of 1/25/2016] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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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-P2F2	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	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: None. 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
20.a.	Assuring Access to Services ACTION: Proposed Final Rule NOTICE: Medicaid Program; Methods for Assuring Access to Covered Medicaid Services AGENCY: CMS	CMS-2328-PFC	Issue Date: 5/6/2011 Due Date: 7/5/2011 ANTHC File Date: 7/5/2011 Date of Subsequent Agency Action, if any: Issued Final Rule 11/2/2015 Due Date: 1/4/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ ANTHC analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> ANTHC recommendations included: ✓ Subsequent Agency action: ✓ Analysis of Agency action: ✓
20.b.	Data Metrics and Alternative Processes for Access to Care ACTION: Request for Information NOTICE: Medicaid Program; Request for Information (RFI)--Data Metrics and Alternative Processes for Access to Care in the Medicaid Program AGENCY: CMS	CMS-2328-NC	Issue Date: 11/2/2015 Due Date: 1/4/2016 NIHB File Date: None Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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23.b.	MACPro: New Online System for State Plan Amendments, Waivers, etc. ACTION: Request for Comment NOTICE: Medicaid and CHIP Program (MACPro) AGENCY: CMS	CMS-10434	<u>Issue Date:</u> 12/21/2012 <u>Due Date:</u> 1/22/2013 <u>TSGAC File Date:</u> 1/22/2013 <u>Date of Subsequent Agency Action, if any:</u> Issued revision 11/9/2015 <u>Due Date:</u> 1/8/2016	<ul style="list-style-type: none"> • Summary of Agency action: ✓ • TSGAC analysis of action: ✓ • Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> • TSGAC recommendations included: ✓ • Subsequent Agency action: • Analysis of Agency action:
26.	Medicaid Home Health ACTION: Proposed Final Rule NOTICE: Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health AGENCY: CMS	CMS-2348-PF	<u>Issue Date:</u> 7/12/2011 <u>Due Date:</u> 9/12/2011 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Final Rule approved by OMB 1/21/2016	<ul style="list-style-type: none"> • Summary of Agency action: ✓ • NIHB analysis of action: 	<ul style="list-style-type: none"> • NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
41.f.	New Safe Harbors ACTION: Notice NOTICE: Solicitation of New Safe Harbors and Special Fraud Alerts AGENCY: HHS OIG	OIG-124-N	<u>Issue Date:</u> 12/23/2015 <u>Due Date:</u> 2/22/2016 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> • Summary of Agency action: ✓ • NIHB analysis of action: 	<ul style="list-style-type: none"> • NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
43.	Medicaid Reimbursement for Outpatient Drugs ACTION: Proposed Final Rule NOTICE: Medicaid Program; Covered Outpatient Drugs AGENCY: CMS	CMS-2345-PF	<u>Issue Date:</u> 2/2/2012 <u>Due Date:</u> 4/2/2012 <u>NIHB File Date:</u> 4/2/2012 <u>Date of Subsequent Agency Action, if any:</u> Final Rule approved by OMB 1/19/2016	<ul style="list-style-type: none"> • Summary of Agency action: ✓ • NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> • NIHB recommendations included: ✓ • Subsequent Agency action: • Analysis of Agency action:

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83.a.	Medicaid Statistical Information System ACTION: Request for Comment NOTICE: Medicaid Statistical Information System AGENCY: CMS	CMS-R-284	<u>Issue Date:</u> 8/15/2012 <u>Due Date:</u> 10/15/2012 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension 10/19/2012; issued revision 12/3/2012, 12/31/2015 <u>Due Date:</u> 11/19/2012; 1/2/2013; 2/29/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: None Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
175.b.	Medicaid Drug Use Review Program ACTION: Request for Comment NOTICE: Medicaid Drug Use Review Program AGENCY: CMS	CMS-R-153	<u>Issue Date:</u> 11/29/2013 <u>Due Date:</u> 1/28/2014 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued revision 3/17/2014, 1/29/2016 <u>Due Date:</u> 4/16/2014; 3/29/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> 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	<u>Issue Date:</u> [Approved by OMB on 4/18/2014] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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188.a.	Emergency Preparedness Requirements ACTION: Proposed Final Rule NOTICE: Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers AGENCY: CMS	CMS-3178-PF	Issue Date: 12/27/2013 Due Date: 2/25/2014 3/31/2014 TTAG File Date: 3/31/2014 Date of Subsequent Agency Action, if any: Issued due date extension 2/21/2014; sent Final Rule to OMB 11/3/2015	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> TTAG recommendations included: ✓ Subsequent Agency action: Analysis of Agency action:
188.b.	Fire Safety Requirements for Certain Health Care Facilities ACTION: Proposed Final Rule NOTICE: Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities AGENCY: CMS	CMS-3277-PF	Issue Date: 4/16/2014 Due Date: 6/16/2014 TTAG File Date: 6/16/2014 Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 11/3/2015	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> TTAG recommendations included: ✓ Subsequent Agency action: Analysis of Agency action:
SECTION II: MEDICARE					
4.n.	CORF Eligibility and Survey Forms ACTION: Request for Comment NOTICE: Comprehensive Outpatient Rehabilitation Facility (CORF) Eligibility and Survey Forms and Supporting Regulations AGENCY: CMS	CMS-359/360	Issue Date: 1/4/2016 Due Date: 3/4/2016 NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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5.a.	PACE Information Request ACTION: Request for Comment NOTICE: Medicare and Medicaid; Programs of All-Inclusive Care for the Elderly (PACE) AGENCY: CMS	CMS-R-244	<u>Issue Date:</u> 7/30/2010 <u>Due Date:</u> 9/28/2010 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension 10/8/2010, 10/4/2013, 12/20/2013, 12/8/2015 <u>Due Date:</u> 11/8/2010; 12/3/2013; 1/21/2014; 2/8/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: None. Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
5.d.	PACE Update ACTION: Proposed Rule NOTICE: Programs of All-Inclusive Care for the Elderly (PACE) Update AGENCY: CMS	CMS-4168-P	<u>Issue Date:</u> [Pending at OMB as of 1/25/2016] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
10.g.	Medicare Shared Savings Program: ACO Benchmarking ACTION: Proposed Rule NOTICE: Medicare Shared Savings Program; Accountable Care Organizations--Revised Benchmarking Methodology AGENCY: CMS	CMS-1644-P	<u>Issue Date:</u> [Approved by OMB 1/27/2016] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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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	<u>Issue Date:</u> 10/5/2012 <u>Due Date:</u> 12/4/2012 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued revision 1/17/2013, 10/4/2013, 12/20/2013, 9/26/2014, 12/24/2014, 9/24/2015, 12/18/2015 <u>Due Date:</u> 2/19/2013; 12/3/2013; 1/21/2014; 11/25/2014; 1/23/2015; 11/23/2015; 1/19/2016	<ul style="list-style-type: none"> • Summary of Agency action: ✓ • NIHB analysis of action: • Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> • NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
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	<u>Issue Date:</u> 10/5/2012 <u>Due Date:</u> 12/4/2012 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued revision 1/17/2013, 11/1/2013, 1/17/2014, 9/26/2014, 12/19/2014, 9/24/2015, 12/18/2015 <u>Due Date:</u> 2/19/2013; 12/31/2013; 2/18/2014; 11/25/2014; 1/20/2015; 11/23/2015; 1/19/2016	<ul style="list-style-type: none"> • Summary of Agency action: ✓ • NIHB analysis of action: ✓ • Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> • NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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11.i.	Medicare Advantage Appeals and Grievance Data Disclosure ACTION: Request for Comment NOTICE: Medicare Advantage Appeals and Grievance Data Disclosure Requirements AGENCY: CMS	CMS-R-282	<u>Issue Date:</u> 2/22/2013 <u>Due Date:</u> 4/23/2013 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u> Issued extension 5/3/2013, 12/14/2015 <u>Due Date:</u> 6/3/2013; 2/12/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
25.cc.	Revisions to Requirements for Discharge Planning for Hospitals ACTION: Proposed Rule NOTICE: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies AGENCY: CMS	CMS-3317-P	<u>Issue Date:</u> 11/3/2015 <u>Due Date:</u> 1/4/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
25.ee.	Design of Survey on Patient Experiences with Care in LTCHs ACTION: Request for Information NOTICE: Medicare Program; Request for Information To Aid in the Design and Development of a Survey Regarding Patient and Family Member Experiences with Care Received in LTCHs AGENCY: CMS	CMS-3327-NC	<u>Issue Date:</u> 11/20/2015 <u>Due Date:</u> 1/19/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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25.ff.	Design of Survey on Patient Experiences with Care in IRFs ACTION: Request for Information NOTICE: Medicare Program; Request for Information To Aid in the Design and Development of a Survey Regarding Patient and Family Member Experiences with Care Received in Inpatient Rehabilitation Facilities AGENCY: CMS	CMS-3328-NC	<u>Issue Date:</u> 11/20/2015 <u>Due Date:</u> 1/19/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
25.gg.	Inpatient Prospective Payment Systems--0.2 Percent Reduction ACTION: Notice NOTICE: Medicare Program; Inpatient Prospective Payment Systems; 0.2 Percent Reduction AGENCY: CMS	CMS-1658-NC	<u>Issue Date:</u> 12/1/2015 <u>Due Date:</u> 2/2/2016 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
25.hh.	Explanation of FY 2004 Outlier Fixed-Loss Threshold ACTION: Notice NOTICE: Medicare Program; Explanation of FY 2004 Outlier Fixed-Loss Threshold as Required by Court Rulings AGENCY: CMS	CMS-1659-N	<u>Issue Date:</u> 1/22/2016 <u>Due Date:</u> None <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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25.ii.	Hospital Changes to Promote Innovation, etc. ACTION: Request for Comment NOTICE: Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care AGENCY: CMS	CMS-3295-P	<u>Issue Date:</u> [Pending at OMB as of 1/4/2016] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
49.a.	Reporting and Returns of Medicare Overpayments ACTION: Proposed Final Rule NOTICE: Medicare Program; Reporting and Returning of Overpayments AGENCY: CMS	CMS-6037-PF	<u>Issue Date:</u> 2/16/2012 <u>Due Date:</u> 4/16/2012 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension notice 2/17/2015; Final Rule sent to OMB 10/21/2015	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
52.q.	Home Health Face-to-Face Encounter Clinical Templates ACTION: Request for Comment NOTICE: Home Health Face-to-Face Encounter Clinical Templates AGENCY: CMS	CMS-10564	<u>Issue Date:</u> 8/12/2015 <u>Due Date:</u> 10/13/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension 12/28/2015 <u>Due Date:</u> 1/27/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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60.i.	Expansion of the CMS Qualified Entity Program ACTION: Request for Comment NOTICE: Expansion of the CMS Qualified Entity Program AGENCY: CMS	CMS-5061-P	<u>Issue Date:</u> [Approved by OMB 1/22/2016] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
71.n.	Medicare ESRD PPS and Quality Incentive Program ACTION: Proposed Final Rule NOTICE: Medicare Program; End-Stage Renal Disease Prospective Payment System, and Quality Incentive Program AGENCY: CMS	CMS-1628-PF	<u>Issue Date:</u> 7/1/2015 <u>Due Date:</u> 8/25/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued correction 9/2/2015; issued Final Rule 11/6/2015; issued correction 12/31/2015	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
71.o.	ESRD Application and Survey and Certification Report ACTION: Request for Comment NOTICE: End Stage Renal Disease Application and Survey and Certification Report AGENCY: CMS	CMS-3427	<u>Issue Date:</u> 11/16/2015 <u>Due Date:</u> 1/15/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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80.b.	Advanced Beneficiary Notice of Noncoverage ACTION: Request for Comment NOTICE: Advance Beneficiary Notice of Noncoverage AGENCY: CMS	CMS-R-131	Issue Date: 12/12/2012 Due Date: 2/11/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 2/26/2013; issued extension 11/9/2015 Due Date: 3/28/2013; 1/8/2016	• Summary of Agency action: ✓ • NIHB analysis of action: • Summary of subsequent Agency action: ✓	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
118.	Hospital Wage Index Occupational Mix Survey ACTION: Request for Comment NOTICE: Hospital Wage Index Occupational Mix Survey and Supporting Regulations AGENCY: CMS	CMS-10079	Issue Date: 12/7/2012 Due Date: 2/5/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 2/28/2013; issued extension 10/9/2015, 12/28/2015 Due Date: 4/1/2013; 12/8/2015; 1/27/2016	• Summary of Agency action: ✓ • NIHB analysis of action: • Summary of subsequent Agency action: ✓	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
121.m.	Medicare Enrollment Application--DMEPOS Suppliers ACTION: Request for Comment NOTICE: Medicare Enrollment Application--Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers AGENCY: CMS	CMS-855S	Issue Date: 9/11/2015 Due Date: 11/10/2015 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued revision 12/18/2015 Due Date: 1/19/2016	• 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.n.	Medicare Registration Application ACTION: Request for Comment NOTICE: Medicare Registration Application AGENCY: CMS	CMS-855O	Issue Date: 12/11/2015 Due Date: 2/9/2016 NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
129.b.	Awarding and Administration of MAC Contracts ACTION: Notice NOTICE: Medicare Program; Request for Information Regarding the Awarding and the Administration of Medicare Administrative Contractor Contracts AGENCY: CMS	CMS-1653-NC	Issue Date: 12/21/2015 Due Date: 2/19/2016 NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
136.c.	PQRS and the eRx Incentive Program Data Assessment ACTION: Request for Comment NOTICE: Physician Quality Reporting System (PQRS) and the Electronic Prescribing Incentive (eRx) Program Data Assessment, Accuracy and Improper Payments Identification Support AGENCY: CMS	CMS-10519	Issue Date: 3/17/2014 Due Date: 5/16/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 9/8/2014; issued revision 9/25/2015, 1/29/2016 Due Date: 10/6/2014; 11/24/2015; 2/29/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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136.e.	Requirements for Reporting Quality Measures ACTION: Request for Information NOTICE: Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs AGENCY: CMS	CMS-3323-NC	<u>Issue Date:</u> 12/31/2016 <u>Due Date:</u> 2/1/2016 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
137.d.	Data Collection for Beneficiaries Receiving Beta Amyloid PET ACTION: Request for Comment NOTICE: Data Collection for Medicare Beneficiaries Receiving Beta Amyloid Positron Emission Tomography (PET) for Dementia and Neurodegenerative Disease AGENCY: CMS	CMS-10583	<u>Issue Date:</u> 9/25/2015 <u>Due Date:</u> 11/24/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued new request 12/8/2015 <u>Due Date:</u> 1/7/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
142.a.	Detailed Notice of Discharge ACTION: Request for Comment NOTICE: Detailed Notice of Discharge (DND) AGENCY: CMS	CMS-10066	<u>Issue Date:</u> 3/6/2013 <u>Due Date:</u> 5/6/2013 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension 5/17/2013, 11/27/2015 <u>Due Date:</u> 6/17/2013; 1/26/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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142.b.	Important Message from Medicare ACTION: Request for Comment NOTICE: Important Message from Medicare (IM) AGENCY: CMS	CMS-R-193	<u>Issue Date:</u> 3/6/2013 <u>Due Date:</u> 5/6/2013 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension 5/17/2013, 12/8/2015 <u>Due Date:</u> 6/17/2013; 2/8/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> 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	<u>Issue Date:</u> [Approved by OMB 10/9/2014] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
195.c.	Collection of Customer Satisfaction Surveys ACTION: Request for Comment NOTICE: Generic Clearance for the Collection of Customer Satisfaction Surveys AGENCY: CMS	CMS-10415	<u>Issue Date:</u> 10/30/2015 <u>Due Date:</u> 12/29/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension 12/30/2015 <u>Due Date:</u> 1/29/2015	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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			SECTION III: HEALTH REFORM		
6.i.	Pre-Existing Health Insurance Plan Program Updates ACTION: Interim Final Rule NOTICE: Pre-Existing Condition Insurance Plan Program Updates AGENCY: CMS	CMS-9995-IFC4	<u>Issue Date:</u> [Pending at OMB as of 2/3/2015] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
7.jjj.	Establishment of QHPs and Exchanges ACTION: Request for Comment NOTICE: Establishment of Qualified Health Plans and American Health Benefit Exchanges AGENCY: CMS	CMS-10400	<u>Issue Date:</u> 11/23/2015 <u>Due Date:</u> 1/22/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
7.kkk.	ECP Petition for 2017 ACTION: Notice NOTICE: Essential Community Provider Petition for the 2017 Benefit Year AGENCY: CCIIO	CCIIO (no reference number)	<u>Issue Date:</u> 12/9/2015 <u>Due Date:</u> 1/8/2016 1/15/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued due date extension	<ul style="list-style-type: none"> Summary of Agency action: ✓ TSGAC analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
7.III.	2017 Letter to Issuers in FFMs ACTION: Guidance NOTICE: Draft 2017 Letter to Issuers in the Federally-Facilitated Marketplaces AGENCY: CCIIO	CCIIO (no reference number)	<u>Issue Date:</u> 12/23/2015 <u>Due Date:</u> 1/17/2016 <u>TSGAC File Date:</u> 1/17/2016 <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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7.mmm.	Establishment of an Exchange by a State and QHPs ACTION: Request for Comment NOTICE: Establishment of an Exchange by a State and Qualified Health Plans AGENCY: CMS	CMS-10593	Issue Date: 12/2/2015 Due Date: 2/1/2016 NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
7.nnn.	Establishment of Exchanges and QHPs--Standards for Employers ACTION: Request for Comment NOTICE: Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers AGENCY: CMS	CMS-10592	Issue Date: 12/2/2015 Due Date: 2/1/2016 NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
7.ooo.	CMS Healthcare.gov Site Wide Online Survey ACTION: Request for Comment NOTICE: CMS Healthcare.gov Site Wide Online Survey AGENCY: CMS	CMS-10597	Issue Date: 12/14/2015 Due Date: 2/12/2016 NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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12.f.	FAQs on the CO-OP Program ACTION: Guidance NOTICE: Frequently Asked Questions on the Consumer Operated and Oriented Plan (CO-OP) Program AGENCY: CCIIO	CCIIO (no reference number)	<u>Issue Date:</u> 1/27/2016 <u>Due Date:</u> None <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
29.d.	Minimum Value of Eligible Employer-Sponsored Plans ACTION: Proposed Final Rule NOTICE: Minimum Value of Eligible Employer-Sponsored Plans and Other Rules Regarding the Health Insurance Premium Tax Credit AGENCY: IRS	REG 125398-12 REG 143800-44 TD 9745	<u>Issue Date:</u> 5/3/2013 <u>Due Date:</u> 7/2/2013 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued supplement to Proposed Rule 9/1/2015; issued Final Rule 12/18/2015; issued correction 1/15/2016 <u>Due Date:</u> 11/2/2015	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
31.ddd.	2017 Actuarial Value Calculator ACTION: Guidance NOTICE: Draft 2017 Actuarial Value Calculator AGENCY: CCIIO	CCIIO (no reference number)	<u>Issue Date:</u> 11/20/2015 <u>Due Date:</u> 12/7/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued Final Guidance 1/21/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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50.f.	Eligibility and Enrollment for Employees in SHOP ACTION: Request for Comment NOTICE: Data Collection to Support Eligibility Determinations and Enrollment for Employees in SHOP AGENCY: CMS	CMS-10438 See also 50.m.	<u>Issue Date:</u> 1/29/2012 <u>Due Date:</u> 2/28/2013 <u>NIHB File Date:</u> 2/28/2013 <u>Date of Subsequent Agency Action, if any:</u> Issued revision 12/11/2015 <u>Due Date:</u> 2/9/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: ✓ Subsequent Agency action: ✓ Analysis of Agency action: ✓
50.g.	Eligibility and Enrollment for Small Businesses in SHOP ACTION: Request for Comment NOTICE: Data Collection to Support Eligibility Determinations and Enrollment for Small Businesses in SHOP AGENCY: CMS	CMS-10439 See also 50.m.	<u>Issue Date:</u> 1/29/2012 <u>Due Date:</u> 2/28/2013 <u>NIHB File Date:</u> 2/28/2013 <u>Date of Subsequent Agency Action, if any:</u> Issued revision 12/11/2015 <u>Due Date:</u> 2/9/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: ✓ Subsequent Agency action: ✓ Analysis of Agency action: ✓
50.h.	Eligibility for Insurance Affordability Programs and Enrollment ACTION: Request for Comment NOTICE: Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment Through Affordable Insurance Exchanges, Medicaid and CHIP Agencies AGENCY: CMS	CMS-10440	<u>Issue Date:</u> 1/29/2012 <u>Due Date:</u> 2/28/2013 <u>NIHB File Date:</u> 2/28/2013 <u>Date of Subsequent Agency Action, if any:</u> 4/30/2013; issued extension 12/2/2015 <u>Due Date:</u> 2/1/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: ✓ Subsequent Agency action: ✓ Analysis of Agency action: ✓

