National Indian Health Board

Regulation Review and Impact Analysis Report v. 9.10

PURPOSE:

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. Furthermore, the RRIAR includes a summary of the regulatory analyses prepared by the National Indian Health Board (NIHB), if any, and indicates the extent to which the recommendations made by NIHB were incorporated into any subsequent CMS actions.

STRUCTURE:

As indicated by this cover page, the RRIAR consists of two main sections, as well as an Index and Number Reference Guide for regulations associated with health reform. Under Sections I and II, first the regulations are shown in a list format, followed by tables with detail for each entry.

- **Section I** lists key regulations issued by CMS on which Tribal organizations filed comments, providing a synopsis of the CMS action, identifying the recommendations made by Tribal organizations, and evaluating the extent to which the recommendations made by Tribal organizations were incorporated into subsequent CMS actions.
- **Section II** lists additional key regulations issued by CMS, providing due dates for comments, a synopsis of the CMS action, and additional analysis, if any, prepared by the NIHB. This section includes final regulations recently released as well as regulations under Office of Management and Budget (OMB) review.
- **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 (both in the current and prior versions of the RRIAR).
- **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.

I. Regulations with comments submitted by NIHB, TTAG, and/or other Tribal organizations—

- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, CMS-9926-P—Submitted 2/19/2019 (Ref. #2019-001)
- Re-Review of Indian-Specific Summary of Benefits and Coverage Documents and Recommendation for Additional, Targeted Action—Submitted 4/11/2019 (Ref. #2019-002)
- Basic Health Program; Federal Funding Methodology for Program Years 2019 and 2020, CMS-2407-PN—Submitted 5/2/2019 (Ref. #2019-003)
- Request for Information Regarding State Relief and Empowerment Waivers, CMS-9936-NC2—Submitted 7/2/2019 (Ref. #2019-004)
- Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission, CMS-2406-P2—Submitted 9/13/2019 (Ref. #2019-005)

II. Additional Regulations

A. Regulations with pending due dates for public comments —

- Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process, CMS-6058-FC—Due 11/4/2019 (Ref. #2019-008)
- Health Reimbursement Arrangements and Other Account-Based Group Health Plans, CMS-10704—Due 11/5/2019 (Ref. #2019-007)
- Health Insurance Common Claims Form, CMS-1500/1490S—Due 11/12/2019 (Ref. #2019-016)
- Independent Diagnostic Testing Facilities (IDTFs) Site Investigation Form, CMS-10221—Due 11/12/2019 (Ref. #2019-017)
- Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits, CMS-10237—Due 11/12/2019 (Ref. #2019-018)
- Physician Certifications/Recertifications in Skilled Nursing Facilities Manual Instructions, CMS-R-5—Due 11/12/2019 (Ref. #2019-019)
- Healthcare Common Procedure Coding System (HCPCS), CMS-10224—Due 11/12/2019 (Ref. #2019-020)
- Home Office Cost Statement, CMS-287-19—Due 11/12/2019 (Ref. #2019-021)
- Notification of FLS and CMS of Co-Located Medicare Providers, CMS-10088—Due 11/18/2019 (Ref. #2019-023)
- Organ Procurement Organization's (OPOs) Health Insurance Benefits Agreement and Supporting Regulations, CMS-576A—Due 11/18/2019 (Ref. #2019-045)
- Medicaid Program Face-to-Face Requirements for Home Health Services and Supporting Regulations, CMS-10609—Due 11/22/2019 (Ref. #2019-025)
- Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP), CMS-10142—Due 11/22/2019 (Ref. #2019-026)
- Collection of Diagnostic Data in the Abbreviated RAPS Format from Medicare Advantage Organizations for Risk Adjusted Payments, CMS-10062—Due 11/25/2019 (Ref. #2019-029)
- Elimination of Cost-Sharing for Full Benefit Dual-Eligible Individuals Receiving Home and Community-Based Services, CMS-10344—Due 11/25/2019 (Ref. #2019-030)
- Electronic Funds Transfer Authorization Agreement, CMS-588—Due 11/25/2019 (Ref. #2019-031)
- Medicare Enrollment Application for Clinics/Group Practices and Other Suppliers, CMS-855B—Due 11/25/2019 (Ref. #2019-032)
- Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices, CMS-10527—Due 11/25/2019 (Ref. #2019-047)
- Establishment of Exchanges and Qualified Health Plans, CMS-10400—Due 11/27/2019 (Ref. #2019-050)
- Hospital Survey for Specified Covered Outpatient Drugs (SCODs), CMS-10709—Due 11/29/2019 (Ref. #2019-035)
- Contract Year 2021 Plan Benefit Package (PBP) Software and Formulary Submission, CMS-R-262—Due 12/3/2019 (Ref. #2019-038)
- Administrative Simplification HIPAA Compliance Review, CMS-10662—Due 12/3/2019 (Ref. #2019-039)
- PACE State Plan Amendment Preprint, CMS-10227—Due 12/17/2019 (Ref. #2019-041)
- Testing Experience and Functional Tools: Functional Assessment Standardized Items (FASI) Based on the CARE Tool, CMS-10243—Due 12/17/2019 (Ref. #2019-042)
- Implementation of the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey, CMS-10316—Due 12/17/2019 (Ref. #2019-043)
- Applicable Integrated Plan Coverage Decision Letter, CMS-10716—Due 12/17/2019 (Ref. #2019-044)
- Cooperative Agreement to Support Navigators in Federally-Facilitated Exchanges, CMS-10463—Due 12/23/2019 (Ref. #2019-046)
- End Stage Renal Disease Application and Survey and Certification Report, CMS-3427—Due 12/27/2019 (Ref. #2019-048)