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50.aa.	SHOP Effective Date and Termination Notice Requirements ACTION: Request for Comment NOTICE: Small Business Health Options Program (SHOP) Effective Date and Termination Notice Requirements AGENCY: CMS	CMS-10555	<u>Issue Date:</u> 3/9/2015 <u>Due Date:</u> 5/8/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued new request 12/14/2015 <u>Due Date:</u> 1/13/2016	<ul style="list-style-type: none"> • Summary of Agency action: ✓ • NIHB analysis of action: ✓ • Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> • 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	<u>Issue Date:</u> [Approved by OMB 4/26/2012] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> • Summary of Agency action: • NIHB analysis of action: 	<ul style="list-style-type: none"> • NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
67.a.	State Consumer Assistance Grants ACTION: Request for Comment NOTICE: Consumer Assistance Program Grants AGENCY: CMS	CMS-10333	<u>Issue Date:</u> 7/27/2012 <u>Due Date:</u> 9/25/2012 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued revision 12/7/2012; issued extension 11/2/2015, 1/20/2016 <u>Due Date:</u> 2/7/2013; 1/4/2016; 2/19/2016	<ul style="list-style-type: none"> • Summary of Agency action: ✓ • NIHB analysis of action: • Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> • NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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89.g.	Cost Sharing Reduction Reconciliation ACTION: Request for Comment NOTICE: Cost Sharing Reduction Reconciliation AGENCY: CMS	CMS-10526	Issue Date: 6/27/2014 Due Date: 8/26/2014 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 9/26/2014; issued revision 9/14/2015, 1/20/2016 Due Date: 10/27/2014; 11/13/2015; 2/19/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
89.n.	Manual for Reconciliation of Advance Payment of CSRs ACTION: Guidance NOTICE: Draft Manual for Reconciliation of Advance Payment of Cost-Sharing Reductions for Benefit Years 2014 and 2015 AGENCY: CCIIO	CCIIO (no reference number)	Issue Date: 1/15/2016 Due Date: 2/15/2016 NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
92.b.	Compliance with Individual and Group Market Reforms ACTION: Request for Comment NOTICE: Information Collection Requirements for Compliance with Individual and Group Market Reforms AGENCY: CMS	CMS-10430	Issue Date: 11/21/2012 Due Date: 1/22/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued reinstatement 2/22/2013; issued revision 12/2/2015 Due Date: 3/25/2013; 2/1/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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92.ccc.	Rate Filing Justifications for 2016 for Single Risk Pool Coverage ACTION: Guidance NOTICE: DRAFT Bulletin: Timing of Submission and Posting of Rate Filing Justifications for the 2016 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2017 AGENCY: CCIIO	CCIIO (no reference number)	Issue Date: 12/23/2015 Due Date: 1/22/2016 NIHB File Date: None Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
92.ddd.	Evaluation of EDGE Data Submissions for 2015 ACTION: Guidance NOTICE: EDGE Server Data Bulletin--INFORMATION: Evaluation of EDGE Data Submissions for 2015 Benefit Year for Interim Reinsurance Payments and Interim Risk Adjustment Summary Report AGENCY: CCIIO	CCIIO (no reference number)	Issue Date: 1/21/2016 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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111.f.	Mental Health Parity Rules: External Review for MSPP ACTION: Request for Comment NOTICE: Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008: Technical Amendment to External Review for MSPP AGENCY: IRS	TD 9640 (OMB 1545-2165)	<u>Issue Date:</u> 11/27/2015 <u>Due Date:</u> 1/26/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
112.d.	IT/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	<u>Issue Date:</u> 12/5/2014 <u>Due Date:</u> 1/20/2015 2/4/2015 <u>NIHB File Date:</u> 2/4/2015 <u>Date of Subsequent Agency Action, if any:</u> Issued due date extension 1/14/2015; sent Final Rule to OMB 12/14/2015	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: ✓ Subsequent Agency action: Analysis of Agency action:
112.i.	Expanded Access to Non-VA Care Through Veterans Choice ACTION: Interim Final Rule NOTICE: Expanded Access to Non-VA Care Through the Veterans Choice Program AGENCY: VA	VA RIN 2900-AP60	<u>Issue Date:</u> 12/1/2015 <u>Due Date:</u> 3/30/2016 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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112.m.	Dear Tribal Leader Letter (Contract Support Costs Policy) ACTION: Notice NOTICE: Dear Tribal Leader Letter AGENCY: IHS	IHS (no reference number)	Issue Date: 1/7/2016 Due Date: Open 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:
112.n.	Catastrophic Health Emergency Fund ACTION: Proposed Rule NOTICE: Catastrophic Health Emergency Fund AGENCY: IHS	IHS RIN 0905-AC97	Issue Date: 1/26/2016 Due Date: 3/11/2016 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:
112.o.	IHS Reimbursement Rates for CY 2016 ACTION: Notice NOTICE: Reimbursement Rates for Calendar Year 2016 AGENCY: IHS	IHS RIN 0917-ZA30	Issue Date: [Pending at OMB as of 12/31/2015] 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:
149.	Evaluation of the Graduate Nurse Education Demonstration ACTION: Request for Comment NOTICE: Evaluation of the Graduate Nurse Education Demonstration Program AGENCY: CMS	CMS-10467	Issue Date: 4/4/2013 Due Date: 6/3/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued new request 6/28/2013; issued revision 10/16/2015, 1/19/2016 Due Date: 7/29/2013; 12/15/2015; 2/28/2016	• 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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			SECTION IV: OTHER		
82.j.	Complaint Forms for Health Information Privacy Issues ACTION: Request for Comment NOTICE: Complaint Forms for Discrimination; Health Information Privacy Complaints AGENCY: HHS OCR	HHS-OS-0945-0002-60D HHS-OS-0945-0002-30D	Issue Date: 10/20/2015 Due Date: 12/21/2015 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 12/28/2015 Due Date: 1/27/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
95.	IHS Forms to Implement the Privacy Rule ACTION: Request for Comment NOTICE: IHS Forms to Implement Privacy Rule (45 CFR Parts 160; 164) AGENCY: IHS	IHS-810, -912-1, -912-2, -913, and -917	Issue Date: 10/2/2012 Due Date: 60 days (approx. 11/30/2012) NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 1/22/2016 Due Date: 3/22/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
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 revision 3/5/2013, 4/23/2013, 7/23/2013, 11/12/2013, 9/2/2014, 10/27/2014, 1/27/2015, 8/17/2015, 11/3/2015, 1/27/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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189.c.	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: 1/25/2016 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:
194.f.	340B Drug Pricing Program Reporting Requirements ACTION: Request for Comment NOTICE: 340B Drug Pricing Program Reporting Requirements AGENCY: HRSA	HRSA (OMB 0915-0176)	Issue Date: 12/23/2015 Due Date: 2/22/2016 NIHB File Date: Date of Subsequent Agency Action, if any:	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: ✓ 	<ul style="list-style-type: none"> 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, 2/9/2015, 1/27/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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205.	Sharing What Works--BPPPLE Form ACTION: Request for Comment NOTICE: IHS Sharing What Works --Best Practice, Promising Practice, and Local Effort (BPPPLE) Form AGENCY: IHS	IHS (OMB 0917-0034)	Issue Date: 10/9/2015 Due Date: 12/8/2015 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 11/17/2015; issued due date extension 12/15/2015 Due Date: 12/17/2015 1/9/2016	<ul style="list-style-type: none"> Summary of Agency action: ✓ NIHB analysis of action: Summary of subsequent Agency action: ✓ 	<ul style="list-style-type: none"> NIHB recommendations included: Subsequent Agency action: Analysis of Agency action:

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1.p.	<p>Health IT Certification Program: Enhanced Oversight</p> <p>ACTION: Proposed Rule</p> <p>NOTICE: ONC Health IT Certification Program: Enhanced Oversight and Accountability</p> <p>AGENCY: HHS ONC</p>	HHS ONC RIN 0955-AA00	<p><u>Issue Date:</u> [Pending at OMB as of 1/25/2016]</p> <p><u>Due Date:</u></p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION:</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	
4.n.	<p>CORF Eligibility and Survey Forms</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Comprehensive Outpatient Rehabilitation Facility (CORF) Eligibility and Survey Forms and Supporting Regulations</p> <p>AGENCY: CMS</p>	CMS-359/360	<p><u>Issue Date:</u> 1/4/2016</p> <p><u>Due Date:</u> 3/4/2016</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension of a currently approved collection; Title: Comprehensive Outpatient Rehabilitation Facility (CORF) Eligibility and Survey Forms and Supporting Regulations; Use: CMS-359 serves as the application for health care providers seeking to participate in the Medicare program as a Comprehensive Outpatient Rehabilitation Facility (CORF). This form initiates the process for facilities to become certified as a CORF and provides the CMS Regional Office State Survey Agency staff identifying information regarding the applicant that is stored in the Automated Survey Processing Environment (ASPEN) system.</i></p> <p>CMS-360 serves as a survey tool used by the State Survey Agencies to record information to determine provider compliance with the CORF Conditions of Participation (CoPs) and to report this information to the federal government. This form includes basic information on the CoP requirements, check boxes to indicate the level of compliance, and a section for recording notes. CMS has the responsibility and authority for certification decisions based on provider compliance with the CoPs, and this form supports that process.</p> <p>https://www.gpo.gov/fdsys/pkg/FR-2016-01-04/pdf/2015-32965.pdf</p>	

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					SUMMARY OF NIHB ANALYSIS:	
5.a.	<p>PACE Information Request</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Medicare and Medicaid; Programs of All-Inclusive Care for the Elderly (PACE)</p> <p>AGENCY: CMS</p>	CMS-R-244	<p><u>Issue Date:</u> 7/30/2010</p> <p><u>Due Date:</u> 9/28/2010</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued extension 10/8/2010, 10/4/2013, 12/20/2013, 12/8/2015</p> <p><u>Due Date:</u> 11/8/2010; 12/3/2013; 1/21/2014; 2/8/2016</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension of a currently approved collection; Title:</i> Programs for All-inclusive Care of the Elderly (PACE) and Supporting Regulations; <i>Use:</i> The PACE organizations must demonstrate their ability to provide quality community-based care for the frail elderly who meet their state nursing home eligibility standards using capitated payments from Medicare and the state. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management, with controlled access to and allocation of all health services. Participants receive physician, therapeutic, ancillary, and social support services in their residence or onsite at the adult day health center. The PACE programs must provide all Medicare and Medicaid covered services, including hospital, nursing home, home health, and other specialized services. Financing of this model occurs through prospective capitation of both Medicare and Medicaid payments. The information collection requirements ensure that only appropriate organizations become PACE organizations and that CMS has the information necessary to monitor the care provided to the frail, vulnerable population served.</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 10/8/2010 issued an extension of this PRA request.</p> <p>CMS on 10/4/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf</p> <p>CMS on 12/20/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30334.pdf</p> <p>CMS on 12/8/2015 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-12-08/pdf/2015-30891.pdf</p> <p>No comments recommended.</p>	
5.d.	PACE Update	CMS-4168-P	<u>Issue Date:</u>		SUMMARY OF AGENCY ACTION: This proposed rule would update the PACE	

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	ACTION: Proposed Rule NOTICE: Programs of All-Inclusive Care for the Elderly (PACE) Update AGENCY: CMS		[Pending at OMB as of 1/25/2016] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		regulations published on 12/8/2006. This proposed rule would improve the quality of the existing regulations, provide operational flexibility and modifications, and remove redundancies and outdated information. These updates seek to ensure the health and safety of PACE participants. SUMMARY OF NIHB ANALYSIS:	
6.i.	Pre-Existing Health Insurance Plan Program Updates ACTION: Interim Final Rule NOTICE: Pre-Existing Condition Insurance Plan Program Updates AGENCY: CMS	CMS-9995-IFC4	<u>Issue Date:</u> [Pending at OMB as of 2/3/2015] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: SUMMARY OF NIHB ANALYSIS:	
7.jjj.	Establishment of QHPs and Exchanges ACTION: Request for Comment	CMS-10400	<u>Issue Date:</u> 11/23/2015 <u>Due Date:</u> 1/22/2015		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Revision of a currently approved collection; Title: Establishment of Qualified Health Plans and American Health Benefit Exchanges; Use: ACA expands access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Insurance Exchanges (Exchanges), including the Small Business Health Options Program (SHOP).</i>	



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	NOTICE: Establishment of Qualified Health Plans and American Health Benefit Exchanges AGENCY: CCIIO		<u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		<p>As directed by the rule titled "Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers" (Exchange rule), each Exchange will assume responsibilities related to the certification and offering of qualified health plans (QHPs). To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as QHPs by the Exchange. A QHP must meet certain minimum certification standards, such as network adequacy, inclusion of essential community providers (ECPs), and non-discrimination. The Exchange must ensure that QHPs meet these minimum certification standards as described in the Exchange rule under 45 CFR 155 and 156, based on ACA, as well as other standards determined by the Exchange. The reporting requirements and data collection in the Exchange rule address federal requirements that various entities must meet with respect to the establishment and operation of an Exchange; minimum requirements that health insurance issuers must meet with respect to participation in a State-Based or Federally-Facilitated Exchange; and requirements that employers must meet with respect to participation in the SHOP and compliance with other provisions of ACA.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-11-23/pdf/2015-29725.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	
7.kkk.	ECP Petition for 2017 ACTION: Notice NOTICE: Essential Community Provider Petition for the 2017 Benefit Year AGENCY: CCIIO	CCIIO (no reference number)	<u>Due Date:</u> 1/8/2016 1/15/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued due date extension		<p>SUMMARY OF AGENCY ACTION: In accordance with section 1311(c)(1)(C) of the ACA, qualified health plan (QHP), including stand-alone dental plan (SADP) issuers must include within their network essential community providers (ECPs), where available, that serve predominantly low-income, medically-underserved individuals. Under this same section of ACA, the HHS Secretary must establish criteria for certification of health plans as QHPs, including criteria for issuer satisfaction of the ECP inclusion requirement. Under 45 CFR 156.235, the HHS Secretary has established criteria for inclusion of a sufficient number and geographic distribution of ECPs, where available, in the networks of issuers to ensure reasonable and timely access to a broad range of such providers for low-income, medically-underserved individuals in their service areas. To satisfy this ECP requirement, QHP and SADP issuers must submit an ECP template as part of their QHP application, in which they must list the ECPs with which they have contracted to provide health care services to low-income, medically-underserved individuals in their service areas.</p>	

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					<p>HHS has compiled a non-exhaustive list of available ECPs, based on data it and other federal agencies maintain, that has served as an initial source of ECP information. The non-exhaustive HHS ECP list for the 2016 benefit year is available at https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/ghp.html. HHS updates this ECP list annually to assist issuers with identifying providers that qualify for inclusion in issuer networks toward satisfaction of the ECP standard under 45 CFR 156.235. That regulation defines ECPs as health care providers serving predominantly low-income, medically-underserved individuals. They include health care providers defined in section 340B(a)(4) of the Public Health Service Act (PHS Act) and described in section 1927(c)(1)(D)(IV) of the Social Security Act (Act).</p> <p>Interested parties should submit their petition by no later than 11:59 p.m. ET on 1/8/2016 in order for HHS to consider their provider data for the 2017 ECP List. HHS will allow petitions submitted after 1/8/2016 but no later than 8/22/2016 as a write-in for a respective issuer that has listed the provider on its ECP template for the 2017 QHP certification cycle.</p> <p>https://data.healthcare.gov/ccio/ecp_petition</p> <p>More information on QHPs is available on the CCIIO Web site at https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/ghp.html.</p> <p>SUMMARY OF TSGAC ANALYSIS: A TSGAC briefing memo on the petition is embedded below.</p> <p> TSGAC-Memo-Action -Needed-to-Retain-St</p> <p>A TSGAC briefing memo that includes the steps to submitting the petition and the final HHS ECP List for 2017 is embedded below.</p> <p> TSGAC Memo - Steps to Update -or</p>	

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7.III.	<p>2017 Letter to Issuers in FFMs</p> <p>ACTION: Guidance</p> <p>NOTICE: Draft 2017 Letter to Issuers in the Federally-Facilitated Marketplaces</p> <p>AGENCY: CCIIO</p>	CCIIO (no reference number)	<p><u>Issue Date:</u> 12/23/2015</p> <p><u>Due Date:</u> 1/17/2016</p> <p><u>TSGAC File Date:</u> 1/17/2016</p> <p><u>Date of Subsequent Agency Action, if any:</u></p>	TSGAC response:	<p>SUMMARY OF AGENCY ACTION: This draft 2017 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 2017. Unless otherwise specified, references to the FFMs include the FF-SHOPs.</p> <p>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 also describes how parts of this Letter apply to issuers in State-Based Marketplaces on the Federal Platform (SBM-FPs). CMS notes that the policies articulated in this Letter apply to the certification process for plan years beginning in 2017.</p> <p>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. CMS proposed additional standards in a proposed rule titled, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017" (2017 Payment Notice Proposed Rule, CMS 9937-P), which appeared in the 12/2/2015 FR. 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.</p> <p>Throughout the plan year, QHP issuers might have to correct deficiencies identified in CMS post-certification activities, as a result of the investigation of consumer cases, oversight by State regulators or by CMS, or an industry-standard internal compliance and risk management program of the issuer. QHP issuers in the FFMs also might have to meet other requirements for plan years beginning in 2017, as indicated in future rulemaking.</p> <p>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 2017 Payment Notice Proposed Rule, stakeholders should comment on those underlying policies through the ongoing rulemaking processes and not through the comment process</p>	See Table C.

TABLE B: SUMMARY OF NOTICES & REGULATIONS
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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.
					<p>for this Letter. Please send comments on other aspects of this Letter to FFEcomments@cms.hhs.gov by 1/17/2016. Interested parties should submit comments organized by subsections of this Letter.</p> <p>https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2017-Letter-to-Issuers-12-23-2015_508.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: A related multi-year analysis of the provisions in this annual Letter is embedded below.</p> <p> Matrix- CCIO Issuer Letters - Select Marke</p>	
7.mmm.	<p>Establishment of an Exchange by a State and QHPs</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Establishment of an Exchange by a State and Qualified Health Plans</p> <p>AGENCY: CMS</p>	CMS-10593	<p><u>Issue Date:</u> 12/2/2015</p> <p><u>Due Date:</u> 2/1/2016</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension of a currently approved collection; Title:</i> Establishment of an Exchange by a State and Qualified Health Plans; <i>Use:</i> ACA expands access to health insurance for individuals and employees of small businesses through the establishment of new Affordable Insurance Exchanges (Exchanges), including the Small Business Health Options Program (SHOP). As directed by the rule Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (77 FR 18310) (Exchange rule), each Exchange will assume responsibilities related to the certification and offering of qualified health plans (QHPs). To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as QHPs by the Exchange. A QHP must meet certain minimum certification standards, such as network adequacy, inclusion of essential community providers (ECPs), and nondiscrimination. The Exchange must ensure that QHPs meet these minimum certification standards as described in the Exchange rule under 45 CFR parts 155 and 156, based on ACA, as well as other standards determined by the Exchange. The reporting requirements and data collection in the Exchange rule address federal requirements that various entities must meet with respect to the establishment and operation of an Exchange; minimum requirements that health insurance issuers must meet with respect to participation in a State-Based or Federally-Facilitated Exchange; and requirements that employers must meet with respect to participation in the SHOP and compliance with other provisions of ACA.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-30534.pdf</p>	

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					SUMMARY OF NIHB ANALYSIS: This PRA notice might include issues on which tribal organizations want to comment.	
7.nnn.	<p>Establishment of Exchanges and QHPs-- Standards for Employers</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers</p> <p>AGENCY: CMS</p>	CMS-10592	<p><u>Issue Date:</u> 12/2/2015</p> <p><u>Due Date:</u> 2/1/2016</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request:</i> <u>New collection</u>; <i>Title:</i> Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; <i>Use:</i> Section 1321(a) requires HHS to issue regulations setting standards for meeting the requirements under Title I of ACA, including the offering of qualified health plans (QHPs) through the Marketplaces. On 3/27/2012, HHS published the rule CMS-9989-F, Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (Exchange rule). The Exchange rule contains provisions that mandate reporting and data collections necessary to ensure that health insurance issuers meet the requirements of ACA. These information collection requirements appear in 45 CFR part 156. The data collection and reporting requirements will assist HHS in creating a seamless and coordinated system of eligibility and enrollment. The data collected by health insurance issuers will help to inform HHS, Marketplaces, and health insurance issuers as to the participation of individuals, employers, and employees in the individual Exchange.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-30534.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: CMS-10592 seeks OMB approval of the regulatory PRA requirements associated with the minimum requirements that health insurance issuers must meet with respect to participation in the Marketplaces, specifically the following sections of 45 CFR part 156:</p> <ul style="list-style-type: none"> • QHP issuer notice of effective date (§156.260(b)); • QHP issuer reconciliation of enrollment files with Exchange (§156.265(f)); • QHP issuer termination notice to the enrollee and Exchange (§156.270(b)); • QHP issuer notice of enrollee nonpayment of premium (§156.270(d)); • QHP issuer notice to providers of the possibility for denied claims (§156.270(d)(3)); • QHP issuer notice of payment delinquency to an enrollee (§156.270(e)); • QHP issuers maintenance of records of terminations of coverage (§156.270(h)); and • QHP issuer notification of plan non-renewal (§156.290). 	

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					This PRA request does not have any associated forms or templates. A Supporting Statement for this PRA request is available at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10592.html .	
7.000.	<p>CMS Healthcare.gov Site Wide Online Survey</p> <p>ACTION: Request for Comment</p> <p>NOTICE: CMS Healthcare.gov Site Wide Online Survey</p> <p>AGENCY: CMS</p>	CMS-10597	<p><u>Issue Date:</u> 12/14/2015</p> <p><u>Due Date:</u> 2/12/2016</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: New collection; Title:</i> CMS Healthcare.gov Site Wide Online Survey; <i>Use:</i> This survey seeks to gain an understanding of user experience, comprehension, and satisfaction with using the federal Health Insurance Marketplace Web site established by ACA. The Marketplace provides coverage to uninsured U.S. residents, as well as those already enrolled in Marketplace health insurance. One of the ways to purchase Marketplace insurance involves the use of the online tools on HealthCare.gov. CMS has developed a survey for consumers to take while using the Web site. This survey represents part of a continuing data collection program mandated by ACA. It seeks to support the program goal to provide tools and information to help consumers successfully find health insurance for which they might not otherwise qualify for or might not find. Monitoring usability and the user experience through this ongoing survey provides the Web site developers with valuable information for use in continuous improvement of the Web site.</p> <p>https://www.gpo.gov/fdsys/pkg/FR-2015-12-14/pdf/2015-31399.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: No comments recommended.</p>	
10.g.	<p>Medicare Shared Savings Program: ACO Benchmarking</p> <p>ACTION: Proposed Rule</p> <p>NOTICE: Medicare Shared Savings Program; Accountable Care Organizations--Revised Benchmarking Methodology</p>	CMS-1644-P	<p><u>Issue Date:</u> [Approved by OMB 1/27/2016]</p> <p><u>Due Date:</u></p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent</u></p>		<p>SUMMARY OF AGENCY ACTION: This proposed rule would address changes to the Medicare Shared Savings Program, specifically a revised benchmarking methodology, which affects Medicare payments to providers of services and suppliers participating in accountable care organizations (ACOs) under the Medicare Shared Savings Program. These changes would apply to existing ACOs and approved ACO applicants participating in the program beginning 1/1/2017.</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	

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	AGENCY: CMS		<u>Agency Action, if any:</u>			
11.d.	<p>Bid Pricing Tool</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDPs)</p> <p>AGENCY: CMS</p>	CMS-10142	<p><u>Issue Date:</u> 10/5/2012</p> <p><u>Due Date:</u> 12/4/2012</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued revision 1/17/2013, 10/4/2013, 12/20/2013, 9/26/2014, 12/24/2014, 9/24/2015, 12/18/2015</p> <p><u>Due Date:</u> 2/19/2013; 12/3/2013; 1/21/2014; 11/25/2014; 1/23/2015; 11/23/2015; 1/19/2016</p>		<p>SUMMARY OF AGENCY ACTION: <i>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.</i></p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>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</p> <p>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</p> <p>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</p> <p>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</p> <p>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</p> <p>CMS on 9/24/2015 issued a revision of this PRA request.</p>	

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					http://www.gpo.gov/fdsys/pkg/FR-2015-09-24/pdf/2015-24263.pdf No comments recommended. CMS on 12/18/2015 issued a revision of this PRA request. CMS has revised this package subsequent to the publication of the 60-day notice in the 9/24/2015 FR (80 FR 57619). https://www.gpo.gov/fdsys/pkg/FR-2015-12-18/pdf/2015-31887.pdf No comments recommended.	
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	<u>Issue Date:</u> 10/5/2012 <u>Due Date:</u> 12/4/2012 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued revision 1/17/2013, 11/1/2013, 1/17/2014, 9/26/2014, 12/19/2014, 9/24/2015, 12/18/2015 <u>Due Date:</u> 2/19/2013;		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Revision of a currently approved collection; Title: Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP); Use:</i> 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.	

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			12/31/2013; 2/18/2014; 11/25/2014; 1/20/2015; 11/23/2015; 1/19/2016		<p>http://www.gpo.gov/fdsys/pkg/FR-2013-01-17/pdf/2013-00858.pdf</p> <p>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</p> <p>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</p> <p>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</p> <p>CMS on 12/19/2014 issued a revision of this PRA request. CMS has revised this 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</p> <p>CMS on 9/24/2015 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-09-24/pdf/2015-24263.pdf</p> <p>No comments recommended.</p> <p>CMS on 12/18/2015 issued a revision of this PRA request. CMS has revised this package subsequent to the publication of the 60-day notice in the 9/24/2015 FR (80 FR 57619). https://www.gpo.gov/fdsys/pkg/FR-2015-12-18/pdf/2015-31887.pdf</p> <p>No comments recommended.</p>	
11.i.	Medicare Advantage Appeals and Grievance Data Disclosure ACTION: Request for Comment	CMS-R-282	<p>Issue Date: 2/22/2013</p> <p>Due Date: 4/23/2013</p> <p>NIHB File</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension of a currently approved collection; Title: Medicare Advantage Appeals and Grievance Data Disclosure Requirements (42 CFR 422.111); Use: Section 1852(c)(2)(C) of the Social Security Act and 42 CFR 422.111(c)(3) require that Medicare Advantage (MA) organizations and demonstrations disclose information pertaining to the number of disputes, as well as their disposition in the aggregate, with the categories of grievances and appeals to any individual eligible to elect an MA organization who requests this</i></p>	

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	<p>NOTICE: Medicare Advantage Appeals and Grievance Data Disclosure Requirements</p> <p>AGENCY: CMS</p>		<p><u>Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued extension 5/3/2013, 12/14/2015</p> <p><u>Due Date:</u> 6/3/2013; 2/12/2016</p>		<p>information. MA organizations and demonstrations remain under a requirement to collect and provide this information to individuals eligible to elect an MA organization, and CMS continues to need the same format and form for reporting.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2013-02-22/pdf/2013-04120.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 5/3/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-05-03/pdf/2013-10530.pdf</p> <p>Instructions for information disclosure, a model disclosure form, and a Supporting Statement are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1205062.html.</p> <p>The Instructions do not require identification of specific categories of appeals (other than expedited appeals).</p> <p>CMS on 12/14/2015 issued an extension of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2015-12-14/pdf/2015-31399.pdf</p> <p>No comments recommended.</p>	
12.f.	<p>FAQs on the CO-OP Program</p> <p>ACTION: Guidance</p> <p>NOTICE: Frequently Asked Questions on the Consumer Operated and Oriented Plan (CO-OP) Program</p> <p>AGENCY: CCIIO</p>	CCIIO (no reference number)	<p><u>Issue Date:</u> 1/27/2016</p> <p><u>Due Date:</u> None</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent</u></p>		<p>SUMMARY OF AGENCY ACTION: This guidance answers several frequently asked questions regarding the Consumer Operated and Oriented Plan (CO-OP) Program.</p> <p>https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CO-OP-Questions-Final-1-27-16.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	

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			<u>Agency Action, if any:</u>			
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-P2F2	<u>Issue Date:</u> 5/3/2012 <u>Due Date:</u> 6/4/2012 7/2/2012 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued due date extension 5/3/2012; Final Rule approved by OMB 1/13/2014		<p>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.</p> <p>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, 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.</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	
20.a.	Assuring Access to Services ACTION: Proposed-Final Rule NOTICE: Medicaid Program; Methods for Assuring	CMS-2328-PFC	<u>Issue Date:</u> 5/6/2011 <u>Due Date:</u> 7/5/2011 <u>ANTHC File Date:</u>		<p>SUMMARY OF AGENCY ACTION: This proposed rule would create a standardized, transparent process for states to follow as part of their broader efforts to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" as required by section 1902(a)(30)(A) of the Social Security Act (Act). This proposed rule also would recognize, as states have requested, electronic publication as an optional means of communicating proposed rate-setting policy changes</p>	

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	Access to Covered Medicaid Services AGENCY: CMS		7/5/2011 <u>Date of Subsequent Agency Action, if any:</u> Issued Final Rule 11/2/2015 <u>Due Date:</u> 1/4/2016		in state plan amendments (SPAs) to the public. SUMMARY OF ANTHC ANALYSIS: Although this proposed rule serves as an excellent first step in efforts to provide clearer standards and more actively monitor compliance with sufficiency and access requirements in section 1902(a)(30)(A), additional attention is needed for areas where access currently is inadequate. ANTHC generally approves of the MACPAC-recommended three-part framework for determining service access data elements: 1) information on enrollee needs, 2) availability of care and providers, and 3) utilization of services. In general, the Indian health system serves a patient population very different from that of the mainstream United States. As a result, if consideration was given to the availability of <i>culturally competent</i> care (and not just "care"), this would help ensure that states consider the unique position of Indian health programs and their patients when evaluating their Medicaid programs. ANTHC supports the proposed requirement that states submit Medicaid access data collected during the prior year in support of state plan amendments that reduce payment rates or restructure provider payments in circumstances when the resulting changes could create access issues, but Medicaid access data could vary tremendously from year to year, resulting in skewed statistics. The proposed rule suggests mechanisms for ongoing beneficiary input; the most effective way of reaching AI/ANs is through Indian health care providers and Tribes and tribal organizations. In soliciting comments on whether to delete the word "significant" from §447.205(a) on notice requirements, CMS correctly recognizes that it is extraordinarily difficult to determine a uniform threshold as to what constitutes a "significant" proposed change in the methods and standards for setting state payment rates for services. The proposed rule did not ask for comments on the exceptions to notice requirements contained in §447.205(b), but the exception for "changes made to conform to Medicare methods or levels of reimbursement" could exempt actions extremely disruptive to access. CMS proposes to allow states to substitute publication on a Web site for publication in print media. Although the additional notice avenue is useful, substituting it for other forms of notice could raise concerns unless some additional protections are added and conditions are satisfied. Given the significant challenges facing tribal health programs, as well as the critical role of third-party reimbursement to the very solvency of the tribal health system, virtually any change in state reimbursement rates will have a "direct effect" on tribal health programs. SUMMARY OF SUBSEQUENT AGENCY ACTION: This final rule with comment period provides for a transparent data-driven process for states to document whether they have sufficient Medicaid payments to enlist providers to assure beneficiary access to covered	

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					care and services consistent with section 1902(a)(30)(A) of the Social Security Act (Act) and to address issues raised by that process. This final rule with comment period also recognizes electronic publication as an optional means of providing public notice of proposed changes in rates or rate-setting methodologies that the state intends to include in a Medicaid state plan amendment (SPA). CMS has provided an opportunity for comment on whether it should make future adjustments to the provisions setting forth requirements for ongoing state reviews of beneficiary access. http://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27697.pdf	
20.b.	Data Metrics and Alternative Processes for Access to Care ACTION: Request for Information NOTICE: Medicaid Program; Request for Information (RFI)--Data Metrics and Alternative Processes for Access to Care in the Medicaid Program AGENCY: CMS	CMS-2328-NC	<u>Issue Date:</u> 11/2/2015 <u>Due Date:</u> 1/4/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: In this request for information (RFI), CMS seeks public input to inform the potential development of standards with regard to access to covered services for beneficiaries under the Medicaid program. Specifically, CMS requests information on core access to care measures and metrics that it could use to measure access to care for beneficiaries in the Medicaid program (including in fee-for-service and managed care delivery systems) and to develop local, state, and national thresholds and goals to inform and improve access in the program. CMS also seeks feedback on approaches to using the metrics, possibly including setting access goals and thresholds and creating formal processes for beneficiaries to raise access concerns. http://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27696.pdf SUMMARY OF NIHB ANALYSIS:	
23.b.	MACPro: New Online System for State Plan Amendments, Waivers, etc. ACTION: Request for Comment NOTICE: Medicaid and	CMS-10434	<u>Issue Date:</u> 12/21/2012 <u>Due Date:</u> 1/22/2013 <u>TSGAC File Date:</u> 1/22/2013	TSGAC response:	SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request:</i> New collection; <i>Title:</i> Medicaid and CHIP Program (MACPro); <i>Use:</i> Medicaid, authorized by Title XIX of the Social Security Act and, CHIP, reauthorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), play an important role in financing health care for approximately 48 million people throughout the country. By 2014, it is expected that an additional 16 million people will become eligible for Medicaid and CHIP as a result of the Affordable Care Act (Pub. L. 111-148). In order to implement the statute, CMS must provide a mechanism to ensure timely approval of Medicaid and CHIP state plans, waivers and demonstrations, and provide a repository for all Medicaid	See Table C.

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	CHIP Program (MACPro) AGENCY: CMS		<u>Date of Subsequent Agency Action, if any:</u> Issued revision 11/9/2015 <u>Due Date:</u> 1/8/2016		<p>and CHIP program data that supplies data to populate Healthcare.gov and other required reports. Additionally, 42 CFR 430.12 sets forth the authority for the submittal and collection of state plans and plan amendment information. Pursuant to this requirement, CMS has created the MACPro system.</p> <p>Generally, MACPro will be used by both state and CMS officials to: Improve the state application and federal review processes, improve federal program management of Medicaid programs and CHIP, and standardize Medicaid program data. More specifically, it will be used by state agencies to (among other things): (1) Submit and amend Medicaid state plans, CHIP state plans, and Information System Advanced Planning Documents, and (2) submit applications and amendments for state waivers, demonstration, and benchmark and grant programs. It will be used by CMS to (among other things): (1) Provide for the review and disposition of applications, and (2) monitor and track application activity. A paper-based version of the MACPro instrument would be sizable and time consuming for interested parties to follow as a paper-based instrument. In our effort to provide the public with the most efficient means to make sense of the MACPro system, we held four webinars in lieu of including a paper-based version of MACPro.</p> <p>SUMMARY OF TSCAG ANALYSIS: MACPro requires the State to submit information on both general and Tribal consultation processes in the "initial application," which the State completes at the outset of any submission. With regard to Tribal consultation, the application first asks whether "one or more Indian Health Programs or Urban Indian Organizations furnish health care services in this State." If the State answers "yes," the application asks whether "this state plan amendment is likely to have a direct effect on Indians, Indian health care programs, or urban Indian organizations." If the State answers "yes," the application asks whether "the State has solicited advice from Tribal governments prior to submission of this SPA application." If the State answers "yes," the application asks for the name of any Indian Tribe, Tribal organization, or urban Indian organization (I/T/U) consulted, the consultation date, and the method/location of the consultation. The State also must upload any copies of the consultation notices sent to I/T/Us. The State does not have to provide any summary of the Tribal comments received and/or its response (if any).</p> <p>After completion of the initial application, MACPro provides the State with a specific submission form that, unlike the general application, is specifically tailored to the exact action or amendments that the State proposes. MACPro also will send the State a</p>	

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					notification reminding it to complete this form. After the State submits its final package to CMS, MACPro will assign a CMS point of contact and review team to the SPA. The package is then "dispositioned" for approval, disapproval, and post-approval. Alternatively, if CMS reviews the package and determines a need for additional information, the review team will notify the State, which must resubmit the package to CMS. SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 11/9/2015 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-11-09/pdf/2015-28449.pdf No comments recommended.	
25.cc.	Revisions to Requirements for Discharge Planning for Hospitals ACTION: Proposed Rule NOTICE: Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies AGENCY: CMS	CMS-3317-P	<u>Issue Date:</u> 11/3/2015 <u>Due Date:</u> 1/4/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: This proposed rule would revise the discharge planning requirements that hospitals, including long-term care hospitals and inpatient rehabilitation facilities, critical access hospitals, and home health agencies must meet to participate in the Medicare and Medicaid programs. This proposed rule also would implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014. SUMMARY OF NIHB ANALYSIS:	
25.ee.	Design of Survey on Patient Experiences with Care in LTCHs ACTION: Request for	CMS-3327-NC	<u>Issue Date:</u> 11/20/2015 <u>Due Date:</u> 1/19/2016		SUMMARY OF AGENCY ACTION: This request for information will aid in the design and development of a survey regarding patient and family member experiences with the care received in long-term care hospitals (LTCHs). http://www.gpo.gov/fdsys/pkg/FR-2015-11-20/pdf/2015-29622.pdf	

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	Information NOTICE: Medicare Program; Request for Information To Aid in the Design and Development of a Survey Regarding Patient and Family Member Experiences with Care Received in Long-Term Care Hospitals AGENCY: CMS		<u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF NIHB ANALYSIS:	
25.ff.	Design of Survey on Patient Experiences with Care in IRFs ACTION: Request for Information NOTICE: Medicare Program; Request for Information To Aid in the Design and Development of a Survey Regarding Patient and Family Member Experiences with Care Received in Inpatient Rehabilitation Facilities AGENCY: CMS	CMS-3328-NC	<u>Issue Date:</u> 11/20/2015 <u>Due Date:</u> 1/19/2016 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: This request for information will aid in the design and development of a survey regarding patient and family member experiences with the care received in inpatient rehabilitation facilities (IRFs). http://www.gpo.gov/fdsys/pkg/FR-2015-11-20/pdf/2015-29623.pdf SUMMARY OF NIHB ANALYSIS:	
25.gg.	Inpatient Prospective Payment Systems--0.2	CMS-1658-NC	<u>Issue Date:</u> 12/1/2015		SUMMARY OF AGENCY ACTION: In accordance with the 10/6/2015 court order in <i>Shands Jacksonville Medical Center, Inc., et al. v. Burwell</i> , No. 14-263 (D.D.C.) and	

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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.
	Percent Reduction ACTION: Notice NOTICE: Medicare Program; Inpatient Prospective Payment Systems; 0.2 Percent Reduction AGENCY: CMS		<u>Due Date:</u> 2/2/2016 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		consolidated cases that challenge the 0.2 percent reduction in inpatient prospective payment systems (IPPS) rates to account for the estimated \$220 million in additional FY 2014 expenditures resulting from the 2-midnight policy, this notice discusses the basis for the 0.2 percent reduction and its underlying assumptions and invites comments on the same to facilitate further CMS consideration of the FY 2014 reduction. CMS will consider and respond to the comments received in response to this notice, and to comments already received on this issue in a final notice, which the agency will publish by 3/18/2016. http://www.gpo.gov/fdsys/pkg/FR-2015-12-01/pdf/2015-30486.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended.	
25.hh.	Explanation of FY 2004 Outlier Fixed-Loss Threshold ACTION: Notice NOTICE: Medicare Program; Explanation of FY 2004 Outlier Fixed-Loss Threshold as Required by Court Rulings AGENCY: CMS	CMS-1659-N	<u>Issue Date:</u> 1/22/2016 <u>Due Date:</u> None <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: In accordance with court rulings in cases that challenge the federal fiscal year (FY) 2004 outlier fixed-loss threshold rulemaking, this document provides further explanation of certain methodological choices made in the FY 2004 fixed-loss threshold determination. https://www.gpo.gov/fdsys/pkg/FR-2016-01-22/pdf/2016-01309.pdf SUMMARY OF NIHB ANALYSIS:	
25.ii.	Hospital Changes to Promote Innovation, etc. ACTION: Proposed Rule NOTICE: Hospital and Critical Access Hospital (CAH) Changes to Promote	CMS-3295-P	<u>Issue Date:</u> [Pending at OMB as of 1/4/2016] <u>Due Date:</u> <u>NIHB File</u>		SUMMARY OF AGENCY ACTION: This proposed rule would update the requirements that hospitals and critical access hospitals (CAHs) must meet to participate in the Medicare and Medicaid programs. This proposed rule would change the requirements to meet current standards of practice, as well as support improvements in quality of care, reduce barriers to care, and reduce some issues that might exacerbate workforce shortage concerns. SUMMARY OF NIHB ANALYSIS:	

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	Innovation, Flexibility, and Improvement in Patient Care AGENCY: CMS		<u>Date:</u> <u>Date of Subsequent Agency Action, if any:</u>			
26.	Medicaid Home Health ACTION: Proposed Final Rule NOTICE: Medicaid Program; Face-to-Face Requirements for Home Health Services; Policy Changes and Clarifications Related to Home Health AGENCY: CMS	CMS-2348-PF	<u>Issue Date:</u> 7/12/2011 <u>Due Date:</u> 9/12/2011 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Final Rule approved by OMB 1/21/2016		SUMMARY OF AGENCY ACTION: This proposed rule would revise the Medicaid home health service definition as required by section 6407 of ACA to add a requirement that physicians document the existence of a face-to-face encounter (including through the use of telehealth) with the Medicaid eligible individual within reasonable timeframes. This proposal would align the timeframes with similar regulatory requirements for Medicare home health services in accordance with section 6407 of ACA and would reflect the commitment of CMS to the general principles of Executive Order 13563, released on 1/18/2011 and titled "Improving Regulation and Regulatory Review." In addition, this rule proposes to amend home health services regulations to clarify the definitions of included medical supplies, equipment, and appliances, as well as clarify that States cannot limit home health services to services delivered in the home, or to services furnished to individuals who are homebound. SUMMARY OF NIHB ANALYSIS:	
29.d.	Minimum Value of Eligible Employer-Sponsored Plans ACTION: Proposed Final Rule NOTICE: Minimum Value of Eligible Employer-Sponsored Plans and Other	REG-125398-12 REG-143800-14 TD 9745	<u>Issue Date:</u> 5/3/2013 <u>Due Date:</u> 7/2/2013 <u>NIHB File Date:</u> None <u>Date of</u>		SUMMARY OF AGENCY ACTION: This document contains proposed regulations relating to the health insurance premium tax credit enacted by ACA, as amended by the Medicare and Medicaid Extenders Act of 2010, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, and the Department of Defense and Full-Year Continuing Appropriations Act, 2011. These proposed regulations affect individuals who enroll in qualified health plans through Affordable Insurance Exchanges (Exchanges) and claim the premium tax credit and Exchanges that make qualified health plans available to individuals and employers. These proposed regulations also provide guidance on determining whether health coverage under an eligible employer-sponsored plan provides minimum value and affect	

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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.
	Rules Regarding the Health Insurance Premium Tax Credit AGENCY: IRS		<u>Subsequent Agency Action, if any:</u> Issued supplement to Proposed Rule 9/1/2015; issued Final Rule 12/18/2015; issued correction 1/15/2016 <u>Due Date:</u> 11/2/2015		employers that offer health coverage and their employees. http://www.gpo.gov/fdsys/pkg/FR-2013-05-03/pdf/2013-10463.pdf SUMMARY OF NIHB ANALYSIS: This proposed rule includes a number of clarifying amendments to the premium tax credit in addition to the proposed regulations for determining acceptable minimum value for employer-sponsored coverage. No comments recommended. SUMMARY OF SUBSEQUENT AGENCY ACTION: IRS on 9/1/2015 issued a document that withdraws, in part, a notice of proposed rulemaking published on 5/3/2013 relating to the health insurance premium tax credit enacted by ACA (including guidance on determining whether health coverage under an eligible employer-sponsored plan provides minimum value) and replaces the withdrawn portion with new proposed regulations providing guidance on determining whether health coverage under an eligible employer-sponsored plan provides minimum value. These proposed regulations affect participants in eligible employer-sponsored health plans and employers that sponsor these plans. http://www.gpo.gov/fdsys/pkg/FR-2015-09-01/pdf/2015-21427.pdf This supplemental notice of proposed rulemaking reviews the IRS-imposed requirement to define "minimum value" of employer-sponsored coverage to include both (1) a requirement to cover at least 60 percent of the average costs of the covered services and (2) a requirement to include hospitalization and physician services, effective pursuant to the dates provided in the proposed rule. IRS on 12/18/2015 issued a document that contains final regulations on the health insurance premium tax credit enacted by ACA, as amended by the Medicare and Medicaid Extenders Act of 2010, the Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011, and the Department of Defense and Full-Year Continuing Appropriations Act, 2011. These final regulations affect individuals who enroll in qualified health plans (QHPs) through Affordable Insurance Exchanges (Exchanges, or Marketplaces) and claim the health insurance premium tax credit and Exchanges that make QHPs available to individuals and employers.	

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					https://www.gpo.gov/fdsys/pkg/FR-2015-12-18/pdf/2015-31866.pdf IRS on 1/15/2016 issued a document that contains corrections to final regulations (TD 9745) published in the 12/18/2015 FR (80 FR 78971). As published, the final regulations contain an error that might prove misleading and needs clarification. Accordingly, this document amends 26 CFR part 1. https://www.gpo.gov/fdsys/pkg/FR-2016-01-15/pdf/2016-00701.pdf	
31.ddd.	2017 Actuarial Value Calculator ACTION: Guidance NOTICE: Draft 2017 Actuarial Value Calculator AGENCY: CCIO	CCIO (no reference number)	<u>Issue Date:</u> 11/20/2015 <u>Due Date:</u> 12/7/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued Final Guidance 1/21/2016		<p>SUMMARY OF AGENCY ACTION: Under the Essential Health Benefits, Actuarial Value, and Accreditation final rule (EHB Final Rule) published in the 2/25/2013 FR (78 FR 12834), 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 (or Marketplaces) for the purposes of determining levels of coverage. Section 1302(d)(2)(A) of ACA stipulates calculation of AV 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 <i>de minimis</i> variation of +/- 2 percentage points of AV for each tier.</p> <p>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 document details the specific methodologies used in the AV calculation.</p> <p>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 draft 2017 AV Calculator. In the second part of this document, CCIO 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. The draft 2017 AV Calculator is available at https://www.cms.gov/CCIO/Resources/Regulations-and-Guidance/Downloads/Draft-2017-AV-Calculator-111615xlsm.xlsm.</p>	

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					<p>CCIIO will accepting comments on the draft 2017 AV Calculator, as well as the draft 2017 AV Calculator User Guide and the draft 2017 AV Calculator Methodology, until 5 p.m. on 12/7/2015. Interested parties should submit comments to the CMS Actuarial Value email at actuarialvalue@cms.hhs.gov.</p> <p>https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2017-AVC-Methodology-111915.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: Under the Essential Health Benefits, Actuarial Value, and Accreditation final rule (EHB Final Rule) published in the February 25, 2013, Federal Register (78 FR 12834), 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 (or Marketplaces) for the purposes of determining levels of coverage. Section 1302(d)(2)(A) of ACA stipulates calculation of AV 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 <i>de minimis</i> variation of +/- 2 percentage points of AV for each tier.</p> <p>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 document details the specific methodologies used in the AV calculation.</p> <p>CCIIO has revised this document from the 2016 version to incorporate updates in the final 2017 version, released on January 21, 2016. 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 2017 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. The final 2017 AV Calculator is available at</p>	

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					https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AV-Calculator-2017.xlsm . CCIIO notes that the final 2017 AV Calculator does not affect any 2016 plans and will only apply for 2017 plans. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-AVC-Methodology-012016.pdf	
41.f.	New Safe Harbors ACTION: Notice NOTICE: Solicitation of New Safe Harbors and Special Fraud Alerts AGENCY: HHS OIG	OIG-124-N	<u>Issue Date:</u> 12/23/2015 <u>Due Date:</u> 2/22/2016 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: In accordance with section 205 of HIPAA, this annual document solicits proposals and recommendations for developing new, and modifying existing, safe harbor provisions under the federal anti-kickback statute (section 1128B(b) of the Social Security Act), as well as developing new HHS OIG Special Fraud Alerts. https://www.gpo.gov/fdsys/pkg/FR-2015-12-23/pdf/2015-32267.pdf SUMMARY OF NIHB ANALYSIS:	
43.	Medicaid Reimbursement for Outpatient Drugs ACTION: Proposed -Final Rule NOTICE: Medicaid Program; Covered Outpatient Drugs AGENCY: CMS	CMS-2345-PF	<u>Issue Date:</u> 2/2/2012 <u>Due Date:</u> 4/2/2012 <u>NIHB File Date:</u> 4/2/2012 <u>Date of Subsequent Agency Action, if any:</u>	NIHB response:	SUMMARY OF AGENCY ACTION: This proposed rule would revise requirements pertaining to Medicaid reimbursement for covered outpatient drugs to implement provisions of ACA. This proposed rule also would revise other requirements related to covered outpatient drugs, including key aspects of Medicaid coverage, payment, and the drug rebate program. http://www.gpo.gov/fdsys/pkg/FR-2012-02-02/pdf/2012-2014.pdf SUMMARY OF NIHB ANALYSIS: As the Proposed Rule notes, I/T/U pharmacies can purchase drugs through the Federal Supply Source (FSS) or the 340B programs. The Proposed Rule also notes that these I/T/U pharmacies are then reimbursed under Medicaid State Plans. In the Proposed Rule, CMS indicates that it considered alternative methodologies but chose instead to propose no specific methodologies for the I/T/U programs and instead "to invite public comment on Medicaid payment levels for these	See Table C.