- Durable Medical Equipment Medicare Administrative Contractor Certificate of Medical Necessity and Supporting Documentation Requirements, CMS-484, et al.—Due Date 12/27/2019 (Ref. #2019-049)
- The PACE Organization Application Process, CMS-10631—Due 12/30/2019 (Ref. #2019-051)
- Proposed Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Process and Requirements for a Potential National Model, CMS-10708—Due 12/30/2019 (Ref. #2019-052)
- Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report, CMS-416—Due Date: 12/30/2019 (Ref. #2019-053)
- Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, CMS-1720-P—Due 12/31/2019 (Ref. #2019-040)

B. Recent final rules issued—

- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, CMS-9926-F—Effective 6/24/2019 (Ref. #2019-001)
- Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process, CMS-6058-FC — Effective 11/4/2019 (Ref. #2019-008)
- Medicaid Program; State Disproportionate Share Hospital Allotment Reductions, CMS-2394-F—Effective 11/25/2019 (Ref. #2019-027)
- Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, CMS-3346-F, CMS-3334-F, & CMS-3295-F—Effective 11/29/2019 (Ref. #2019-033)
- Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, CMS-3317-F & CMS-3295-F—Effective 11/29/2019 (Ref. #2019-034)

C. Regulations under Office of Management and Budget (OMB) review (listed below only; not shown in table)—

- State Medicaid Director Letter: Medicaid Value and Accountability Demonstration Opportunity– Received 6/4/2019
- Conditions for Coverage for End-Stage Renal Disease Facilities—Third Party Payments, CMS-3337-P—Received 6/6/2019
- International Pricing Index Model For Medicare Part B Drugs, CMS-5528-P—Received 6/20/2019
- Medicaid Fiscal Accountability, CMS-2393-P—Received 7/23/2019
- Medicare Coverage of Innovative Technologies, CMS-3372-P—Received 7/30/2019
- Comprehensive Care for Joint Replacement Model Three Year Extension and Modifications to Episode Definition and Pricing, CMS-5529-P—Received 8/22/2019
- Covered Outpatient Drug; Further Delay of Inclusion of Territories In Definitions of State and United States, CMS-2345-IFC3—Received 9/18/2019
- Civil Money Penalties and Medicare Secondary Payer Reporting Requirements, CMS-6061-P—Received 9/19/2019
- Organ Procurement Organizations (OPOs), CMS-3380-P—Received 9/23/2019
- Transparency in Coverage—Received 9/24/2019
- Medicaid and CHIP Managed Care, CMS-2408-F—Received 9/26/2019