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			Final Rule approved by OMB 1/19/2016		<p>facilities." The Proposed Rule goes on to state, however, that CMS is proposing "that States that do not have specific methodologies develop such methodologies for these providers consistent with [CMS'] proposed shift from [estimated acquisition cost (EAC)] to [actual acquisition cost (AAC)]."</p> <p>In addition, the Proposed Rule would require States to submit a State Plan Amendment through the formal review process (including all consultation requirements) when submitting plans to change how dispensing is reimbursed. The Proposed Rule notes that States still would have to substantiate "how their dispensing fee reimbursement to pharmacy providers reasonably reflects the cost of dispensing a drug and will ensure access for these drugs to Medicaid beneficiaries." Most importantly, with regard to dispensing fees, the Proposed Rule would require that, "[w]here the professional dispensing fee might differ because of unique circumstances for 340B covered entities or IHS and tribal pharmacies, the State should look at these circumstances to determine if a different professional dispensing fee is warranted for these entities."</p>	
49.a.	<p>Reporting and Returns of Medicare Overpayments</p> <p>ACTION: Proposed Final Rule</p> <p>NOTICE: Medicare Program; Reporting and Returning of Overpayments</p> <p>AGENCY: CMS</p>	CMS-6037-PF	<p><u>Issue Date:</u> 2/16/2012</p> <p><u>Due Date:</u> 4/16/2012</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued extension notice 2/17/2015; Final Rule sent to OMB 10/21/2015</p>		<p>SUMMARY OF AGENCY ACTION: This proposed rule would require providers and suppliers receiving funds under the Medicare program to report and return overpayments by the later of the date which is 60 days after the date on which the overpayment was identified; or any corresponding cost report is due, if applicable.</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 2/17/2015 issued a document (CMS-6037-RCN) to announce the extension of the timeline for publication of the "Medicare Program; Reporting and Returning of Overpayments" final rule. CMS has issued this notice in accordance with the Social Security Act (the Act), which requires provision of notice in the FR if exceptional circumstances cause the agency to publish a final rule more than 3 years after the publication date of the proposed rule. In this case, the complexity of the rule and scope of comments warrants the extension of the timeline for publication.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-02-17/pdf/2015-03072.pdf</p>	

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50.f.	<p>Eligibility and Enrollment for Employees in SHOP</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Data Collection to Support Eligibility Determinations and Enrollment for Employees in SHOP</p> <p>AGENCY: CMS</p>	<p>CMS-10438</p> <p>See also 50.m.</p>	<p><u>Issue Date:</u> 1/29/2012</p> <p><u>Due Date:</u> 2/28/2013</p> <p><u>NIHB File Date:</u> 2/28/2013</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued revision 12/11/2015</p> <p><u>Due Date:</u> 2/9/2016</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request:</i> <u>New collection</u>; <i>Title:</i> Data Collection to Support Eligibility Determinations and Enrollment for Employees in the Small Business Health Options Program; <i>Use:</i> Section 1311(b)(1)(B) of ACA requires that the Small Business health Option Program (SHOP) assist qualified small employers in facilitating the enrollment of their employees in qualified health programs (OHPs) offered in the small group market. Section 1311(c)(1)(F) of ACA requires HHS to establish criteria for certification of health plans as OHPs and that these criteria must require plans to utilize a uniform enrollment form that qualified employers may use. Further, section 1311(c)(5)(B) requires HHS to develop a model application and Web site that assists employers in determining whether they qualify to participate in SHOP. HHS has developed a single, streamlined form that employees will use apply to SHOP. Section 155.730 of the Exchanges Final Rule (77 FR 18310) provides more detail about this "single employee application," which will determine employee eligibility.</p> <p>Employees will have to provide the information upon initial application, with subsequent information collections for the purposes of confirming accuracy of or updating information from previous submissions. Information collection will begin during initial open enrollment in October 2013, per § 155.410 of the Exchanges Final Rule. Collection of applications for SHOP will occur year round, per the rolling enrollment requirements of § 155.725 of the Exchanges Final Rule. Employees will have the ability to submit an application for SHOP online, via a paper application, over the phone through a call center operated by an Exchange, or in person through an agent, broker, or Navigator, per § 155.730(f) of the Exchanges Final Rule. Applicants also will have to verify their understanding of the application and sign attestations regarding information in the application. The employer's state will receive completed applications.</p> <p>In response to the notice published in the 7/6/2012 FR (77 FR 40061), CMS received public comments from more than 20 entities. Some of commenters raised concerns about duplicate or overly burdensome data collection as related to the employee application. CMS has worked with states to minimize any required document submission to streamline and reduce duplication, especially in future years. CMS has considered all of the proposed suggestions and has made changes to this collection of information, such as adding a privacy statement, including information on the availability of other coverage, pre-populating certain applicant information, and indicating whether the</p>	See Table C.

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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.
					<p>employee has waived SHOP coverage.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2013-01-29/pdf/2013-01770.pdf</p> <p>CMS-10438 is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10438.html.</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/11/2015 issued a revision of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2015-12-11/pdf/2015-31302.pdf</p> <p>No comments recommended.</p>	
50.g.	<p>Eligibility and Enrollment for Small Businesses in SHOP</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Data Collection to Support Eligibility Determinations and Enrollment for Small Businesses in SHOP</p> <p>AGENCY: CMS</p>	<p>CMS-10439</p> <p>See also 50.m.</p>	<p><u>Issue Date:</u> 1/29/2012</p> <p><u>Due Date:</u> 2/28/2013</p> <p><u>NIHB File Date:</u> 2/28/2013</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued revision 12/11/2015</p> <p><u>Due Date:</u> 2/9/2016</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: New collection; Title:</i> Data Collection to Support Eligibility Determinations and Enrollment for Small Businesses in the Small Business Health Options Program; <i>Use:</i> Section 1311(b)(1)(B) of ACA requires that the Small Business health Option Program (SHOP) assist qualified small employers in facilitating the enrollment of their employees in qualified health programs (QHPs) offered in the small group market. Section 1311(c)(1)(F) of ACA mandates that HHS establish criteria for certification of health plans as QHPs and that these criteria require plans to utilize a uniform enrollment form for qualified employers. Further, section 1311(c)(5)(B) requires HHS to develop a model application and web site that assists employers in determining whether they qualify to participate in SHOP. HHS has developed a single, streamlined form that employers will use apply to SHOP. Section 155.730 of the Exchanges Final Rule provides more detail about this "single employer application," which will determine employer eligibility.</p> <p>Employers will have to provide the information upon initial application, with subsequent information collections for the purposes of confirming accuracy of or updating information from previous submissions. Information collection will begin during initial open enrollment in October 2013, per § 155.410 of the Exchanges Final Rule. Collection of applications for SHOP will occur year round, per the rolling enrollment requirements of § 155.725 of the Exchanges Final Rule. Employers will have the ability to submit an application for</p>	See Table C.

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					<p>SHOP online, via a paper application, over the phone through a call center operated by an Exchange, or in person through an agent, broker, or Navigator, per § 155.730(f) of the Exchanges Final Rule. Applicants also will have to verify their understanding of the application and sign attestations regarding information in the application. The employer's state will receive completed applications.</p> <p>In response to the notice published in the 7/6/2012 FR (77 FR 40061), CMS received public comments from more than 20 entities. Some commenters raised concerns about duplicate or overly burdensome data collection as related to the employer application. CMS has worked with States to minimize any required document submission to streamline and reduce duplication, especially in future years. CMS has considered all of the proposed suggestions and has made changes to this collection of information, such as adding a privacy statement, including information on "doing business as" and information on employer type, and making electronic notices the default option. CMS also has removed some information related to the employer choice of plan offerings and contribution because it is not necessary for an eligibility determination.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2013-01-29/pdf/2013-01770.pdf</p> <p>CMS-10439 is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10439.html.</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/11/2015 issued a revision of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2015-12-11/pdf/2015-31302.pdf</p> <p>No comments recommended.</p>	
50.h.	<p>Eligibility for Insurance Affordability Programs and Enrollment</p> <p>ACTION: Request for</p>	CMS-10440	<p><u>Issue Date:</u> 1/29/2012</p> <p><u>Due Date:</u> 2/28/2013</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: New collection; Title: Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment through Affordable Insurance Exchanges, Medicaid and Children's Health Insurance Program Agencies; Use: Section 1413 of ACA directs the Secretary of HHS to develop and provide to each State a single, streamlined</i></p>	See Table C.

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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.
	<p>Comment</p> <p>NOTICE: Data Collection to Support Eligibility Determinations for Insurance Affordability Programs and Enrollment Through Affordable Insurance Exchanges, Medicaid and CHIP Agencies</p> <p>AGENCY: CMS</p>		<p><u>NIHB File Date:</u> 2/28/2013</p> <p><u>Date of Subsequent Agency Action, if any:</u> 4/30/2013; issued extension 12/2/2015</p> <p><u>Due Date:</u> 2/1/2016</p>		<p>form for applying for coverage through the Exchange and Insurance Affordability Programs, including Medicaid, CHIP, and the Basic Health Program, as applicable. The application must maximize the ability of applicants to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for the programs. A State may develop and use its own single streamlined application if approved by the Secretary, in accordance with section 1413, and if it meets the standards established by the Secretary.</p> <p>Section 155.405(a) of the Exchange Final Rule (77 FR 18310) provides more detail about the application that the Exchange must use to determine eligibility and to collect information necessary for enrollment. The regulations in § 435.907 and § 457.330 establish the requirements for State Medicaid and CHIP agencies related to the use of the single, streamlined application. CMS has designed the single, streamlined application as a dynamic online application that will tailor the amount of data required from applicants based on their circumstances and responses to particular questions. CMS has designed a paper version of the application to collect only the data required to determine eligibility. Individuals will have the ability to submit an application online, through the mail, over the phone through a call center, or in person, per § 155.405(c)(2) of the Exchange Final Rule, as well as through other commonly available electronic means as noted in § 435.907(a) and § 457.330 of the Medicaid Final Rule. Individuals can submit the application to an Exchange, Medicaid, or CHIP agency.</p> <p>In response to the notice published in the July 6, 2012, FR (77 FR 40061), CMS received approximately 65 public comments. In response, CMS has made significant changes to the application materials, such as moving from categories of data elements to completed draft applications, among others. http://www.gpo.gov/fdsys/pkg/FR-2013-01-29/pdf/2013-01770.pdf</p> <p>CMS-10440 is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html.</p> <p>Video demonstrations of the online application are available at http://www.youtube.com/user/CMSHHSgov/.</p> <p>SUMMARY OF NIHB ANALYSIS: CMS-10440 contains two Exchange-related <u>paper</u> applications. One of the paper applications is for persons applying for financial</p>	

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					<p>assistance (FA). The other paper application is for persons who do not want to apply for financial assistance (non-FA) / do not want to provide information on their finances. There is also a comprehensive list of all questions asked through the online and paper applications. The primary AI/AN-related questions are in Step 4 (page 17) of the FA application and Step 3 (page 5) of the non-FA application.</p> <p>On pages 38 and 41 of the comprehensive list of questions ("508_CMS-10440_Appendix_A_ Individual_Questionnaire"), there are questions pertaining to the identification of persons eligible for Indian-specific benefits. On page 19, there is a question on documenting citizenship status, with the identification of "Document indicating member of a federally-recognized Indian tribe" as one of the options. On page 22, there is a question on race. On page 24, there is question (Q. 6) on who is AI/AN. On page 31, there are questions on Indian-specific income to be excluded from income calculations for Medicaid and CHIP.</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/2/2015 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-30534.pdf</p> <p>No comments recommended.</p>	
50.aa.	<p>SHOP Effective Date and Termination Notice Requirements</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Small Business Health Options Program (SHOP) Effective Date and Termination Notice Requirements</p> <p>AGENCY: CMS</p>	CMS-10555	<p><u>Issue Date:</u> 3/9/2015</p> <p><u>Due Date:</u> 5/8/2015</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued new request</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: New collection; Title:</i> Small Business Health Options Program (SHOP) Effective Date and Termination Notice Requirements; <i>Use:</i> CMS requires that, for plan years beginning on or after 1/1/2017, the Small Business Health Options Program (SHOP) must ensure that a qualified health plan (QHP) issuer notifies qualified employees, enrollees, and new enrollees in a QHP through the SHOP of the effective date of coverage. As required by the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameter for 2016 (CMS-9944-F), published on 2/27/2015, if any enrollee has his or her coverage terminated through the SHOP due to non-payment of premiums or a loss of eligibility to participate in the SHOP, the SHOP must notify the enrollee or the qualified employer of the termination of such coverage. In the termination of coverage, the SHOP must include the termination date and reason for termination to the enrollee or qualified employer.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-03-09/pdf/2015-05420.pdf</p>	

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			12/14/2015 <u>Due Date:</u> 1/13/2016		SUMMARY OF NIHB ANALYSIS: No comments recommended. SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/14/2015 issued a new version of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2015-12-14/pdf/2015-31398.pdf No comments recommended.	
52.q.	Home Health Face-to-Face Encounter Clinical Templates ACTION: Request for Comment NOTICE: Home Health Face-to-Face Encounter Clinical Templates AGENCY: CMS	CMS-10564	<u>Issue Date:</u> 8/12/2015 <u>Due Date:</u> 10/13/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension 12/28/2015 <u>Due Date:</u> 1/27/2016		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request:</i> <u>New collection</u> ; <i>Title:</i> Home Health Face-to-Face Encounter Clinical Templates; <i>Use:</i> CMS requires this collection of data to support the eligibility of Medicare home health services. Home health services are covered under the Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B) benefits of the Medicare program. These services consist of part-time, medically necessary skilled care (nursing, physical therapy, occupational therapy, and speech-language therapy) ordered by a physician. CMS has developed a list of clinical elements within a suggested electronic clinical template that would allow electronic health record vendors to create prompts to assist physicians when documenting the home health face-to-face encounter for Medicare purposes. Once completed by the physician, the resulting progress note or clinic note would become part of the medical record. The primary users of these new clinical templates will include physicians and/or allowed non-physician practitioners (NPPs). The templates will help users to capture the necessary information needed to complete the face-to-face encounter documentation. This will help physicians and/or allowed NPPs comply with Medicare policy requirements, thereby reducing the possibility of non-payment of a home health claim because of failure to meet Medicare requirements. http://www.gpo.gov/fdsys/pkg/FR-2015-08-12/pdf/2015-19818.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended. SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/28/2015 issued an extension of this PRA request. CMS has revised this information collection request with non-substantive changes since the publication of the 60-day notice in the 8/12/2015 FR (80 FR 48320). https://www.gpo.gov/fdsys/pkg/FR-2015-12-28/pdf/2015-32435.pdf	

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					No comments recommended.	
54.	ESI Coverage Verification ACTION: Notice NOTICE: Employer-Sponsored Coverage Verification: Preliminary Informational Statement AGENCY: CMS	CMS RIN 0938-ZB09	<u>Issue Date:</u> [Approved by OMB 4/26/2012 but not yet published] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: SUMMARY OF NIHB ANALYSIS:	
60.I.	Expansion of the CMS Qualified Entity Program ACTION: Request for Comment NOTICE: Expansion of the CMS Qualified Entity Program AGENCY: CMS	CMS-5061-P	<u>Issue Date:</u> [Approved by OMB 1/22/2016] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: SUMMARY OF NIHB ANALYSIS:	

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67.a.	<p>State Consumer Assistance Grants</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Consumer Assistance Program Grants</p> <p>AGENCY: CMS</p>	CMS-10333	<p><u>Issue Date:</u> 7/27/2012</p> <p><u>Due Date:</u> 9/25/2012</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued revision 12/7/2012; issued extension 11/2/2015, 1/20/2016</p> <p><u>Due Date:</u> 2/7/2013; 1/4/2016; 2/19/2016</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request:</i> <u>Revision of a currently approved collection</u>; <i>Title:</i> Consumer Assistance Program Grants; <i>Use:</i> Section 1002 of ACA provides for the establishment of consumer assistance (or ombudsman) programs (CAPs), starting in FY 2010. Federal grants will support CAPs, which will assist consumers with filing complaints and appeals; assist consumers with enrollment into health coverage, collect data on consumer inquiries and complaints to identify problems in the marketplace; educate consumers on their rights and responsibilities; and with the establishment of the new Exchange marketplaces, resolve problems with premium credits for Exchange coverage. ACA requires CAPs to report data to the HHS Secretary "on the types of problems and inquiries encountered by consumers" (section 2793 (d)). Analysis of this data reporting will help identify patterns of practice in the insurance marketplaces and uncover suspected patterns of noncompliance. HHS must share program data reports with the Departments of Labor and Treasury and state regulators. Program data also can offer CMS one indication of the effectiveness of state enforcement, affording opportunities to provide technical assistance and support to state insurance regulators and, in extreme cases, inform the need to trigger federal enforcement.</p> <p>A summary of how each state or territory will use the new resources is available at http://www.healthcare.gov/news/factsheets/2010/10/capgrants_states.html.</p> <p>Awards are made to States, and to qualify to receive a grant, a State must designate an independent office of health insurance consumer assistance, or an ombudsman, that, directly or in coordination with State health insurance regulators and consumer assistance organizations to collect and report data to the HHS Secretary on the types of problems and inquiries encountered by consumers.</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/7/2012 issued a revision of this PRA request. CMS received 21 comments in response to the 60-day notice on this information collection published in the 7/27/2012 FR. The majority of these comments, which CMS has addressed in this notice, involved feedback on providing CAPs with more flexibility in collecting and reporting data.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29626.pdf</p>	

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					<p>CMS on 11/2/2015 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-11-02/pdf/2015-27859.pdf</p> <p>CMS on 1/20/2016 issued an extension of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2016-01-20/pdf/2016-00994.pdf</p> <p>No comments recommended.</p>	
71.n.	<p>Medicare ESRD PPS and Quality Incentive Program</p> <p>ACTION: Proposed Final Rule</p> <p>NOTICE: Medicare Program; End-Stage Renal Disease Prospective Payment System, and Quality Incentive Program</p> <p>AGENCY: CMS</p>	CMS-1628-PF	<p><u>Issue Date:</u> 7/1/2015</p> <p><u>Due Date:</u> 8/25/2015</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued correction 9/2/2015; issued Final Rule 11/6/2015; issued correction 12/31/2015</p>		<p>SUMMARY OF AGENCY ACTION: This proposed rule would update and make revisions to the End-Stage Renal Disease (ESRD) prospective payment system (PPS) for calendar year (CY) 2016. The proposals in this rule would ensure that ESRD facilities receive accurate Medicare payment amounts for furnishing outpatient maintenance dialysis treatments during CY 2016. This rule also proposes to set forth requirements for the ESRD Quality Incentive Program (QIP) for CY 2016. In an effort to incentivize ongoing quality improvement among eligible providers, the ESRD QIP proposes to establish and revise requirements for quality reporting and measurement, including the inclusion of new quality measures for payment year (PY) 2019 and beyond and updates to programmatic policies for the PY 2017 and PY 2018 ESRD QIP.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-07-01/pdf/2015-16074.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: This proposed rule would implement an incentive payment adjustment for ESRD services.</p> <p>SUMMARY OF AGENCY ACTION: CMS on 9/2/2015 issued a document (CMS-1628-CN) to correct a technical error that appeared in the proposed rule titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, and Quality Incentive Program" and published in the 7/1/2015 FR (80 FR 37808). This document makes the following correction: on page 37814, second column, second full paragraph, in line 16, the reference to "13A" is corrected to read "11A".</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-09-02/pdf/2015-21783.pdf</p> <p>CMS on 11/6/2015 issued a final rule that updates and makes revisions to the end-stage renal disease (ESRD) prospective payment system (PPS) for CY 2016. This final rule will</p>	

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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.
					<p>ensure that ESRD facilities receive accurate Medicare payment amounts for furnishing outpatient maintenance dialysis treatments during CY 2016. This final rule also will set forth requirements for the ESRD Quality Incentive Program (QIP), including for PYs 2017 through 2019.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-11-06/pdf/2015-27928.pdf</p> <p>CMS on 12/31/2015 issued a document (CMS-1628-CN2) to correct technical and typographical errors that appeared in the final rule published in the 11/6/2015 FR and titled "Medicare Program; End-Stage Renal Disease Prospective Payment System, and Quality Incentive Program."</p> <p>https://www.gpo.gov/fdsys/pkg/FR-2015-12-31/pdf/2015-32967.pdf</p>	
71.o.	<p>ESRD Application and Survey and Certification Report</p> <p>ACTION: Request for Comment</p> <p>NOTICE: End Stage Renal Disease Application and Survey and Certification Report</p> <p>AGENCY: CMS</p>	CMS-3427	<p><u>Issue Date:</u> 11/16/2015</p> <p><u>Due Date:</u> 1/15/2016</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Revision of a currently approved collection; Title:</i> End Stage Renal Disease Application and Survey and Certification Report; <i>Use:</i> Part I of this form serves as a facility identification and screening measurement used to initiate the certification and recertification of ESRD facilities. The Medicare/Medicaid State survey agency completes Part II of this form to determine facility compliance with ESRD conditions for coverage.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-29160.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: No comments recommended.</p>	
80.b.	<p>Advanced Beneficiary Notice of Noncoverage</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Advance</p>	CMS-R-131	<p><u>Issue Date:</u> 12/12/2012</p> <p><u>Due Date:</u> 2/11/2013</p> <p><u>NIHB File</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Revision of a currently approved collection; Title:</i> Advance Beneficiary Notice of Noncoverage (ABN); <i>Use:</i> Certain Medicare providers and suppliers use the Advanced Beneficiary Notice of Noncoverage (ABN) (CMS-R-131) to inform fee-for-service (FFS) beneficiaries of potential liability for certain items/services billed to the program. Under section 1879 of the Social Security Act, Medicare beneficiaries can have financial responsibility for items or services usually covered under the program, but denied in an individual case</p>	