RRIAR TABLE: Listing, Summary, and Analysis Report on Regulations Reviewed (September-October 2019)

- Interoperability and Patient Access, CMS-9115-F—Received 9/26/2019
- HHS Notice of Benefit and Payment Parameters for 2021, CMS-9916-P—Received 9/27/2019
- CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates, CMS-1717- F—Received 10/11/2019
- Basic Health Program; Federal Funding Methodology for Program Year 2019 and 2020, CMS-2407-FN—Received 10/17/2019
- Basic Health Program; Federal Funding Methodology for Program Year 2021, CMS-2432-PN—Received 10/21/2019
- Exchange Program Integrity, CMS-9922-F—Received 10/25/2019
- Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2021, CMS-4190-P—Received 10/29/2019
- CY 2020 Hospital Outpatient PPS Policy Changes: Price Transparency Requirements for Hospitals to Make Standard Charges Public,CMS-1717-F2—Received 10/29/2019
- Preadmission Screening and Resident Review—Update, CMS-2418-P—Received 10/31/2019

I. REGULATIONS WITH COMMENTS RECENTLY SUBMITTED BY NIHB, TTAG, AND/OR OTHER TRIBAL ORGANIZATIONS					
Ref. #	**Short Title/Current Status/Agency/File Code**	**Dates (Issued/ Due/ Action)**	**Brief Summary of Proposed Agency Action**	**Summary of NIHB/TTAG/TSGAC Recommendations**	**NIHB Analysis**
2019-001	**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020** ACTION: ~~Proposed~~ Final Rule AGENCY: CMS, HHS FILE CODE: CMS-9926-~~P~~F RIN: 0938-AT37	Published: 1/24/2019 Due Date: 2/19/2019 NIHB File Date: 2/19/2019 Subsequent Action: Final Rule issued 4/25/2019 Effective Date: 6/24/2019	This final rule sets forth payment parameters and provisions related to the risk adjustment and risk adjustment data validation programs; cost-sharing parameters; and user fees for Federally-Facilitated Exchanges (FFEs) and State-Based Exchanges on the Federal Platform (SBE-FPs). It finalizes changes that will allow greater flexibility related to the duties and training requirements for the Navigator program and changes that will provide greater flexibility for direct enrollment entities, while strengthening program integrity oversight over those entities. It finalizes a change intended to reduce the costs of prescription drugs. This final rule also includes changes to Exchange standards related to eligibility and enrollment; exemptions; and other related topics.	NIHB recommendations— 1. **Regulatory Action to Address "Silver Loading"**: Silver loading—the practice of increasing of silver plan premiums to compensate for the termination of CSR payments to issuers by the Trump administration in late 2017—has helped stabilize the Marketplace and make Marketplace coverage more affordable for AI/ANs and others; CMS should continue to allow silver loading until Congress passes legislation that would appropriate funding for CSR payments and end silver loading. 2. **Allowance of Mid-Year Formulary Changes**: The proposed rule would allow individual, small group, and large group market issuers, if providing enrollees with 120 days notice, to adopt mid-year formulary changes to incentivize greater	In the 4/25/2019 Final Rule— 1. **Regulatory Action to Address "Silver Loading"**: Accepted in part. CMS indicated that the agency will take into consideration all comments regarding potential regulation action to address silver loading. 2. **Allowance of Mid-Year Formulary Changes**: Accepted. CMS stated, "Given the complexity of this issue, and the challenges of balancing the interests of consumers with the importance of

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				enrollee use of lower-cost generic drugs—a provision that might disrupt access to certain drugs for enrollees or make enrollees responsible for new or unexpected costs; in the final rule, CMS should, at minimum, retain the requirement that issuers provide enrollees with 120 days notice prior to any mid-year formulary changes but also should consider eliminating this provision.	mitigating the effects of rising prescription drug costs, we are not finalizing the proposal at this time. Rather, we will continue to examine the issue of mid-year formulary changes and may provide guidance on this issue in the future. In the meantime, to the extent issuers make mid-year formulary changes consistent with applicable state law, our expectation is that all issuers (in the individual, small group, and large group markets) will continue to provide certain consumer protections that ... are generally consistent with current industry practice."
2019-002	**Re-Review of Indian-Specific Summary of Benefits and Coverage Documents and Recommendation for Additional, Targeted Action** ACTION: Letter to CCIIO AGENCY: TTAG FILE CODE: NA RIN: NA	Published: 4/11/2019 Due Date: None	This letter highlights findings from a re-review of Summary of Benefits and Coverage (SBC) documents issued by qualified health plan (QHP) issuers operating through Health Insurance Marketplaces. The TSGAC re-reviewed a sample of SBC documents for 2019 to assess their accuracy in describing the cost-sharing protections provided to eligible AI/ANs under the ACA. The re-review was conducted following 1) a prior finding of significant deficiencies in the SBCs and 2) a subsequent effort by CCIIO to educate health plan issuers and state regulators on the proper application of the Indian-specific cost-sharing protections.	TTAG/TSGAC recommendations— 1. **Response to TSGAC Re-Review of SBCs**: In response to the TSGAC re-review, 1) contact individual health plan issuers identified in the report, inform them of the deficiencies in their SBCs, and educate them on the need to act rapidly to correct these deficiencies; and 2) given the amount of time that certain health plan issuers have posted inaccurate descriptions of the Indian-specific cost-sharing protections in their SBCs, conduct a review of the operations of these issuers to determine if they have applied the L-CSVs correctly and completely, and, if they have not, require them to make whole individual AI/AN enrollees for any erroneous cost-sharing expenditures made. 2. **Authority for SBC Reviews**: In sub-regulatory guidance, clarify which governmental agency has lead responsibility for reviewing the SBCs,	

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				depending on the type of Marketplace, and indicate that CCIIO will enforce requirements in the absence of adequate lead-party oversight. 3. **Scope of SBC Reviews**: Indicate that reviews of SBCs are not performed merely to determine if SBC documents are posted at a live Web link but that a thorough evaluation of their content is required. 4. **Recommendation of Specific Corrections to SBC**: Although the Z-CSV and L-CSV SBC templates are offered as a guide to issuers and the specific language contained in the templates are not mandated for use, in reviewing issuer SBCs, recommend specific language to correct inaccuracies or confusing descriptions. 5. **Descriptors for Z-CSV and L-CSV Plan SBCs**: Establish consistent descriptors to place in the header on the front page of each Indian-specific SBC—such as (1) "AI/AN 02 CSV" and "AI/AN 03 CSV," (2) "AI/AN Z-CSV" and "AI/AN L-CSV," or (3) "AI/AN Zero" and "AI/AN Limited"—and through a link to the "Glossary of Health Coverage and Medical Terms," define the descriptors. 6. **Indication of Limited AI/AN Eligibility for Z-CSV and L-CSV Plans**: Through a link to the "Glossary of Health Coverage and Medical Terms," indicate that "AI/AN" eligibility for the Z-CSV and L-CSV plans, in part, is limited to "an enrolled Tribal member in a federally-recognized Tribe or a	