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	Beneficiary Notice of Noncoverage AGENCY: CMS		<u>Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued revision 2/26/2013; issued extension 11/9/2015 <u>Due Date:</u> 3/28/2013; 1/8/2016		under specific statutory exclusions, if beneficiaries are informed that Medicare likely will deny payment prior to furnishing the items or services. When required, Part B paid physicians, providers (including institutional providers, such as outpatient hospitals), practitioners (such as chiropractors), and suppliers, as well as hospice providers and Religious Non-Medical Health Care Institutions paid under Part A, deliver ABN. The revised ABN in this information collection request incorporates expanded use by Home Health Agencies (HHAs), with no substantive changes to the form or changes that will affect existing ABN users. http://www.gpo.gov/fdsys/pkg/FR-2012-12-12/pdf/2012-29951.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 2/26/2013 issued a revision of this PRA request. The revised ABN in this information collection request incorporates expanded use by HHAs, with no substantive changes to the form and no changes that will affect existing ABN users. http://www.gpo.gov/fdsys/pkg/FR-2013-02-26/pdf/2013-04313.pdf CMS on 11/9/2015 issued an extension of this PRA request. With this PRA submission, CMS has made minimal formatting changes to the ABN form, including the addition of language informing beneficiaries of their rights under Section 504 of the Rehabilitation Act of 1973 (section 504) by alerting the beneficiary to CMS nondiscrimination practices and the availability of alternate forms of this notice, if needed. Additionally, CMS has made minor language and grammatical changes to the instructions to improve provider/supplier comprehension and decrease the probability of errors in completing the ABN. CMS has made no substantive changes to the form or to the instructions. http://www.gpo.gov/fdsys/pkg/FR-2015-11-09/pdf/2015-28449.pdf No comments recommended.	
82.j.	Complaint Forms for Health Information Privacy Issues	HHS-OS-0945-0002-60D	<u>Issue Date:</u> 10/20/2015 <u>Due Date:</u>		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request:</i> Extension of a currently approved collection; <i>Title:</i> Complaint Forms for Discrimination; Health Information Privacy Complaints; <i>Use:</i> Individuals can file written complaints with the HHS Office for Civil Rights (OCR) when they believe programs or entities that receive federal	

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	ACTION: Request for Comment NOTICE: Complaint Forms for Discrimination; Health Information Privacy Complaints AGENCY: HHS OCR	HHS-OS-0945-0002-30D	12/21/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension 12/28/2015 <u>Due Date:</u> 1/27/2016		financial assistance from HHS have discriminated against them or violated their right to the privacy of protected health information. http://www.gpo.gov/fdsys/pkg/FR-2015-10-20/pdf/2015-26604.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended. SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/28/2015 issued an extension of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2015-12-28/pdf/2015-32551.pdf No comments recommended.	
83.a.	Medicaid/Transformed Medicaid Statistical Information System ACTION: Request for Comment NOTICE: Medicaid Statistical Information System (MSIS) and Transformed-Medicaid Statistical Information System (T-MSIS) AGENCY: CMS	CMS-R-284	<u>Issue Date:</u> 8/15/2012 <u>Due Date:</u> 10/15/2012 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued extension 10/19/2012; issued revision 12/3/2012, 12/31/2015 <u>Due Date:</u>		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension without change of a currently approved collection; Title:</i> Medicaid Statistical Information System (MSIS); <i>Use:</i> States and other jurisdictions use MSIS to report fundamental statistical data on the operation of their Medicaid program. The data provides the only national-level information available on enrollees, beneficiaries, and expenditures. It also provides the only national-level information available on Medicaid utilization. This information serves as the basis for analyses and for cost savings estimates for HHS cost-sharing legislative initiatives to Congress. The data also plays a crucial role in CMS and HHS actuarial forecasts. SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/31/2015 issued a revision of this PRA request. CMS has added the Transformed-Medicaid Statistical Information System (T-MSIS) to this information collection. https://www.gpo.gov/fdsys/pkg/FR-2015-12-31/pdf/2015-32880.pdf T-MSIS has the capacity to capture the status of an individual as an IHS beneficiary, which is important for purposes of ensuring that AI/ANs receive cost-sharing and other	

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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.
			11/19/2012; 1/2/2013; 2/29/2016		Indian-specific protections. Tribal organizations might want to submit comments on this issue.	
89.g.	Cost Sharing Reduction Reconciliation ACTION: Request for Comment NOTICE: Cost Sharing Reduction Reconciliation AGENCY: CMS	CMS-10526	<u>Issue Date:</u> 6/27/2014 <u>Due Date:</u> 8/26/2014 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued new request 9/26/2014; issued revision 9/14/2015, 1/20/2016 <u>Due Date:</u> 10/27/2014; 11/13/2015; 2/19/2016		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request:</i> <u>New collection</u> ; <i>Title:</i> Cost Sharing Reduction Reconciliation; <i>Use:</i> Under established HHS regulations, qualified health plan (QHP) issuers will receive estimated advance payments of cost-sharing reductions throughout the year. Each issuer will then undergo a reconciliation process at the end of the benefit year to ensure that HHS reimburses each issuer only for actual cost sharing. This information collection establishes the data elements that a QHP issuer would have to report to HHS to establish the cost-sharing reductions provided on behalf of enrollees for the benefit year. http://www.gpo.gov/fdsys/pkg/FR-2014-06-27/pdf/2014-15075.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended. ACA provides for cost-sharing reductions (CSRs) for eligible individuals who purchase health insurance from a qualified health plan (QHP) through an Exchange. On 3/11/2013, CMS issued a final rule (CMS-9964-F, Payment Notice) that detailed a plan in which HHS would advance monthly payments to issuers for estimated CSRs and then reconcile the advanced amounts against actual CSRs provided by issuers to eligible enrollees during the benefit year. The Payment Notice detailed a methodology for issuers to use when calculating and submitting to HHS the actual CSR amounts provided to enrollees in a benefit year. In response to concerns about the complexity of the methodology, CMS on 10/30/2013 issued a final rule (CMS-9957-F2/CMS-9964-F3) that allows QHP issuers to elect to use a simplified formula during the first three years of the program, from 2014 through 2016, to estimate CSRs provided to enrollees. Under this PRA request, CMS proposes to collect data for both the standard and simplified methodologies through the CSR Reconciliation Data Template. This information collection would allow HHS to gather data necessary to reconcile dollar amounts advanced to QHP issuers by HHS with dollar amounts paid (either actual or re-estimated) by the issuer on behalf of an enrollee and recoup or remit the balance. In prior recommendations, TTAG suggested that CMS "should continue to use as the primary payment methodology a mechanism based on actual (and not estimated)	

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					<p>payments made by issuers for the cost-sharing protections provided to AI/ANs under the limited and zero cost-sharing variations and propose to transition to an alternative payment mechanism only after demonstrating such an alternative would not create counter-productive financial incentives." This recommendation sought to diminish opportunities for health plans to receive payments from CMS for cost-sharing reductions and not actually provide the cost-sharing reductions due to enrollees. In response, CMS indicated that issuers will have to use the standard methodology, which relies on actual cost-sharing reduction payments, after 2016. However, CMS stated that CMS "will continue to consider alternative approaches for reimbursing QHP issuers for the future, including a capitated payment system" (See 89.b. and 7.bb. for additional details).</p> <p>TTAG also recommended that CMS ensure the collection of a robust amount of data on the actual payments made by issuers under the Indian-specific cost-sharing variations and ensure the collection of data represents the experiences of all health plans, with consideration to factors such as the service areas of plans, the degree of I/T/U penetration in the service areas, the percentage of AI/ANs enrolled in a plan, plan size and market concentration, and whether plans provided protections under the limited or zero cost-sharing variations. Again, this recommendation sought to ensure any estimated or capitated systems reflect actual payment made on behalf of AI/ANs and not inadvertently create incentives for health plans to deny the cost-sharing protections due to AI/ANs.</p> <p>This PRA request is consistent with the TTAG recommendations in that it is for the purpose of gathering data from health plans to permit CMS to reconcile advance payments made with actual (and re-estimated) payments made and potentially to develop alternative payment approaches for future periods based on a robust set of data.</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 9/26/2014 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-09-26/pdf/2014-22980.pdf</p> <p>CMS on 9/14/2015 issued a revision of this PRA request. This revised collection eliminates some data elements and requires summary plan level reporting and reporting in the 2016 reconciliation cycle on the dollar amount of 2014 cost-sharing reductions used in calculations for medical loss ratio and risk corridors programs reporting. http://www.gpo.gov/fdsys/pkg/FR-2015-09-14/pdf/2015-22959.pdf</p>	

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					<p>The revised CSR Reconciliation Data Elements form and a Supporting Statement for this PRA request are available at https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10526-.html.</p> <p>On 4/30/2013, tribal organizations submitted comments in response to CMS-9964-IFC (see 89.b.), which included an alternative, optional methodology for calculating the value of cost-sharing reductions provided for the purpose of reconciliation of advance payments of cost-sharing reductions and created a transition period permitting the use of this alternative.</p> <p>CMS on 1/20/2016 issued a revision of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2016-01-20/pdf/2016-00994.pdf</p> <p>No comments recommended.</p>	
89.n.	<p>Manual for Reconciliation of Advance Payment of CSRs</p> <p>ACTION: Guidance</p> <p>NOTICE: Draft Manual for Reconciliation of Advance Payment of Cost-Sharing Reductions for Benefit Years 2014 and 2015</p> <p>AGENCY: CCIO</p>	CCIO (no reference number)	<p><u>Issue Date:</u> 1/15/2016</p> <p><u>Due Date:</u> 2/15/2016</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: This draft manual for all issuers offering a qualified health plan (QHP) through a health insurance Marketplace provides information on the process for reconciling advance payment of cost-sharing reduction amounts that QHP issuers have received to reflect the cost-sharing reduction amounts those issuers provided to eligible Marketplace enrollees. This draft manual provides QHP issuers with general instructions on using the standard, simplified, and actuarial value methodologies described at 45 CFR § 156.430 for the purpose of determining the value of cost-sharing reduction amounts provided to eligible Marketplace enrollees and further describes the data elements issuers must submit when the annual cost-sharing reduction reconciliation process begins in spring 2016.</p> <p>CMS requests comment on this draft manual. Please submit comments to CSRreview@cms.hhs.gov by 5 p.m. on 2/15/2016. When submitting comments, please indicate the section of the draft manual to which the comment pertains. After carefully considering comments received, CMS intends to publish a final version of this manual prior to data submission. Collection of these data elements has approval under OMB control number 0938-1266. Technical guidance on actual submission of data will appear in separate documents posted with this manual (see below).</p> <p>https://www.cms.gov/CCIO/Resources/Regulations-and-Guidance/Downloads/CMS-</p>	

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					Guidance-on-CSR-Reconciliation.pdf The document titled "CSR Reconciliation: Issuer to MIDAS Attestation Inbound Specification" is available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CSR-Recon-Issuer-to-MIDAS-Attestation-Inbound-Specification-DRAFT.pdf . The document titled "CSR Reconciliation: Issuer to MIDAS Inbound Specification" is available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CSR-Recon-Issuer-to-MIDAS-Inbound-Specification_DRAFT.pdf . The document titled "CSR Reconciliation: Sample Pipe Delimited Format" is available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CSR-Reconciliation-Sample-Pipe-Delimited-Format-DRAFT-01-13-2016.pdf . SUMMARY OF NIHB ANALYSIS:	
92.b.	Compliance with Individual and Group Market Reforms ACTION: Request for Comment NOTICE: Information Collection Requirements for Compliance with Individual and Group Market Reforms AGENCY: CMS	CMS-10430	<u>Issue Date:</u> 11/21/2012 <u>Due Date:</u> 1/22/2013 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued reinstatement 2/22/2013; issued revision 12/2/2015		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request:</i> Reinstatement of a previously approved collection; <i>Title:</i> Information Collection Requirements for Compliance with Individual and Group Market Reforms under Title XXVII of the Public Health Service Act; <i>Use:</i> The provisions of title XXVII of the Public Health Service Act (PHS Act) promote access to health insurance and reduce allowable limitations on coverage. Sections 2723 and 2761 of the PHS Act direct CMS to enforce title XXVII with respect to health insurance issuers when a state has notified CMS that it has not enacted legislation to enforce or that it is not otherwise enforcing a provision (or provisions) of the individual and group market reforms with respect to health insurance issuers, or when CMS has determined that a state is not substantially enforcing one or more of those provisions. This collection also pertains to notices issued by individual and group health insurance issuers and self-funded non-Federal governmental plans. This collection includes the issuance of certificates of creditable coverage; notification of preexisting condition exclusions; notification of special enrollment rights; and review of issuer filings of individual and group market products or similar Federal review in cases in which a state is not enforcing a title XXVII individual or group market provision. SUMMARY OF NIHB ANALYSIS: The underlying policies pertaining to individual and group market reforms under ACA (and prior law) are presented in various proposed rules	

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			<u>Due Date:</u> 3/25/2013; 2/1/2016		<p>by CMS, with the most recent being CMS-9972: Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review; Proposed Rule. This Paperwork Reduction Act comment request merely identifies the applicable provisions of title XXVII of the PHSA and the estimated number of hours for insurers to file the information that may be requested by CMS.</p> <p>CMS-10430 is instructive, though, in identifying the sections of the PHSA for which they will evaluate state enforcement efforts and undertake enforcement actions if determined to be needed. The statutory provisions and implementing regulations that are the subject of this submission implement group and individual market reforms under title XXVII of the PHS Act, as they apply to non-Federal governmental group health plans and group and individual health insurance issuers. The group provisions apply to employment-related group health plans and to the issuers who sell insurance in connection with group health plans. For purposes of title XXVII of the PHS Act, all other health insurance is sold in the individual market.</p> <p>The topics contained in the applicable provisions identified in CMS-10430 include:</p> <ul style="list-style-type: none"> • Certificates and disclosure of prior coverage; • Notice of preexisting condition exclusion; • Notice to participants regarding special enrollment periods; • Notice of impaired financial capability; • Federal review of policy forms to ensure guaranteed availability; • Notice of intent to discontinue a product or abandon the market; • Federal review of policy forms to ensure guaranteed renewability; • Full disclosure by issuers to all small employers of materials on all products and other information; • Federal review of policy forms to ensure coverage for the essential health benefits package; • Notice to Federal government of self-funded, non-Federal government plan opt-out; and • Notice to non-Federal government plan enrollees of opt-out. <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 2/22/2013 issued a restatement of this PRA request. This information collection includes minimal changes to reflect laws passed since the approval of the previous collection document, which</p>	

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					<p>expired 9/30/2012. The OMB control number for this proposed collection will remain the same, but it will receive a new CMS Form Number. http://www.gpo.gov/fdsys/pkg/FR-2013-02-22/pdf/2013-04135.pdf</p> <p>CMS on 12/2/2015 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-12-02/pdf/2015-30534.pdf</p> <p>No comments recommended.</p>	
92.ccc.	<p>Rate Filing Justifications for 2016 for Single Risk Pool Coverage</p> <p>ACTION: Guidance</p> <p>NOTICE: DRAFT Bulletin: Timing of Submission and Posting of Rate Filing Justifications for the 2016 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2017</p> <p>AGENCY: CCIIO</p>	CCIIO (no reference number)	<p><u>Issue Date:</u> 12/23/2015</p> <p><u>Due Date:</u> 1/22/2016</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: This draft bulletin seeks comment on the proposed uniform timeline for submission and posting of information about rates for single risk pool coverage, consistent with the proposed amendments to the rate review regulations at 45 CFR Part 154 in the 2017 Payment Notice Proposed Rule. Specifically, this bulletin proposes guidance for purposes of establishing the uniform deadline under 45 CFR 154.220(b) for health insurance issuers to submit the Unified Rate Review Template for proposed rates in the individual and small group markets. It also proposes guidance for purposes of establishing the uniform posting deadline under 45 CFR 154.301(b)(1)(i) for a state with an effective rate review program to provide public access to information regarding proposed rate increases subject to review.</p> <p>The bulletin also identifies the deadline for posting of final rate increases (including those not subject to review) and the CMS Web address for use by states with an effective rate review program that elect to provide public access from their website through a link to the rate information made available on the CMS Web site. The timelines specified in this bulletin would apply to rates filed in 2016 (2016 filing year) for single risk pool coverage (including both qualified health plans (QHPs) and non-QHPs) effective on or after 1/1/2017.</p> <p>In addition, 45 CFR 154.301(b)(3) requires states with an effective rate review program to post the required information on proposed rate increases subject to review and final rate increases (including those not subject to review) at a uniform time and not on a rolling basis. That requirement applies to rate increase information for single risk pool coverage, including both QHP and non-QHPs, both inside and outside of Marketplaces. The timelines in this bulletin reflect that policy. CMS seeks comments from states, issuers, and other interested parties on how to implement that requirement consistent with state legislative and regulatory requirements.</p>	

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					<p>CMS understands that some states that operate a State-Based Marketplace, as well as certain states that utilize the Federally-Facilitated Marketplace platform, faced significant challenges in meeting the timeline specified for the 2015 filing year, due to state legislative or regulatory requirements and the timing of negotiations with issuers. Accordingly, CMS has issued this request for comments so that those states, as well as other interested parties, can provide information to inform future regulations or changes to the timeline. Interested parties should submit comments to RateReview@cms.hhs.gov no later than 1/22/2016. CMS intends to finalize the timeline no later than March 2016.</p> <p>https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Timeline-Bulletin-12-23-15-FINAL.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	
92.ddd.	<p>Evaluation of EDGE Data Submissions for 2015</p> <p>ACTION: Guidance</p> <p>NOTICE: EDGE Server Data Bulletin--INFORMATION: Evaluation of EDGE Data Submissions for 2015 Benefit Year for Interim Reinsurance Payments and Interim Risk Adjustment Summary Report</p> <p>AGENCY: CCIIO</p>	CCIIO (no reference number)	<p><u>Issue Date:</u> 1/21/2016</p> <p><u>Due Date:</u> None</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: This bulletin provides guidance on the operational processes that CMS will use to evaluate issuer EDGE server data for the 2015 benefit year for the release of interim reinsurance payments and interim risk adjustment summary reports. This analysis will help CMS determine whether an issuer has provided sufficient access to EDGE server data for CMS to calculate interim reinsurance payments and release an interim risk adjustment summary report in a specific state and market.</p> <p>https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Evaluation_of_EDGE_Data_Submissions_for_2015_Benefit_Year_for_Interim_Reinsurance_Payments_and_Interim_Risk_Adjustment_S.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	
95.	<p>IHS Forms to Implement the Privacy Rule</p> <p>ACTION: Request for</p>	IHS-810, -912-1, -912-2, -913, and -917	<p><u>Issue Date:</u> 10/2/2012</p> <p><u>Due Date:</u> 60</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request:</i> Extension without change of currently approved collection; <i>Title:</i> IHS Forms to Implement the Privacy Rule (45 CFR Parts 160 & 164); <i>Use:</i> The HHS rule titled "Standards for Privacy of Individually Identifiable Health Information" (Privacy Rule), which implements the</p>	

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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.
	<p>Comment</p> <p>NOTICE: IHS Forms to Implement Privacy Rule (45 CFR Parts 160 & 164)</p> <p>AGENCY: IHS</p>		<p>days (approx. 11/30/2012)</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued extension 1/22/2016</p> <p><u>Due Date:</u> 3/22/2016</p>		<p>privacy requirements of the Administrative Simplification subtitle of HIPAA, requires this information collection. This rule creates national standards to protect personal health information and gives patients increased access to their medical records. This rule requires the collection of information to implement these protection standards and access requirements.</p> <p>SUMMARY OF NIHB ANALYSIS: This PRA request includes no changes to the current forms that IHS uses to implement the Privacy Rule. IHS will use the following data collection instruments to meet the information collection requirements contained in the Privacy Rule:</p> <ul style="list-style-type: none"> • IHS-810: The rule requires covered entities to obtain or receive a valid authorization for its use or disclosure of protected health information other than for treatment, payment, and health care operations. This form, "Authorization for Use or Disclosure of Protected Health Information," is used to document an individual's authorization to use or disclose their protected health information. • IHS-912-1: The rule requires a covered entity to permit individuals to request that the covered entity restrict the use and disclosure of their protected health information, and the covered entity may or may not agree to the restriction. This form, "Request for Restrictions(s)," is used to document an individual's request for restriction of their protected health information and whether IHS agreed or disagreed with the restriction. • IHS-912-2: The rule permits a covered entity to terminate its agreement to a restriction if the individual agrees to or requests the termination in writing. This form, "Request for Revocation of Restriction(s)," is used to document the agency or individual request to terminate a formerly agreed to restriction regarding the use and disclosure of protected health information. • IHS-913: The rule requires covered entities to permit individuals to request that the covered entity provide an accounting of disclosures of protected health information made by the covered entity. This form, "Request for an Accounting of Disclosures," is used to document an individual's request for an accounting of disclosures of their protected health information and the agency's handling of the request. • IHS-917: The rule requires covered entities to permit an individual to request that the covered entity amend protected health information. If the covered entity accepts the requested amendment, in whole or in part, the covered entity must inform the individual that the amendment is accepted. If the covered entity denies the requested amendment, in whole or in part, the covered entity must provide the 	

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					<p>individual with a written denial. This form, "Request for Correction/Amendment of Protected Health Information," will be used to document an individual's request to amend their protected health information and the agency's decision to accept or deny the request.</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 1/22/2016 issued an extension of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2016-01-22/pdf/2016-01208.pdf</p> <p>No comments recommended.</p>	
111.f.	<p>Mental Health Parity Rules: External Review for MSPP</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008: Technical Amendment to External Review for MSPP</p> <p>AGENCY: IRS</p>	TD 9640 (OMB 1545-2165)	<p><u>Issue Date:</u> 11/27/2015</p> <p><u>Due Date:</u> 1/26/2016</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension of a currently approved collection; Title:</i> Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008: Technical Amendment to External Review for Multi-State Plan Program; <i>Use:</i> The final regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations under group health plans and group and individual health insurance coverage, includes disclosure provisions for group health plans and health insurance coverage offered in connection with a group health plan, included an amendment to the interim final regulations implementing Public Health Service Act (PHS Act) section 2719 to specify that the federal external review process under PHS Act section 2719(b)(2) and paragraph (d) of the internal claims and appeals and external review regulations apply to the Multi-State Plan Program (MSPP) administered by OPM. Section 2719 of the PHS Act and its implementing regulations provide that group health plans and health insurance issuers must comply with either a state external review process or the federal external review process. This information collection request addresses this requirement.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-11-27/pdf/2015-30101.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: No comments recommended.</p>	
112.d.	I/T/U Payment for Physician and Non-	IHS RIN 0917-	<p><u>Issue Date:</u> 12/5/2014</p>	NIHB response:	<p>SUMMARY OF AGENCY ACTION: This proposed rule would amend IHS Purchased and Referred Care (PRC), formally known as Contract Health Services (CHS),</p>	See Table C.