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				shareholder in an Alaska Native regional or village corporation." 7. **Application of Indian-Specific Protections in Coverage Examples**: Require issuers to present the net out-of-pocket costs in the Coverage Examples to reflect application of the Indian-specific cost-sharing protections (i.e., assuming enrollees receive services from an IHCP or from a non-IHCP through a referral from an IHCP) and insert a note indicating that cost-sharing might be greater if seen at a non-IHCP without referral from an IHCP. 8. **Revised SBC Templates for Z-CSV and L-CSV Plans**: Revise the CCIIO Z-CSV and L-CSV SBC templates, as appropriate, based on the review of existing SBCs.	
2019-003	**Basic Health Program; Federal Funding Methodology for Program Years 2019 and 2020** ACTION: Proposed Methodology AGENCY: CMS, HHS FILE CODE: CMS-2407-PN RIN: 0938-ZB42	Published: 4/2/2019 Due Date: 5/2/2019 TTAG File Date: 5/2/2019	This document proposes the methodology and data sources necessary to determine federal payment amounts in program years 2019 and 2020 to states that elect to establish a Basic Health Program (BHP) under the ACA to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges. Prior to the publication of the final notice, the federal government will make BHP payments using the methodology described in the Final Administrative Order published on 8/24/2018. The federal government will conform payments for 2019 to the finalized 2019 payment methodology through reconciliation.	TTAG recommendations— 1. **Reference Premium for CSR Calculation**: In the final methodology, CMS should modify the assumption used with regard to the selection of QHPs by AI/ANs and assume that AI/ANs who enroll in QHPs will enroll in the second lowest-cost bronze plan, rather than the lowest-cost bronze plan, to reflect more accurately actual plan selections by AI/ANs. 2. **PTC Adjustment**: In the final methodology, CMS should maintain the assumption that AI/ANs who enroll in a QHP will expend the full value of PTCs available to them.	
2019-004	**Request for Information Regarding State Relief and**	Published: 5/3/2019	This request for information (RFI) solicits public comment on ideas for innovative	TTAG recommendations—	

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(See also pre-2017 RRIAR #14.c.)	**Empowerment Waivers** ACTION: Notice AGENCY: CMS, HHS FILE CODE: CMS-9936-NC2	Due Date: 7/2/2019 TTAG File Date: 7/2/2019	programs and waiver concepts that states could consider in developing a 1332 waiver plan. Treasury and CMS (collectively, the Departments) seek feedback and ideas on how states might take advantage of new flexibilities provided in recently published October 2018 guidance.	1. **Indian-Specific Protections Under the ACA**: The ACA contains a number of Indian-specific protections, and a section 1332 waiver could have a direct negative impact on AI/ANs because of changes in Indian-specific and non-Indian specific provisions of the law; to ensure that a section 1332 waiver does not adversely affect AI/ANs, CMS should clarify that representations made by a state pertaining to the state satisfying the requirements for granting such a waiver must consider the specific impact on each individual AI/AN and not remain limited to the overall, or average, impact on the population as a whole. 2. **Other Indian-Specific Protections**: The Balanced Budget Act of 1997 (BBA) established Social Security Act section 1932(a)(2)(C)—which provides that no state can require AI/ANs to enroll in a Medicaid managed care system, except in cases in which an I/T/U operates the system—and American Recovery and Reinvestment Act of 2009 (ARRA) section 5006 provides a number of protections for AI/ANs who elect to enroll in Medicaid managed care; to ensure that a section 1332 waiver does not adversely affect AI/ANs, CMS should emphasize the importance of maintaining the Indian-specific protections contained in section 1932(a)(2)(C) and section 5006 under such a waiver. 3. **Tribal Consultation**: Final CMS/Treasury guidance on section 1332 waivers issued on 10/24/2018 does not discuss the health care and health insurance concerns unique	

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				to AI/ANs or the status of Tribes as sovereign nations with a government-to-government relationship with the United States; CMS should ensure that states engage in meaningful consultation with Tribes as they explore and pursue creative ways to design section 1332 waivers.	
2019-005	**Medicaid Program; Methods for Assuring Access to Covered Medicaid Services-Rescission** ACTION: Proposed Rule AGENCY: CMS, HHS FILE CODE: CMS-2406-P2 RIN: 0938-AT41	Published: 7/15/2019 Due Date: 9/13/2019 TTAG File Date: 9/13/2019	This proposed rule would remove the regulatory text that sets forth the current required process for states to document whether Medicaid payments in fee-for-service systems are sufficient to enlist enough providers to assure beneficiary access to covered care and services consistent with the Medicaid statute.	TTAG recommendations— 1. **Withdrawal of Rule**: CMS should withdraw the proposed rule, which would significantly weaken the ability of agency to monitor and enforce access to covered services in Medicaid programs and would repeal essentially all requirements state Medicaid programs must follow to ensure and demonstrate that their rates satisfy Medicaid access requirements. 2. **Alternative Changes**: CMS should consider more modest changes to reduce the administrative burden for states; these changes could include, for example, adopting a standard reporting template and metrics for Access Monitoring Review Plans (AMRPs) and offering states more technical and financial assistance. 3. **Tribal Consultation**: Along with states, CMS should involve Tribes in efforts to develop a comprehensive strategy for monitoring access to covered care and services in Medicaid.	

II. ADDITIONAL REGULATIONS				
Ref. #	**Short Title/Current Status/Agency/File Code**	**Dates (Issued/ Due/ Action)**	**Brief Summary of Proposed Agency Action**	**NIHB Analysis**
2019-006	**FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 39** ACTION: Guidance AGENCY: CCIIO/CMS, HHS FILE CODE: NA RIN: NA	Published: 9/5/2019 Due Date: None	This guidance, prepared jointly by HHS, DoL, and Treasury (Departments), answers frequently asked questions (FAQ) regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as well as implementation of the 21st Century Cures Act (Cures Act), the SUPPORT for Patient and Communities Act (Support Act), and the Employee Retirement Income Security Act (ERISA).	
2019-007	**Health Reimbursement Arrangements and Other Account-Based Group Health Plans** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10704 OCN: 0938-1361	Published: 9/6/2019 Due Date: 11/5/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Health Reimbursement Arrangements and Other Account-Based Group Health Plans; *Use*: On 6/20/2019, Treasury, DoL, and HHS (collectively, the Departments) issued final regulations titled "Health Reimbursement Arrangements and Other Account-Based Group Health Plans" under section 2711 of the PHS Act and the health nondiscrimination provisions of HIPAA. The regulations expand the use of health reimbursement arrangements and other account-based group health plans (collectively referred to as HRAs). In general, the regulations expand the use of HRAs by eliminating the current prohibition on integrating HRAs with individual health insurance coverage, thereby permitting employers to offer individual coverage HRAs to employees that they can integrate with individual health insurance coverage or Medicare. The regulations allow employees to use amounts in an individual coverage HRA to pay expenses for medical care (including premiums for individual health insurance coverage and Medicare), subject to certain requirements.	
2019-008	**Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process** ACTION: Final Rule AGENCY: CMS, HHS FILE CODE: CMS-6058-FC	Published: 9/10/2019 Due Date: 11/4/2019 Effective Date: 11/4/2019	This final rule with comment period implements statutory provisions that require Medicare, Medicaid, and Children's Health Insurance Program (CHIP) providers and suppliers to disclose certain current and previous affiliations with other providers and suppliers. In addition, this final rule provides the agency with additional authority to deny or revoke Medicare enrollment for providers and suppliers in certain specified circumstances.	The rule's affiliation disclosure requirement implements an Affordable Care Act provision that is intended to identify individuals and entities that pose a risk to the programs based on their relationships with previously sanctioned entities. The newly added definition of "affiliation" is broad and includes not only ownership interests but even reassignment relationships.

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	RIN: 0938-AS84			An affiliation must be disclosed when it is with a provider or supplier that has one of the following "disclosable events" (also a newly defined term): • Currently has uncollected debt to Medicare, Medicaid or CHIP; • Has been or is subject to a payment suspension under a federal health care program; • Has been or is excluded from Medicare, Medicaid or CHIP; or • Has had its Medicare, Medicaid or CHIP billing privileges denied, revoked or terminated. For now, providers and suppliers will not be required to disclose affiliations unless CMS determines that the provider or supplier has at least one affiliation that includes any of the four disclosable events and specifically requests it to do so.
2019-009 (See also pre-2017 RRIAR #121.j.)	**Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-R-263 OCN: 0938-0749	Published: 9/10/2019 Due Date: 10/10/2019	*Type of Information Collection Request*: Reinstatement without change of a previously approved collection; *Title*: Site Investigation for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS); *Use*: The primary function of the site investigation form is to provide a standardized, uniform tool to gather information from a DMEPOS supplier that tells us whether it meets certain qualifications to be a DMEPOS supplier (as found in 42 CFR 424.57(c)) and where it practices or renders its services. This site investigation form also aides the Medicare contractor (the National Supplier Clearinghouse Medicare Administrative Contractor (NSC MAC)) in verifying compliance with the required supplier standards found in 42 CFR 424.57(c).	
2019-010 (See	**Part C Medicare Advantage Reporting Requirements**	Published: 9/11/2019 Due Date: 10/11/2019	*Type of Information Collection Request*: Revision with change of a previously approved collection; *Title*: Part C Medicare Advantage Reporting Requirements and Supporting Regulations in 42 CFR 422.516(a); *Use*: Section 1852(m) of the Social Security Act (Act) and CMS regulations at 42 CFR 422.135 allow Medicare Advantage (MA) plans the ability to	