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	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	AA12	<u>Due Date:</u> 1/20/2015 2/4/2015 <u>NIHB File Date:</u> 2/4/2015 <u>Date of Subsequent Agency Action, if any:</u> Issued due date extension 1/14/2015; sent Final Rule to OMB 12/14/2015		<p>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.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2014-12-05/pdf/2014-28508.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: NIHB strongly supports expanding Medicare-Like Rates beyond hospital-based providers and believes this proposed rule serves as a good step toward achieving that goal. However, as drafted, this proposed rule does not provide the flexibility necessary to ensure continued access to care for AI/ANs through the Purchased/Referred Care (PRC) programs. Without a mechanism to ensure such flexibility, this proposed rule could operate to deny many AI/ANs access to critically important and life-saving services. This proposed rule requires revisions to provide the flexibility needed to ensure continued access to care while still lowering costs.</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: IHS on 1/14/2015 issued a document that extends the comment period for the Payment for Physician and Other Health Care 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.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-01-14/pdf/2015-00400.pdf</p>	
112.I.	Expanded Access to Non-VA Care Through Veterans Choice	VA RIN 2900-AP60	<u>Issue Date:</u> 12/1/2015		<p>SUMMARY OF AGENCY ACTION: VA revises its medical regulations that implement section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), which requires VA to establish a program to furnish hospital care and medical services</p>	

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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: Interim Final Rule NOTICE: Expanded Access to Non-VA Care Through the Veterans Choice Program AGENCY: VA		<u>Due Date:</u> 3/30/2016 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		<p>through eligible non-VA health care providers to eligible veterans who either cannot receive care within the wait-time goals of the Veterans Health Administration (VHA) or who qualify based on their place of residence (Veterans Choice Program or Program). The most recent amendments to the Choice Act made by the Construction Authorization and Choice Improvement Act of 2014 and by the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 require these regulatory revisions. The Construction Authorization and Choice Improvement Act of 2014 amended the Choice Act to define additional criteria that VA can use to determine that travel to a VA medical facility constitutes an "unusual or excessive burden," and the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015 amended the Choice Act to cover all veterans enrolled in the VA health care system, remove the 60-day limit on an episode of care, modify the wait-time and 40-mile distance eligibility criteria, and expand provider eligibility based on criteria as determined by VA. This interim final rule revises VA regulations consistent with the changes made to the Choice Act as described above.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-12-01/pdf/2015-29865.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: This interim final rule includes no Indian-specific provisions and does not address a previous tribal recommendation that VA use existing sharing agreements with I/T/U facilities, rather than requiring these facilities to negotiate new agreements, when implementing section 101 of the Choice Act. Previously, VA has indicated that it remains "committed to using existing agreements and partnerships where possible."</p>	
112.m.	Dear Tribal Leader Letter (Contract Support Costs Policy) ACTION: Notice NOTICE: Dear Tribal Leader Letter AGENCY: IHS	IHS (no reference number)	<u>Issue Date:</u> 1/7/2016 <u>Due Date:</u> Open <u>NIHB File Date:</u> <u>Date of Subsequent</u>		<p>SUMMARY OF AGENCY ACTION: This letter seeks to initiate a consultation on the IHS Contract Support Costs (CSC) policy. IHS plans to update and implement a new policy in 2016. The policy, developed in 1992 and revised several times since then through coordination and consultation with AI/AN Tribes and tribal organizations, aims to provide uniform and equitable guidance on the preparation and negotiation of requests for CSC funds for new and existing awards authorized by the Indian Self-Determination and Education Assistance Act (ISDEAA). The new policy comes in response to a June 2012 Supreme Court decision on CSC claims against the Department of the Interior in the case <i>Salazar v. Ramah Navajo Chapter</i> (Ramah). The impact of this decision generated additional review for IHS, although not a party to the Ramah case, and its CSC policy.</p>	

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			<u>Agency Action, if any:</u>		<p>The current CSC policy appears in the Indian Health Manual at Part 6, Chapter 3 (2007), available online at https://www.ihs.gov/ihs/index.cfm?module=dsp_ihm_pc_p6c3. IHS last initiated consultation on this policy in October 2011. As IHS updates this policy, please send written input or feedback to Robert G. McSwain by mail at the address below or by e-mail at consultation@ihs.gov.</p> <p>Robert G. McSwain Principal Deputy Director Indian Health Service 5600 Fishers Lane Mail stop: 08E86 Rockville, MD 20857</p> <p>http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2016_Letters/54891-1_DTLL_CSC_Consultation_to_OD_1-7-16.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	
112.n.	<p>Catastrophic Health Emergency Fund</p> <p>ACTION: Proposed Rule</p> <p>NOTICE: Catastrophic Health Emergency Fund</p> <p>AGENCY: IHS</p>	IHS RIN 0905-AC97	<p><u>Issue Date:</u> 1/26/2016</p> <p><u>Due Date:</u> 3/11/2016</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: IHS administers the Catastrophic Health Emergency Fund (CHEF), which serves to meet the extraordinary medical costs associated with the treatment of victims of disasters or catastrophic illnesses within the responsibility of the agency. This proposed rule would establish: definitions governing CHEF; a requirement that a Service Unit shall not qualify for reimbursement for the cost of treatment until the cost of the episode of care has reached a certain threshold; a procedure for reimbursement for certain services exceeding a threshold cost; a procedure for payment for certain cases; and a procedure to ensure payment will occur from CHEF if other sources of payment (federal, state, local, or private) are available.</p> <p>https://www.gpo.gov/fdsys/pkg/FR-2016-01-26/pdf/2016-01138.pdf</p> <p>An IHS press release on this proposed rule is available at https://www.ihs.gov/newsroom/index.cfm/pressreleases/2016pressreleases/ihs-seeks-comment-on-new-regulation-for-catastrophic-health-emergency-fund/.</p> <p>SUMMARY OF NIHB ANALYSIS: A summary of this proposed rule is embedded below.</p>	

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					 IHS CHEF Proposed Rule analysis 2016-0	
112.o.	IHS Reimbursement Rates for CY 2016 ACTION: Notice NOTICE: Reimbursement Rates for Calendar Year 2016 AGENCY: IHS	IHS RIN 0917-ZA30	<u>Issue Date:</u> [Pending at OMB as of 12/31/2015] <u>Due Date:</u> <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: SUMMARY OF NIHB ANALYSIS:	
118.	Hospital Wage Index Occupational Mix Survey ACTION: Request for Comment NOTICE: Hospital Wage Index Occupational Mix Survey and Supporting Regulations AGENCY: CMS	CMS-10079	<u>Issue Date:</u> 12/7/2012 <u>Due Date:</u> 2/5/2013 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued revision 2/28/2013;		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Revision of a currently approved collection; Title: Hospital Wage Index Occupational Mix Survey and Supporting Regulations in 42 CFR, Section 412.64; Use: Section 304(c) of Public Law 106-554 amended section 1886(d)(3)(E) of the Social Security Act to require CMS to collect data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in Medicare to construct an occupational mix adjustment to the wage index for application beginning 10/1/2004 (the FY 2005 wage index). The occupational mix adjustment seeks to control for the effect of hospital employment choices on the wage index.</i> http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29627.pdf SUMMARY OF NIHB ANALYSIS: SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 2/28/2013 issued a revision of this PRA request.	

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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 extension 10/9/2015, 12/28/2015 <u>Due Date:</u> 4/1/2013; 12/8/2015; 1/27/2016		http://www.gpo.gov/fdsys/pkg/FR-2013-02-28/pdf/2013-04548.pdf CMS on 10/9/2015 issued an extension of this PRA request. The FY 2016 survey will provide for the collection of hospital-specific wages and hours data for calendar year 2016 (i.e., payroll periods ending between 1/1/2016 and 12/31/2016). The 2016 Medicare occupational mix survey will apply beginning with the FY 2019 wage index. http://www.gpo.gov/fdsys/pkg/FR-2015-10-09/pdf/2015-25809.pdf No comments recommended. CMS on 12/28/2015 issued an extension of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2015-12-28/pdf/2015-32435.pdf No comments recommended.	
121.m.	Medicare Enrollment Application--DMEPOS Suppliers ACTION: Request for Comment NOTICE: Medicare Enrollment Application--Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers AGENCY: CMS	CMS-855S	<u>Issue Date:</u> 9/11/2015 <u>Due Date:</u> 11/10/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued revision 12/18/2015 <u>Due Date:</u> 1/19/2016		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Revision of a currently approved collection; Title:</i> Medicare Enrollment Application--Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers; <i>Use:</i> The CMS-855S Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier enrollment application gathers from a supplier information that tells CMS its name, whether it meets certain qualifications of a health care supplier, where it renders its services or supplies, the identity of the owners of the enrolling entity, and information necessary to establish correct claims payment. This revision of CMS-855S seeks to simplify and clarify the current data collection and to remove obsolete and/or redundant questions. CMS has corrected grammar and spelling errors and has added limited informational text within the application form and instructions in conjunction with links to Web sites when greater detail is needed by the supplier. To clarify current data collection differentiations and to comport with accreditation coding, CMS has updated Section 3D ("Products and Services Furnished by This Supplier"). This revision does not offer any new material data collection. http://www.gpo.gov/fdsys/pkg/FR-2015-09-11/pdf/2015-22944.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended.	

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					<p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/18/2015 issued a revision of this PRA request. CMS received one comment in response to the 60-day notice.</p> <p>https://www.gpo.gov/fdsys/pkg/FR-2015-12-18/pdf/2015-31887.pdf</p> <p>No comments recommended.</p>	
121.n.	<p>Medicare Registration Application</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Medicare Registration Application</p> <p>AGENCY: CMS</p>	CMS-855O	<p><u>Issue Date:</u> 12/11/2015</p> <p><u>Due Date:</u> 2/9/2016</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Revision of a currently approved collection; Title: Medicare Registration Application; Use: CMS-855O</i> serves to gather information from a physician or other eligible professional to help CMS determine whether he or she meets certain qualifications for enrollment in the Medicare program for the sole purpose of ordering or certifying certain Medicare items or services and/or prescribing Medicare Part D drugs for Medicare beneficiaries. The application allows a physician or other eligible professional to enroll in Medicare without approval for billing privileges. Applicants submit the required information is submitted when requesting enrollment in Medicare for the sole purpose of ordering and certifying certain Medicare items and services or for prescribing Medicare Part D drugs. Medicare contractors use the application to collect data to help ensure that the applicant has the necessary credentials to order and certify certain Medicare items and services or to prescribe Medicare Part D drugs. This includes ensuring that the physician is not excluded from the Medicare program.</p> <p>https://www.gpo.gov/fdsys/pkg/FR-2015-12-11/pdf/2015-31302.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: No comments recommended.</p>	
125.	<p>Interest Rate on Overdue Debts</p> <p>ACTION: Notice</p> <p>NOTICE: Notice of Interest Rate on Overdue Debts</p>	HHS (no reference number)	<p><u>Issue Date:</u> 12/28/2012</p> <p><u>Due Date:</u> None</p> <p><u>NIHB File Date:</u></p>		<p>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</p>	

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	AGENCY: HHS		<u>Date of Subsequent Agency Action, if any:</u> Issued revisions 3/5/2013, 4/23/2013, 7/23/2013, 11/12/2013, 9/2/2014, 10/27/2014, 1/27/2015, 8/17/2015, 11/3/2015, 1/27/2016		<p>the Treasury may revise this rate quarterly. HHS publishes this rate in the Fed Reg.</p> <p>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.</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>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</p> <p>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</p> <p>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</p> <p>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</p> <p>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</p>	

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					<p>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</p> <p>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 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</p> <p>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</p> <p>Under the 8/17/2015 revision, the current rate of 9 3/4%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 6/30/2015. 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-2015-08-17/pdf/2015-20217.pdf</p> <p>Under the 11/3/2015 revision, the current rate of 10.0%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 9/30/2015. 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-2015-08-17/pdf/2015-20217.pdf</p> <p>Under the 1/27/2016 revision, the current rate of 9 3/4%, as fixed by the Secretary of the Treasury, is certified for the quarter ended 12/31/2015. This rate is based on the Interest Rates for Specific Legislation, "National Health Services Corps Scholarship Program"</p>	

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					and "National Research Service Award Program." This interest rate will apply to overdue debt until HHS publishes a revision. https://www.gpo.gov/fdsys/pkg/FR-2016-01-27/pdf/2016-01649.pdf	
129.b.	Awarding and Administration of MAC Contracts ACTION: Notice NOTICE: Medicare Program; Request for Information Regarding the Awarding and the Administration of Medicare Administrative Contractor Contracts AGENCY: CMS	CMS-1653-NC	<u>Issue Date:</u> 12/21/2015 <u>Due Date:</u> 2/19/2016 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: This request for information solicits public comment on the processes and procedures that CMS could use to leverage new legal authorities to incentivize and reward exceptional Medicare Administrative Contractor (MAC) contract performance; publish performance information on each MAC, to the extent permitted by law; and make MAC jurisdictional changes. https://www.gpo.gov/fdsys/pkg/FR-2015-12-21/pdf/2015-32027.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended.	
136.c.	PQRS and the eRx Incentive Program Data Assessment ACTION: Request for Comment NOTICE: Physician Quality Reporting System (PQRS) and the Electronic Prescribing Incentive (eRx) Program Data Assessment, Accuracy and Improper Payments Identification Support	CMS-10519	<u>Issue Date:</u> 3/17/2014 <u>Due Date:</u> 5/16/2014 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued new request		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: New collection; Title:</i> Physician Quality Reporting System (PQRS) and the Electronic Prescribing Incentive (eRx) Program Data Assessment, Accuracy and Improper Payments Identification Support; <i>Use:</i> PQRS and the eRx Incentive Program have data integrity issues, such as rejected and improper payments. This four-year project will evaluate incentive payment information for accuracy and identify improper payments, with the goal of recovering these payments. Additionally, the results of the project will contribute to recommendations to avoid future data integrity issues. CMS will analyze data submission, processing, and reporting for potential errors, inconsistencies, and gaps related to data handling, program requirements, and clinical quality measure specifications of PQRS and the eRx Incentive Program. CMS will conduct surveys of Group Practices, Registries, and Data Submission Vendors (DSVs) to evaluate PQRS and the eRx Incentive Program. Follow-up interviews will occur with a small number of respondents.	

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	AGENCY: CMS		9/8/2014; issued revision 9/25/2015, 1/29/2016 <u>Due Date:</u> 10/6/2014; 11/24/2015; 2/29/2016		http://www.gpo.gov/fdsys/pkg/FR-2014-03-17/pdf/2014-05845.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended, given that this PRA request focuses on PQRS data integrity issues. SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 9/8/2014 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-09-05/pdf/2014-21179.pdf CMS on 9/25/2015 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-09-25/pdf/2015-24474.pdf No comments recommended. CMS on 1/29/2016 issued a revision of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2016-01-29/pdf/2016-01689.pdf	
136.e.	Requirements for Reporting Quality Measures ACTION: Request for Information NOTICE: Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures Under CMS Programs AGENCY: CMS	CMS-3323-NC	<u>Issue Date:</u> 12/31/2016 <u>Due Date:</u> 2/1/2016 <u>NIHB File Date:</u> <u>Date of Subsequent Agency Action, if any:</u>		SUMMARY OF AGENCY ACTION: This request for information seeks public comment regarding several items related to the certification of health information technology (IT), including electronic health records (EHR) products used for reporting to certain CMS quality reporting programs such as, but not limited to, the Hospital Inpatient Quality Reporting (IQR) Program and the Physician Quality Reporting System (PQRS). In addition, CMS seeks feedback on how often to require recertification, the number of clinical quality measures (CQMs) to which a certified Health IT Module should have to certify, and testing of certified Health IT Module(s). Specifically, CMS seeks public input on the following areas of certification and testing of health IT, particularly relating to how often to require recertification, the number of CQMs a certified Health IT Module should have to certify to, and the testing of certified Health IT Module(s) to reduce the burden and further streamline the process for providers and health IT developers while ensuring such products are certified and tested appropriately for effectiveness. The feedback will inform CMS and HHS ONC of elements that might need consideration for future rules relating to the reporting of quality measures under CMS programs. This request for information serves as part of the effort of CMS to streamline/reduce EP, eligible hospital, CAH, and health IT developer burden.	

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					https://www.gpo.gov/fdsys/pkg/FR-2015-12-31/pdf/2015-32931.pdf SUMMARY OF NIHB ANALYSIS: Tribal representatives might want to provide comments specific to EHR technologies used by I/Ts.	
137.d.	Data Collection for Beneficiaries Receiving Beta Amyloid PET ACTION: Request for Comment NOTICE: Data Collection for Medicare Beneficiaries Receiving Beta Amyloid Positron Emission Tomography (PET) for Dementia and Neurodegenerative Disease AGENCY: CMS	CMS-10583	<u>Issue Date:</u> 9/25/2015 <u>Due Date:</u> 11/24/2015 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued new request 12/8/2015 <u>Due Date:</u> 1/7/2016		SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: New collection; Title:</i> Data Collection for Medicare Beneficiaries Receiving Beta Amyloid Positron Emission Tomography (PET) for Dementia and Neurodegenerative Disease; <i>Use:</i> In the Decision Memorandum #CAG-00431N issued on 9/27/2013, CMS determined sufficient evidence exists to support the use of beta amyloid PET in 2 scenarios: (1) to exclude Alzheimer's disease (AD) in narrowly defined and clinically difficult differential diagnoses; and (2) to enrich clinical trials seeking better treatments or prevention strategies for AD. CMS will cover one beta amyloid PET scan per patient through Coverage with Evidence Development under section 1862(a)(1)(E) of the Social Security Act (Act) in clinical studies that meet specific criteria established by CMS. Clinical studies must have CMS approval, involve subjects from appropriate populations, and use comparative and longitudinal methods. Radiopharmaceuticals used in the scan must have FDA approval. Approved studies must address defined research questions established by CMS. Clinical studies in this National Coverage Determination (NCD) must adhere to the designated timeframe and meet standards established by CMS in the NCD. Consistent with section 1142 of the Act, AHRQ supports clinical research studies that CMS determines to meet specifically identified requirements and research questions. To qualify for payment, providers must prescribe beta amyloid PET for beneficiaries with a set of clinical criteria specific to each cancer. Providers must transmit data elements to CMS for evaluation of the short and long-term benefits of beta amyloid PET to beneficiaries and for use in future clinical decision making. http://www.gpo.gov/fdsys/pkg/FR-2015-09-25/pdf/2015-24474.pdf SUMMARY OF NIHB ANALYSIS: No comments recommended. SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/8/2015 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-12-08/pdf/2015-30892.pdf	

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					No comments recommended.	
142.a.	<p>Detailed Notice of Discharge ACTION: Request for Comment</p> <p>NOTICE: Detailed Notice of Discharge (DND)</p> <p>AGENCY: CMS</p>	CMS-10066	<p><u>Issue Date:</u> 3/6/2013</p> <p><u>Due Date:</u> 5/6/2013</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued extension 5/17/2013, 11/27/2015</p> <p><u>Due Date:</u> 6/17/2013; 1/26/2016</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension of a currently approved collection; Title:</i> Detailed Notice of Discharge (DND); <i>Use:</i> When a Medicare beneficiary requests a Quality Improvement Organization review of his/her inpatient hospital discharge, hospitals and Medicare plans have used DND to provide the beneficiary with a detailed explanation regarding the reason for discharge.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2013-03-06/pdf/2013-05176.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 5/17/2013 issued an extension of this PRA request.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2013-05-17/pdf/2013-11811.pdf</p> <p>CMS on 11/27/2015 issued an extension of this PRA request.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-11-27/pdf/2015-30070.pdf</p> <p>No comments recommended.</p>	
142.b.	<p>Important Message from Medicare</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Important Message from Medicare (IM)</p> <p>AGENCY: CMS</p>	CMS-R-193	<p><u>Issue Date:</u> 3/6/2013</p> <p><u>Due Date:</u> 5/6/2013</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension of a currently approved collection; Title:</i> Important Message from Medicare (IM); <i>Use:</i> Hospitals have used IM to inform original Medicare, Medicare Advantage, and other Medicare plan beneficiaries who are hospital inpatients about their hospital rights and discharge rights. In particular, IM provides information about when a beneficiary will and will not have liability for charges for a continued stay in a hospital and offers a detailed description of the Quality Improvement Organization review process.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2013-03-06/pdf/2013-05176.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	

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			<u>Agency Action, if any:</u> Issued extension 5/17/2013, 12/8/2015 <u>Due Date:</u> 6/17/2013; 2/8/2016		<p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 5/17/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-05-17/pdf/2013-11811.pdf</p> <p>CMS on 12/8/2015 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-12-08/pdf/2015-30891.pdf</p> <p>No comments recommended.</p>	
149.	Evaluation of the Graduate Nurse Education Demonstration ACTION: Request for Comment NOTICE: Evaluation of the Graduate Nurse Education Demonstration Program AGENCY: CMS	CMS-10467	<u>Issue Date:</u> 4/4/2013 <u>Due Date:</u> 6/3/2013 <u>NIHB File Date:</u> None <u>Date of Subsequent Agency Action, if any:</u> Issued new request 6/28/2013; issued revision 10/16/2015, 1/19/2016 <u>Due Date:</u> 7/29/2013; 12/15/2015; 2/28/2016		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: New collection; Title:</i> Evaluation of the Graduate Nurse Education Demonstration Program; <i>Use:</i> Section 5509 of ACA, under title XVIII of the Social Security Act, requires the Graduate Nurse Education (GNE) Demonstration Under section 5509, the five selected demonstration sites receive "payment for the hospital's reasonable costs for the provision of qualified clinical training to advance practice registered nurses." Section 5509 also requires completion of an evaluation of the GNE Demonstration by October 17, 2017. This evaluation includes analysis of the following: (1) growth in the number of advanced practice registered nurses (APRNs) with respect to a specific base year as a result of the demonstration; (2) growth for each of the following specialties: clinical nurse specialist, nurse practitioner, certified nurse anesthetist, and certified nurse midwife; and (3) costs to the Medicare program as result of the demonstration.</p> <p>For this evaluation, CMS will collect primary data through site visits, key stakeholder interviews, small discussion groups and focus groups, telephone interviews, electronic templates for quantitative data submission, and quarterly demonstration site reports. CMS will collect secondary data from mandatory hospital cost reports and several other existing data sources, such as the American Association of Colleges of Nursing (AACN). http://www.gpo.gov/fdsys/pkg/FR-2013-04-04/pdf/2013-07798.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 6/28/2013 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-06-28/pdf/2013-15539.pdf</p>	

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					<p>CMS on 10/16/2015 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2015-10-16/pdf/2015-26390.pdf</p> <p>No comments recommended.</p> <p>CMS on 1/19/2016 issued a revision of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2016-01-19/pdf/2016-00844.pdf</p>	
164.b.	<p>Medicare Secondary Payer and "Future Medicals"</p> <p>ACTION: Proposed Rule</p> <p>NOTICE: Medicare Secondary Payer and "Future Medicals"</p> <p>AGENCY: CMS</p>	CMS-6047	<p><u>Issue Date:</u> [Approved by OMB 10/9/2014]</p> <p><u>Due Date:</u></p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>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.</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	
175.b.	<p>Medicaid Drug Use Review Program</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Medicaid Drug Use Review (DUR) Program</p> <p>AGENCY: CMS</p>	CMS-R-153	<p><u>Issue Date:</u> 11/29/2013</p> <p><u>Due Date:</u> 1/28/2014</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension of a currently approved collection; Title: Medicaid Drug Use Review (DUR) Program; Use:</i> This information collection serves to: establish patient profiles in pharmacies, identify problems in prescribing, dispensing, or both prescribing and dispensing; determine the ability of each program to meet minimum standards required for federal financial participation; and ensure quality pharmaceutical care for Medicaid patients. State Medicaid agencies that have prescription drug programs must perform prospective and retrospective drug use review to identify aberrations in prescribing, dispensing, and patient behavior.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28537.pdf</p>	

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			<u>Agency Action, if any:</u> Issued revision 3/17/2014, 1/29/2016 <u>Due Date:</u> 4/16/2014; 3/29/2016		<p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 3/17/2014 issued a revision of this PRA request. CMS has revised the information collection request subsequent to the publication of the 60-day notice in the 11/29/2013 FR.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2014-03-17/pdf/2014-05785.pdf</p> <p><u>Background</u> Section 4401 of the Omnibus Budget Reconciliation Act of 1990 and section 1927(g) of the Social Security Act require states to operate a Drug Use Review (DUR) program for covered outpatient drugs under fee-for-service Medicaid. The DUR program must ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results. The DUR program must consist of prospective drug use review (ProDUR), retrospective drug use review (RetroDUR), data assessment of drug use against predetermined standards, and ongoing educational outreach activities. In addition, states must submit an annual DUR program report that includes a description of the nature and scope of their DUR activities as outlined in the statute and regulations. Form CMS-R-153, a survey, serves as the collection instrument for state reporting of their DUR program. Over the years, technology has changed as has the practice of pharmacy. Therefore, CMS has revised the survey to address more fully the current practices and areas of concern within the Medicaid Pharmacy Programs.</p> <p><u>Analysis</u> The survey included in this PRA request includes no AI/AN-specific or I/T/U-specific sections, questions, or revisions. Among the most significant changes to the survey, CMS has added several questions to the ProDUR section (II) to clarify state data processing and authorization requirements. CMS also has added a question to the Generic Policy and Utilization Data section (VI) to clarify state authorization requirements for dispensation of brand-name drugs in lieu of generics. In the Fraud, Waste, and Abuse Detection section (VIII), CMS has added several new subsections that address state pain management program practices, screening and restrictions on opioid prescribing, monitoring of morphine-equivalent daily dose prescribing, and monitoring of buprenorphine prescribing.</p> <p>In addition to these revisions to the survey, this PRA request provides an opportunity to</p>	

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					<p>comment on any past problems that might have occurred regarding this information collection.</p> <p>According to the notice, this information collection is necessary to establish patient profiles in pharmacies, identify problems in prescribing and/or dispensing, determine the ability of each state DUR program to meet minimum standards required for federal financial participation, and ensure quality pharmaceutical care for Medicaid patients. CMS seeks to provide non-statistical information, comparisons, and trends back to states based on their reported experiences with DUR. States might benefit from this information and might fine tune their programs each year based on state-reported innovative practices and CMS-identified best practices gathered from the DUR annual reports.</p> <p>CMS on 1/29/2016 issued a revision of this PRA request.</p> <p>https://www.gpo.gov/fdsys/pkg/FR-2016-01-29/pdf/2016-01688.pdf</p>	
180.	<p>Flu Vaccination Standard for Certain Providers and Suppliers</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Influenza Vaccination Standard for Certain Participating Providers and Suppliers</p> <p>AGENCY: CMS</p>	CMS-3213-F	<p><u>Issue Date:</u> [Approved by OMB on 4/18/2014]</p> <p><u>Due Date:</u></p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>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.</p> <p>SUMMARY OF NIHB ANALYSIS:</p>	
188.a.	<p>Emergency Preparedness Requirements</p> <p>ACTION: Proposed Final</p>	CMS-3178-PF	<p><u>Issue Date:</u> 12/27/2013</p> <p><u>Due Date:</u></p>	TTAG response:	<p>SUMMARY OF AGENCY ACTION: This proposed rule would establish national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to ensure that they adequately plan for both natural and man-made disasters and coordinate with federal, state, tribal, regional, and local emergency</p>	See Table C.

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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.
	<p>Rule</p> <p>NOTICE: Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers</p> <p>AGENCY: CMS</p>		<p>2/25/2014 3/31/2014</p> <p><u>TTAG File Date:</u> 3/31/2014</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued due date extension 2/21/2014; sent Final Rule to OMB 11/3/2015</p>		<p>preparedness systems. It also would ensure that these providers and suppliers adequately prepare to meet the needs of patients, residents, clients, and participants during disasters and emergency situations.</p> <p>CMS proposes emergency preparedness requirements that 17 provider and supplier types must meet to participate in the Medicare and Medicaid programs. Since existing Medicare and Medicaid requirements vary across the types of providers and suppliers, CMS also proposes variations in these requirements. CMS has based these variations on existing statutory and regulatory policies and differing needs of each provider or supplier type and the individuals to whom they provide health care services. Despite these variations, this proposed rule would provide generally consistent emergency preparedness requirements, enhance patient safety during emergencies for persons served by Medicare- and Medicaid-participating facilities, and establish a more coordinated and defined response to natural and man-made disasters.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30724.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: This proposed rule, which seeks to ensure the availability of health care during emergencies, would impose substantial new emergency and disaster preparedness requirements on various Medicare and Medicaid providers and suppliers in an effort to safeguard human resources, ensure business continuity, and protect physical resources. Of note, this proposed rule directs providers to "comply with all applicable Federal and State emergency preparedness requirements" and requires a communications plan that complies with federal and state law, provisions potentially imposing additional emergency preparedness requirements that Tribes currently do not consider applicable. This proposed rule does not include any references to compliance with tribal law.</p> <p>A Health Policy Alternatives summary report on this proposed rule is available at http://www.chausa.org/docs/default-source/advocacy/010814-cha-summary-of-emergency-preparedness-rule.pdf.</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 2/21/2014 issued document (CMS-3178-N) that extends the comment period for this proposed rule from 2/25/2014 to 3/31/2014.</p> <p>CMS have received inquiries from industry organizations regarding the short time to</p>	

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					<p>canvass their membership for input on this proposed rule. One organization stated that it needed additional time to respond because of current regional emergencies requiring the attention of emergency management personnel who likely would have an interest in commenting on this proposed rule. Because of its scope, and because CMS specifically seeks comments to benefit from the vast experiences of emergency management and provider/supplier communities, the agency wants to allow ample time for all sections of the public to comment on this proposed rule.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2014-02-21/pdf/2014-03710.pdf</p>	
188.b.	<p>Fire Safety Requirements for Certain Health Care Facilities</p> <p>ACTION: Proposed Final Rule</p> <p>NOTICE: Medicare and Medicaid Programs; Fire Safety Requirements for Certain Health Care Facilities</p> <p>AGENCY: CMS</p>	CMS-3277-PF	<p><u>Issue Date:</u> 4/16/2014</p> <p><u>Due Date:</u> 6/16/2014</p> <p><u>TTAG File Date:</u> 6/16/2014</p> <p><u>Date of Subsequent Agency Action, if any:</u> Sent Final Rule to OMB 11/3/2015</p>	TTAG response:	<p>SUMMARY OF AGENCY ACTION: This proposed rule would amend the fire safety standards for Medicare and Medicaid participating hospitals, critical access hospitals (CAHs), long-term care facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IID), ambulatory surgery centers (ASCs), hospices that provide inpatient services, religious non-medical health care institutions (RNHCIs), and programs of all-inclusive care for the elderly (PACE) facilities. Further, this proposed rule would adopt the 2012 edition of the Life Safety Code (LSC) and eliminate references in CMS regulations to all earlier editions. It also would adopt the 2012 edition of the Health Care Facilities Code, with some exceptions. This proposed rule provides the LSC citation, a description of the 2012 requirement, and an explanation of its benefits for health care facilities, patients, staff, and visitors over the 2000 version in each occupancy section.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2014-04-16/pdf/2014-08602.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: These proposed regulations might exceed building code requirements in some jurisdictions, as well as the current or planned fire safety standards for some THO facilities.</p> <p>This proposed rule does not specifically discuss applicability to Indian/tribal health care facilities.</p> <p>The document below includes a summary of the proposed regulations applicable to various provider types.</p> <p> CMS-3277-P summary 2014-04-1</p>	See Table C.

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189.c.	<p>Annual Update of the HHS Poverty Guidelines</p> <p>ACTION: Notice</p> <p>NOTICE: Annual Update of the HHS Poverty Guidelines</p> <p>AGENCY: HHS</p>	HHS (no reference number)	<p><u>Issue Date:</u> 1/25/2016</p> <p><u>Due Date:</u> None</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>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.</p> <p>https://www.gpo.gov/fdsys/pkg/FR-2016-01-25/pdf/2016-01450.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: A TSGAC memo on applicable federal poverty level (FPL) thresholds for Medicaid and Marketplace coverage is embedded below.</p> <p> TSGAC - 2016 and 2017 FPL Handout -</p>	
194.f.	<p>340B Drug Pricing Program Reporting Requirements</p> <p>ACTION: Request for Comment</p> <p>NOTICE: 340B Drug Pricing Program Reporting Requirements</p> <p>AGENCY: HRSA</p>	HRSA (OMB 0915-0176)	<p><u>Issue Date:</u> 12/23/2015</p> <p><u>Due Date:</u> 2/22/2016</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u></p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Revision a currently approved collection; Title: 340B Drug Pricing Program Reporting Requirements; Use: Section 602 of the Veterans Health Care Act of 1992 enacted section 340B of the Public Health Service Act (PHS Act), "Limitation on Prices of Drugs Purchased by Covered Entities."</i> Under section 340B, a manufacturer that participates in Medicaid must sign a Pharmaceutical Pricing Agreement with the HHS Secretary in which the manufacturer agrees to charge enrolled covered entities a price for covered outpatient drugs that will not exceed an amount determined under a statutory formula. Covered entities that choose to participate in the section 340B Drug Pricing Program must comply with the requirements of 340B(a)(5) of the PHS Act. Section 340B(a)(5)(A) prohibits a covered entity from requesting Medicaid reimbursement from a drug discounted under the 340B Program. Further, section 340B(a)(5)(B) prohibits a covered entity from reselling or otherwise transferring a discounted drug to an individual who is not a patient of the entity.</p> <p>Section 340B(a)(5)(C) of the PHS Act permits the HHS Secretary and manufacturers of a covered outpatient drug to conduct audits of covered entities in accordance with procedures established by the HHS Secretary related to the number, duration, and scope of the audits. In response to the statutory mandate of section 340B(a)(5)(C) and because of the potential for disputes involving covered entities and participating drug</p>	

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					<p>manufacturers, the HRSA Office of Pharmacy Affairs (OPA) developed an informal voluntary dispute resolution process for manufacturers and covered entities, which, prior to filing a request for resolution of a dispute with OPA, should attempt in good faith to resolve the dispute. All parties involved in the dispute must maintain written documentation as evidence of a good faith attempt to resolve the dispute. If the dispute is not resolved and dispute resolution is desired, a party must submit a written request for a review of the dispute to OPA. A committee appointed to review the documentation will send a letter to the party alleged to have committed a violation. The party will have the opportunity to provide a response to or a rebuttal of the allegations.</p> <p>HRSA published a notice in 1996 and a policy release in 2011 on manufacturer audit guidelines and the informal dispute resolution process. The expected revision to this package includes additional background information on the dispute resolution process and clarifies the need and proposed use of information regarding the manufacturer audit guidelines and the informal dispute resolution process.</p> <p>https://www.gpo.gov/fdsys/pkg/FR-2015-12-23/pdf/2015-32171.pdf</p> <p>SUMMARY OF NIHB ANALYSIS: Although this is only a PRA notice, tribal organizations might have concerns with the implementation of this policy.</p>	
195.c.	<p>Collection of Customer Satisfaction Surveys</p> <p>ACTION: Request for Comment</p> <p>NOTICE: Generic Clearance for the Collection of Customer Satisfaction Surveys</p> <p>AGENCY: CMS</p>	CMS-10415	<p><u>Issue Date:</u> 10/30/2015</p> <p><u>Due Date:</u> 12/29/2015</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued extension</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension of a currently approved collection; Title:</i> Generic Clearance for the Collection Customer Satisfaction Surveys; <i>Use:</i> This information collection allows CMS to garner customer and stakeholder feedback in an efficient, timely manner, in accordance with its commitment to improving service delivery. The information collected from customers and stakeholders will help ensure that users have an effective, efficient, and satisfying experience with CMS programs. This feedback will provide insights into customer or stakeholder perceptions, experiences, and expectations; serve as an early warning of issues with service; and focus attention on areas where communication, training, or changes in operations might improve delivery of products or services. This collection will allow for ongoing, collaborative, and actionable communications between CMS and its customers and stakeholders. It also will allow feedback to contribute directly to the improvement of program management.</p> <p>Collecting voluntary customer feedback serves as the least burdensome, most effective</p>	

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			12/30/2015 <u>Due Date:</u> 1/29/2015		<p>way for CMS to determine whether its public Web sites are useful to and used by its customers. CMS needs generic clearance to ensure that it can continuously improve its Web sites through regular surveys developed from these pre-defined questions. Surveying the CMS Web sites on a regular, ongoing basis will help ensure that users have an effective, efficient, and satisfying experience, maximizing the impact of the information and resulting in optimum benefit for the public. The surveys will ensure that this communication channel meets customer and partner priorities, builds CMS brands, and contributes to the health and human services impact goals of the agency.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-10-30/pdf/2015-27619.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/30/2015 issued an extension of this PRA request. https://www.gpo.gov/fdsys/pkg/FR-2015-12-30/pdf/2015-32633.pdf</p>	
199.b.	<p>CLAS County Data</p> <p>ACTION: Guidance</p> <p>NOTICE: CLAS County Data</p> <p>AGENCY: CCIIO</p>	CCIIO (no reference number)	<p><u>Issue Date:</u> 12/12/2014</p> <p><u>Due Date:</u> None</p> <p><u>NIHB File Date:</u></p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued revised Guidance 1/7/2015, 2/9/2015, 1/27/2016</p>		<p>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)).</p> <p>Section 2715 of the PHS Act requires group health plans and health insurance 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. <u>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.</u> http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data_12-05-14_clean_508.pdf</p>	

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					<p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: CCIIIO 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</p> <p>CCIIIO on 2/9/2015 issued a revised version of this guidance. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2009-13-CLAS-County-Data.pdf</p> <p>CCIIIO on 1/27/2016 issued a revised version of this guidance. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/CO-OP-Questions-Final-1-27-16.pdf</p>	
205.	<p>Sharing What Works--BPPPLE Form</p> <p>ACTION: Request for Comment</p> <p>NOTICE: IHS Sharing What Works --Best Practice, Promising Practice, and Local Effort (BPPPLE) Form</p> <p>AGENCY: IHS</p>	IHS (OMB 0917-0034)	<p><u>Issue Date:</u> 10/9/2015</p> <p><u>Due Date:</u> 12/8/2015</p> <p><u>NIHB File Date:</u> None</p> <p><u>Date of Subsequent Agency Action, if any:</u> Issued extension 11/17/2015, issued due date extension 12/15/2015</p>		<p>SUMMARY OF AGENCY ACTION: <i>Type of Information Collection Request: Extension without change of a currently approved collection; Title:</i> IHS Sharing What Works--Best Practice, Promising Practice, and Local Effort (BPPPLE) Form; <i>Use:</i> IHS seeks to raise the health status of the AI/AN population to the highest possible level by providing comprehensive health care and preventive health services. To support the IHS mission and encourage the creation and utilization of performance driven products/services by IHS, tribal, and urban Indian health (I/T/U) programs, Office of Preventive and Clinical Services program divisions (i.e., behavioral health, health promotion/disease prevention, nursing, and dental) have developed a centralized program database of best practices, promising practices, and local efforts (BPPPLE) and resources. This collection serves to further the development of a database of BPPPLE, resources, and policies available to the public on the IHS Web site. This database will serve as a resource for program evaluation and for modeling examples of various health care projects occurring in AI/AN communities.</p> <p>http://www.gpo.gov/fdsys/pkg/FR-2015-10-09/pdf/2015-25733.pdf</p> <p>SUMMARY OF NIHB ANALYSIS:</p> <p>SUMMARY OF SUBSEQUENT AGENCY ACTION: IHS on 11/17/2015 issued an</p>	

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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: 12/17/2015 1/9/2016		<p>extension of this PRA request. IHS received no comments in response to the 60-day notice on this information collection published in the 10/9/2015 FR (80 FR 61215). http://www.gpo.gov/fdsys/pkg/FR-2015-11-17/pdf/2015-29251.pdf</p> <p>No comments recommended.</p> <p>IHS on 12/15/2015 issued a document that extends the due date to submit comments regarding the 30-day notice on this information collection to 1/9/2016, as the agency issued the 30-day notice before the comment period for the 60-day notice ended on 12/8/2015. https://www.gpo.gov/fdsys/pkg/FR-2015-12-15/pdf/2015-31534.pdf</p>	



**TABLE C: NIHB RECOMMENDATIONS AND
EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS
UPDATED THROUGH 1/31/2016**

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.III.	<p>2017 Letter to Issuers in FFMs</p> <p>ACTION: Guidance</p> <p>NOTICE: Draft 2017 Letter to Issuers in the Federally-Facilitated Marketplaces</p> <p>AGENCY: CCIIO</p>	<p>CCIIO (no reference number)</p> <p><u>Issue Date:</u> 12/23/2015</p> <p><u>Due Date:</u> 1/17/2016</p> <p><u>TSGAC File Date:</u> 1/17/2016</p> <p><u>Date of Subsequent Agency Action, if any:</u></p>	<p>TSGAC recommendations--</p> <ol style="list-style-type: none"> Chapter 1, Section 4--Standardized Options: Under the 2017 Issuer Letter, qualified health plan (QHP) issuers would have to offer "standardized options," with each option standardized in terms of in-network cost-sharing--deductible, annual limitation on cost-sharing, and copayment or coinsurance for a key set of essential health benefits (EHBs) that comprise a large percentage of total spending for the average enrollee; CCIIO should include balance billing charges and policies as an element of the standardized options to enable better plan comparisons and to facilitate selection of plans with the greatest value for QHP enrollees. Chapter 3, Section 3--Out-of-Pocket Cost Comparison Tool: CCIIO has created an out-of-pocket (OOP) cost comparison tool to help improve the ability of consumers to make comparisons between QHP offerings and determine the QHP that offers the greatest value depending on a variety of factors; in designing the OOP cost comparison tool, CCIIO should incorporate the impact of the Indian-specific cost-sharing protections or, if not feasible for the 2017 coverage year, at least provide information indicating to potential AI/AN enrollees that the calculations do not include the impact of the Indian-specific cost-sharing protections. 	<p>No subsequent Agency action taken (as of 1/31/2016).</p>



RRIAR INDEX: HEALTH REFORM
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RRIAR Index: Health Reform ¹						
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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.12)	2016 (v.6.01)	
Indian-specific ACA provisions						
Cost-sharing reductions						
Eligibility				7.ccc. (29/10), 89.a. (/34), 89.k. (210/42)		
General	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. (68), 89.a. (194/79), 89.b. (195/87), 111.b. (238/96),	31.w. (133/14), 31.x. (135/16)	7.www. (26), 7.xx. (27), 27.n. (97), 89.h. (203/35)	50.h. (29)	

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, IHCA), 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 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, IHCA), 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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Referrals		111.c. (240/102)		89.i. (211/48)		
Definition of Indian	7.a. (18/16), 7.b. (21/22), 7.c. (24/67), 7.d. (26/75)	7.u. (32/12), 31.e. (94/40), 50.d. (136/61), 50.f. (64), 50.h. (68), 89.a. (194/79), 111.b. (238/96)			50.f. (27), 50.h. (29)	
Employer mandate				31.ccc. (136/26)		
Essential community providers	7.a. (18/16), 7.b. (21/22)	7.i. (19), 7.n. (23/1), 50.c. (135/54), 111.b. (238/96)	7.ee. (29/4), 92.cc. (255)	7.vv. (24/9), 7.ddd. (33), 50.e. (147), 89.h. (203/35), 92.ii. (218/54)	7.kkk. (4), 7.iii. (6/1)	
Exemption from tax penalty		31.e. (94/40), 31.g. (103/44), 31.q. (114/47)	7.mm. (42), 31.v. (133/13)	7.www. (26), 89.h. (203/35)		
Fees	116. (154)	89.a. (194/79)		145.c. (279)		
Implementation of section 402 of IHCA			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. (24/9), 89.h. (203/35)	7.iii. (6/1)	
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),	7.ee. (29/4), 50.t. (176/29), 65. (199/36),	7.vv. (24/9), 31.pp. (119/21), 89.h. (203/35),	7.iii. (6/1)	



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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.12)	2016 (v.6.01)	
Premium sponsorship	7.a. (18/16), 7.b. (21/22), 7.g. (29/76), 29.a. (70/112)	111.a. (237/94) 50.d. (136/61), 111.a. (237/94), 111.b. (238/96)	92.u. (242/49), 92.cc. (255) 7.b. (3), 7.ee. (29/4), 50.q. (173), 50.r. (175), 50.x. (179/30), 65. (199/36)	92.ii. (218/54), 168. (287/68) 7.vv. (24/9)	7.iii. (6/1)	
Tribal consultation			64.a. (196/31), 64.b (198/33)	64.c. (173/30)		
Tribal Employer Participation in FEHBP			174.d. (317)			
Tobacco use (ceremonial)		50.d. (136/61), 50.f. (64), 50.h. (68), 92.a. (202/91)			50.f. (27), 50.h. (29)	
1311 Funding for Change orders		67.c. (164)	67.d. (202), 67.f. (203)	50.bb. (156), 67.g. (176)		
Basic Health Program	39.a. (80/123)		39.b. (155/19), 39.c. (157/23), 39.d. (159)	39.e. (138), 39.f. (140)		
Consumer assistance grants					67.a. (34)	
Consumer Operated and Oriented Plan (CO-OP) Program	12.a. (44), 12.b. (46/94)	12.c. (58)		12.d. (64), 12.e. (65)	12.f. (13)	
Cost-sharing reductions	7.a. (18/16), 45. (87)	29.f. (89), 50.d. (136/61), 50.h. (68),	29.g. (107/12), 29.h. (108), 31.w. (133/14),	27.n. (97), 89.k. (210/42), 89.l. (211/48),	50.h. (29), 89.g. (39), 89.n. (41)	



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		50.n. (146), 89.a. (194/79), 89.b. (195/87), 89.d. (198), 89.f. (201), 111.c. (240/102)	50.w (178),	92.uu. (225)		
Early retiree reinsurance program		88.a. (193), 88.b. (194)				
Electronic funds transfers	63.a. (113)	63.b. (159)				
Employer requirements (see also Shared responsibility)						
Coverage		31.i. (107), 92.l. (211), 92.m. (212)	92.bb. (254), 92.jj. (266)	31.ccc. (136/26)	29.d. (21)	
Excise tax				31.ss. (124/22), 31.aaa. (132/26)		
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)	31.yy. (130), 31.ccc. (136/26), 31.eee. (137)		
Self-funded, non-federal governmental plans			92.ee. (259)			
Employer tax credits			31.m. (127), 31.n. (128)			
Essential health benefits						



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Excepted benefits		31.i. (107)	31.t. (131)	31.oo. (117), 31.qq. (122)		
General				31.vv. (127), 31.zz (131)		
Preventive services	31.a. (74/115), 31.b. (77)	31.c. (91), 31.j. (108)	31.y. (136), 31.ee. (144), 31.ff. (145)	31.dd. (108), 31.gg. (110), 31.ll. (112), 31.xx. (128)		
Standards	7.g. (29/76), 31.a. (74/115), 45. (87), 50.b. (98)	31.d. (93)	92.aa. (253)			
Exchanges						
<i>Federally-facilitated and state-partnership</i>						
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. (68), 50.k. (143/73)	7.ff. (33), 7.qq. (47), 7.rr. (48), 7.uu. (51), 67.e. (202), 92.dd. (257/52)	7.eee. (35), 7.hhh. (37), 7.ppp. (45), 92.hh. (215), 92.oo. (220)	50.h. (29)	



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Enrollee satisfaction	7.a. (18/16)			168. (287/68)		
Establishment					7.mmm. (7), 7.nnn. (8)	
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.gg. (35), 7.hh. (36)	7.vv. (24/9), 7.bbb. (29), 7.rrr (47)	7.III. (6/1)	
Health insurance affordability programs (see Cost-sharing reductions and Premium tax credits)						
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)	7.ddd. (33), 50.e. (147), 89.i. (207)	7.kkk. (4)	
Minimum acceptable risk standards				7.iii. (39)		
Navigators and non-Navigator assistance personnel	7.a. (18/16)	7.o. (26/3), 7.p. (27)	7.oo. (44)	7.q. (19), 7.v. (22), 7.kk. (23)		
Out-of-pocket costs				7.ccc. (29/10)		
Outreach	7.a. (18/16),	67.b. (163)	7.pp. (46)			



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Policy-based payments	7.g. (29/76)			7.qqq. (47)		
Program integrity		7.s. (30/11)				
Quality	100.a. (144)	31.h. (105)	100.b. (271)	7.yy. (27), 7.aaa. (28), 29.r. (107)		
Special enrollment periods			6.h. (22), 7.ii. (38), 7.jj. (38), 29.i. (108)			
Stand-alone dental plans		7.u. (32/12)		7.l. (18)		
Web portal	7.g. (29/76)		65. (199/36)		7.ooo. (9)	
State-based						
General		7.dd. (40), 50.u. (150)	50.o. (172), 50.s. (175)	7.t. (20)		
Shared responsibility payment exemptions		50.k. (143/73), 50.l. (144)		50.cc. (157)		
State alternative applications						
Federal Employees Health Benefits Program (FEHBP)		174.a. (323), 174.b. (325)	174.c. (315), 174.d. (317), 174.e. (318)	174.f. (290)		
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),		92.bbb. (232), 128.e. (263),		



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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.12)	2016 (v.6.01)	
Contraceptive services		128.c. (261), 128.d. (262) 31.i. (107)	31.y. (136), 31.ee. (144), 31.ff. (145)	128.f. (263) 31.dd. (108), 31.gg. (110), 31.ll. (112), 31.nn. (117), 31.xx. (128) 89.j. (207)		
Cost-sharing limitations					54. (33)	
Employer-sponsored insurance verification						
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)	92.bbb. (232)		
Information reporting		31.k. (108), 31.l. (110), 92.c. (205)	31.aa. (138), 31.cc. (142), 31.ii. (147), 92.g. (232), 145.b. (302),	31.kk. (112), 31.yy. (130), 31.eee. (137), 92.pp. (221), 92.qq. (221), 92.rr. (222), 92.uu. (225), 92.xx. (228), 92.yy. (228)	92.b. (42), 92.ddd. (45)	
Mental health services	31.a. (74/115)		92.t. (241)	92.zz. (231)		
Network/provider issues			92.w. (249/51), 92.cc. (255),	89.j. (207), 92.ll. (218/54)		



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PACE Act			145.a. (301)	145.c. (279), 145.d. (279) 50.ee. (159), 92.aaa. (231)		
Preventive services (see Essential health benefits)						
Product modification/withdrawal				92.vv. (225)		
Rate review		92.o. (213)	92.g. (232), 92.s. (240)	92.mm. (218), 92.nn. (219), 92.ss. (223)	92.ccc. (44)	
Reference pricing			92.gg. (261)			
Same-sex spouses			92.z. (252)			
Stop-loss insurance	56. (106)					
Student insurance	51.a. (101)			51.b. (159)		
Transitional policy			92.x. (250), 92.aa. (253)			
Unique plan identifiers	77.a. (125)			77.e. (190)		
Notices						
Annual/lifetime limits		92.d. (205), 92.j. (210)		92.bbb. (232)		
Coverage (Summary of Benefits and Coverage)		122.c. (254)		31.pp. (119/21), 31.tt. (125), 31.uu. (126), 31.bbb. (133), 92.kk. (217)		
Enrollment opportunity		92.j. (210)		92.v. (215)		



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Market discontinuation/renewal		92.f. (207)	92.y. (251)	92.www. (227)		
Patient protection		92.d. (205), 92.j. (210)	92.k. (236), 92.r. (238)	92.bbb. (232)		
Pre-existing condition exclusion		122.b. (254)		92.bbb. (232)		
Rescission		92.d. (205), 92.j. (210)	92.i. (235), 92.q. (237)	92.bbb. (232)		
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. (24/9)		
2017 Issuer Letter					7.III. (6/1)	
Marketplaces (see Exchanges)						
Medical loss ratio						
General requirements	48.a. (96)	48.d. (131), 48.g. (133), 89.a. (194/79)	48.e. (169)	27.n. (97), 48.b. (143), 48.h. (145), 48.i. (145)		
Medicare Parts C and D		48.c. (131), 48.f. (132)				
Medicaid/CHIP						
Application of essential health benefits	31.a. (74/115)					



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RRIAR Index: Health Reform¹

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) ² Red = Table B Blue = Table C					Other Citations
	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.12)	2016 (v.6.01)	
Community First Choice Option	16.a. (49/100)					
Eligibility/enrollment under ACA	7.a. (18/16), 7.c. (24/67), 7.g. (29/76)	28.a. (82/24), 28.c. (84/30)	28.e. (104)			
Federal Medical Assistance Percentage rates		28.d. (85/38)				
Medicare						
Accountable Care Organization standards	10.b. (138/82)		159.b. (310/60)			
Federally Qualified Health Center payments						
Minimum 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)	31.rr. (123)		
Multi-State Plan Program		111.a. (237/94), 111.b. (238/96), 111.c. (240/102), 111.d. (241)		111.e. (240)	111.f. (47)	
Nondiscrimination		99.b. (221/94), 111.b. (238/96)		181.b. (291/72)		
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. (203/35)		
2017				89.m. (212)		
Patient-Centered Outcomes Research Trust Fund	116. (154)					



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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.12)	2016 (v.6.01)	
Pre-Existing Condition Insurance Plan	6.a. (16/15), 6.b. (17)	6.c., (17), 6.d. (18), 6.e. (18), 6.f. (19)	6.g. (22), 6.h. (22)		6.i. (3)	
Premium tax credits General	29.a. (70/112)	29.b. (86), 29.c. (87), 29.f. (89), 50.d. (136/61), 50.h. (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. (106), 92.uu. (225)	29.d. (21), 50.h. (29),	
Relation to cost-sharing reduction eligibility				89.a. (/34)		
Prescription drug fee			198.a. (347), 198.b. (347)	198.c. (306)		
Qualified health plans Accreditation	50.b. (98)	31.d. (93), 50.j. (142)		7.bbb. (29), 7.rrr (47)		
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. (114)	31.ddd. (23)	
Enrollee satisfaction				168. (287/68)		
Essential community providers	7.a. (18/16), 7.b. (21/22)	7.i. (19), 7.n. (23/1), 50.c. (135/54),	7.ee. (29/4), 92.cc. (255)	7.ddd. (33), 50.e. (147)	7.kkk. (4)	



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Terms	RRIAR Entry Numbers (Page Numbers) ²					Other Citations
	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.12)	2016 (v.6.01)	
General	7.b. (21/22)	111.b. (238/96) 50.p. (147), 89.c. (198/89)	7.b. (3)			
Guaranteed availability			92.aa. (253)			
Network adequacy			50.t. (176/29)	92.tt. (224)	7.jjj. (3)	
Quality improvement/rating system		50.i. (142)	50.q. (173), 50.x. (179/30), 50.y. (182)			
State evaluation	7.a. (18/16), 7.b. (21/22), 7.g. (29/76), 29.a. (70/112)					
Third-party payments						
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. (93), 27.k. (94), 27.l. (95), 27.m. (96), 27.n. (97), 27.o. (98), 27.p. (98), 27.q. (98), 27.r. (100), 27.s. (100), 27.t. (101)		
Shared responsibility payments						
Employers		31.k. (108)	31.f. (120)	31.ccc. (136/26)		
Exemptions		31.e. (94/40), 31.h. (105), 31.q. (114/47)	7.jj. (38), 7.ll. (41), 7.mm. (42),	50.cc. (157)		



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	2012 (v.2.12)	2013 (v.3.12)	2014 (v.4.12)	2015 (v.5.12)	2016 (v.6.01)	
Individuals			7.nn. (43), 7.tt. (51), 29.m. (113), 31.v. (133/13), 31.bb. (139/18), 31.g. (103/44), 31.r. (116)			
Small Business Health Options Program (SHOP)						
Aggregation of premiums			50.z. (183)			
Direct Enrollment				50.bb. (156)		
General	7.c. (24/67)	7.s. (30/11), 7.dd. (40), 50.f. (64), 50.g. (66), 89.c. (198/89)	7.ee. (29/4), 50.z. (183)	7.vv. (24/9), 7.hhh. (37), 50.dd. (159)	7.III. (6/1), 50.f. (27), 50.g. (28), 50.aa. (31)	
State alternative applications		50.m. (145)				
Waivers for state innovation	14.a. (49/98)			14.b. (66), 14.c. (69)		
Wellness programs		99.a. (220)	99.c. (269)	99.d. (233), 99.e. (235)		



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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
6.i.	Interim Final Rule	Pre-Existing Health Insurance Plan Program Updates	CMS
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



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RRIAR Number	Action	Short Title	Agency
7.aa.	Guidance	Federally Facilitated Marketplace Enrollment Operational Policy	CCIIO
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 FFM	CCIIO
7.ff.	Guidance	Enrollment and Termination Policies for Marketplace Issuers	CCIIO
7.gg.	Guidance	Casework Guidance for Issuers in FFM	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 Assistants: 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 FFM	CCIIO
7.ww.	Guidance	Special Protections for AI/ANs	CMS
7.xx.	Guidance	AI/AN Trust Income and MAGI	CMS
7.yy.	Notice	Special Enrollment Period for Tax Season	CMS
7.zz.	Guidance	Hardship Exemptions for Persons Meeting Certain Criteria	CCIIO
7.aaa.	Guidance	Ending Special Enrollment Periods for Coverage in 2014	CCIIO
7.bbb.	Guidance	Key Dates in 2015: QHP Certification in the FFM, et al.	CCIIO
7.ccc.	Guidance	Out-of-Pocket Cost Comparison Tool for FFM	CCIIO
7.ddd.	Request for Comment	ECP Data Collection to Support QHP Certification for PY 2017	CMS
7.eee.	Guidance	2016 Reenrollment in the FFM	CCIIO
7.fff.	Guidance	FAQs Regarding the FFM 2016 Employer Notice Program	CCIIO
7.ggg.	Guidance	Periodic Data Matching in the FFM	CCIIO
7.hhh.	Guidance	FFM and Federally-Facilitated SHOP Enrollment Manual	CCIIO



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RRIAR Number	Action	Short Title	Agency
7.iii.	Guidance	FAQ on Minimum Acceptable Risk Standards for Exchanges	CCIIO
7.jjj.	Request for Comment	Establishment of QHPs and Exchanges	CMS
7.kkk.	Notice	ECP Petition for 2017	CCIIO
7.III.	Guidance	2017 Letter to Issuers in FFMs	CCIIO
7.mmm.	Request for Comment	Establishment of an Exchange by a State and QHPs	CMS
7.nnn.	Request for Comment	Establishment of Exchanges and QHPs--Standards for Employers	CMS
7.ooo.	Request for Comment	CMS Healthcare.gov Site Wide Online Survey	CMS
7.ppp.	Guidance	Unaffiliated Issuer Enrollments and 2016 Reenrollment in FFMs	CCIIO
7.qqq.	Guidance	Policy-Based Payments: Approach for 2016	CCIIO
7.rrr.	Guidance	Key Dates for CY 2016: QHP Certification in the FFM, et al.	CCIIO
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
12.e.	Guidance	CO-OP Program Guidance Manual	CCIIO
12.f.	Guidance	FAQs on the CO-OP Program	CCIIO
14.a.	Final Rule	ACA Waivers for State Innovation	Treasury/CMS
14.b.	Guidance	Fact Sheet/FAQs on Section 1332 State Innovation Waivers	CCIIO
14.c.	Notice	Waivers for State Innovation	CMS/Treasury
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
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
27.k.	Guidance	Transitional Reinsurance Program Collections for 2014	CCIIO
27.l.	Guidance	Transitional Reinsurance Program--Timing of Refunds	CCIIO
27.m.	Guidance	Transitional Adjustment for 2014 Risk Corridors Program	CCIIO



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RRIAR Number	Action	Short Title	Agency
27.n.	Guidance	CSR Amounts in Risk Corridors and MLR Reporting	CCIIO
27.o.	Guidance	Risk Corridors Program Results	CCIIO
27.p.	Guidance	FY 2016 ICD-10 Crosswalk for HHS Risk Adjustment Model	CCIIO
27.q.	Guidance	Adjustment of Risk Adjustment Transfers	CCIIO
27.r.	Guidance	Early Reinsurance Payments for the 2015 Benefit Year	CCIIO
27.s.	Guidance	HHS-Developed Risk Adjustment Model Algorithm Software	CCIIO
27.t.	Guidance	Risk Corridors Payments for the 2014 Benefit Year	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.	Final 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
29.r.	Guidance	Victims of Domestic Abuse and Spousal Abandonment	CCIIO
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



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31.f.	Final Rule	Employer Shared Responsibility	IRS
31.g.	Final Rule	Shared Responsibility for Not Maintaining Essential Coverage	IRS
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.	Final 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



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31.nn.	Request for Comment	Notification of Objection to Covering Contraceptive Services	CMS
31.oo.	Final Rule	Amendments to Excepted Benefits	IRS/DoL/CMS
31.pp.	Final Rule	Summary of Benefits and Coverage and Uniform Glossary	IRS/DoL/CMS
31.qq.	Guidance	FAQ About Excepted Benefits	CCIIO
31.rr.	Guidance	Minimum Essential Coverage Application Review Process	CCIIO
31.ss.	Guidance	Excise Tax on High Cost Employer Health Coverage	IRS
31.tt.	Request for Comment	ACA Section 2715 Summary Disclosures	DoL
31.uu.	Guidance	ACA Implementation FAQs (SBC)	CCIIO
31.vv.	Guidance	EHBs: List of the Largest Three Small Group Products by State	CCIIO
31.xx.	Guidance	ACA Implementation FAQs (Preventive Services)	CCIIO
31.yy.	Guidance	ACA Information Returns Reference Guide	IRS
31.zz.	Guidance	EHB Benchmark Plans for 2017 and Beyond	CCIIO
31.aaa.	Guidance	Excise Tax on High Cost Employer Health Coverage	IRS
31.bbb.	Guidance	SBC Online Posting of Documents	CCIIO
31.ccc.	Letters to IRS	Relief from ACA Employer Mandate on Tribes	TSGAC
31.ddd.	Guidance	2017 Actuarial Value Calculator	CCIIO
31.eee.	Guidance	Extension of Due Dates for 2015 Information Reporting	IRS
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.	Final Methodology	Basic Health Program: Federal Funding Methodology for 2016	CMS
39.f.	Proposed Methodology	Basic Health Program: Federal Funding Methodology for 2017	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
48.h.	Guidance	Q&A on MLR Reporting and Rebate Requirements	CCIIO
48.i.	Guidance	Q&A on MLR Reporting and Rebate Requirements for 2014	CCIIO
50.b.	Final Rule	EHB and QHP Standards	CMS



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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
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
50.aa.	Request for Comment	SHOP Effective Date and Termination Notice Requirements	CMS
50.bb.	Guidance	FAQs on Flexibilities for State-Based SHOP Direct Enrollment	CCIIO
50.cc.	Guidance	FAQs on SBM Options for Shared Responsibility Exemptions	CCIIO
50.dd.	Guidance	FAQs on Agents and Brokers Operating in SHOP	CCIIO
50.ee.	Guidance	FAQs on the Impact of PACE Act on State Small Group Expansion	CCIIO
51.a.	Final Rule	Student Insurance Coverage	CMS
51.b.	Guidance	FAQ on Rate Review of Student Health Plans	CCIIO
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



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RRIAR Number	Action	Short Title	Agency
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
67.g.	Guidance	FAQs on Use of 1311 Funds for Establishment Activities	CCIIO
68.	Request for Comment	Security of Electronic Health Information	CMS
77.a.	Final Rule	Unique Plan Identifiers	CMS
77.e.	Request for Information	Requirements for the Health Plan Identifier	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.	Final Rule	Notice of Benefit and Payment Parameters for 2016	CMS
89.i.	Request for Comment	Information Collection for Machine-Readable Data for QHPs	CMS
89.j.	Guidance	ACA Implementation FAQs (Cost-Sharing Limitations)	CCIIO
89.k.	Letter to CCIIO	Eligibility Determinations for Indian-Specific CSVs	TTAG
89.l.	Request for Information	Referrals for Cost-Sharing Protections Under Limited CSVs	CMS
89.m.	Proposed Rule	Notice of Benefit and Payment Parameters for 2017	CMS
89.n.	Guidance	Manual for Reconciliation of Advance Payment of CSRs	CCIIO
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
91.c.	Final Rule	Waiting Period Limitation	IRS/DoL/CMS



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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
92.hh.	Request for Comment	Annual Eligibility Redetermination Notices, et al.	CMS



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RRIAR Number	Action	Short Title	Agency
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
92.mm.	Guidance	Rate Review Requirements	CCIIO
92.nn.	Guidance	Rate Filing Justifications for Single Risk Pool Coverage	CCIIO
92.oo.	Guidance	Eligibility Redeterminations for Marketplace Coverage	CCIIO
92.pp.	Guidance	ACA Reporting Requirements for Health Coverage Providers	IRS
92.qq.	Guidance	Evaluation of EDGE Data Submissions	CCIIO
92.rr.	Guidance	EDGE Data Submission Grace Period	CCIIO
92.ss.	Guidance	Rate Review Requirements in States with SBMs	CCIIO
92.tt.	Request for Comment	QIS Implementation Plan and Progress Report	CMS
92.uu.	Guidance	Information Distribution on PTCs and CSRs for FFM Coverage	CCIIO
92.vv.	Guidance	FAQs on Uniform Modification and Plan/Product Withdrawal	CCIIO
92.ww.	Guidance	Standard Notices of Product Discontinuation and Renewal	CCIIO
92.xx.	Guidance	FAQ on Transparency Reporting for Non-QHP Coverage	CCIIO
92.yy.	Request for Comment	Transparency in Coverage Reporting by QHP Issuers	CMS
92.zz.	Guidance	FAQs on the Impact of PACE Act on State Small Group Expansion	CCIIO
92.aaa.	Guidance	FAQs on ACA and Mental Health Parity Implementation	CCIIO
92.bbb.	Final Rule	Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, et al.	IRS/DoL/CMS
92.ccc.	Guidance	Rate Filing Justifications for 2016 for Single Risk Pool Coverage	CCIIO
92.ddd.	Guidance	Evaluation of EDGE Data Submissions for 2015	CCIIO
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
99.d.	Guidance	FAQs About ACA Implementation (Wellness Programs)	CCIIO
99.e.	Guidance	FAQs on Market Reforms and Wellness Programs	CCIIO
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.	Final Rule	Establishment of Multi-State Plan Program for Exchanges	OPM



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111.f.	Request for Comment	Mental Health Parity Rules: External Review for MSPP	IRS
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
128.e.	Guidance	Electing a Federal External Review Process	CCIIO
128.f.	Request for Comment	ACA Internal Claims and Appeals and External Review Procedures	DoL
145.a.	Final Rule	Health Insurance Providers Fee	IRS
145.b.	Request for Comment	Report of Health Insurance Provider Information	IRS
145.c.	Proposed Rule	Health Insurance Providers Fee	IRS
145.d.	Final/Temporary Rule	Health Insurance Providers Fee	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.	Final Rule	FEHBP: Rate Setting for Community-Rated Plans	OPM
181.b.	Final Rule	Nondiscrimination Under ACA	HHS OCR
198.a.	Final/Temporary Rule	Branded Prescription Drug Fee	IRS
198.b.	Proposed Rule	Branded Prescription Drug Fee	IRS
198.c.	Request for Comment	Branded Prescription Drug Fee	IRS