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also pre-2017 RRIAR #11.g.)	ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10261 OCN: 0938-1054		provide "additional telehealth benefits" to enrollees starting in plan year 2020 and treat them as basic benefits. MA additional telehealth benefits are limited to services for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act. In addition, MA additional telehealth benefits are services identified by the MA plan for the applicable year as clinically appropriate to furnish through electronic information and telecommunications technology (or "electronic exchange") when the physician (as defined in section 1861(r) of the Act) or practitioner (as defined in section 1842(b)(18)(C) of the Act) providing the service is not in the same location as the enrollee. Per § 422.135(d), MA plans can furnish MA additional telehealth benefits only using contracted providers. The changes for the 2020 Reporting Requirements will require plans to report telehealth benefits. The data collected in this measure will provide CMS with a better understanding of the number of organizations utilizing telehealth per contract and also will capture those specialties used for both in-person and telehealth. These data will allow CMS to improve its policy and process surrounding telehealth. In addition, the specialist and facility data aligns with some of the provider and facility specialty types that organizations are required to include in their networks and to submit on their HSD tables in the Network Management Module in Health Plan Management System.	
2019-011	**Medical Necessity and Contract Amendments Under Mental Health Parity** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10556 OCN: 0938-1280	Published: 9/11/2019 Due Date: 10/11/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Medical Necessity and Contract Amendments Under Mental Health Parity; *Use*: Upon request, regulated entities must provide a medical necessity disclosure. Receiving this information will enable potential and current enrollees to make more educated decisions given the choices available to them through their plans and may result in better treatment of their mental health or substance use disorder (MH/SUD) conditions. States use the information collected and reported as part of their contracting process with managed care entities, as well as their compliance oversight role. In states where a Medicaid managed care organization (MCO) is responsible for providing the full scope of medical/surgical and MH/SUD services to beneficiaries, the state will review the parity analysis provided by the MCO to confirm that the MCO benefits are in compliance. CMS uses the information collected and reported in an oversight role of State Medicaid managed care programs.	
2019-012 (See	**External Quality Review (EQR) of Medicaid Managed Care Organizations (MCOs)**	Published: 9/11/2019 Due Date: 10/11/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: External Quality Review (EQR) of Medicaid Managed Care Organizations (MCOs) and Supporting Regulations; *Use*: State agencies must provide to the external quality review organization (EQRO) information obtained through methods consistent with the protocols	

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also pre-2017 RRIAR #62.)	ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-R-305 OCN: 0938-0786		specified by CMS. This information is used by the EQRO to determine the quality of care furnished by an MCO. Since the EQR results are made available to the general public, this allows Medicaid/CHIP enrollees and potential enrollees to make informed choices regarding the selection of their providers. It also allows advocacy organizations, researchers, and other interested parties access to information on the quality of care provided to Medicaid beneficiaries enrolled in Medicaid/CHIP MCOs. States use the information during their oversight of these organizations.	
2019-013 (See also pre-2017 RRIAR #110.i.)	**Medicare Self-Referral Disclosure Protocol** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10328 OCN: 0938-1106	Published: 9/11/2019 Due Date: 10/11/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Medicare Self-Referral Disclosure Protocol; *Use*: Section 6409 of the ACA requires the HHS secretary to establish a voluntary self-disclosure process that allows providers of services and suppliers to self-disclose actual or potential violations of section 1877 of the Social Security Act. In addition, section 6409(b) of the ACA gives the HHS secretary authority to reduce the amounts due and owing for the violations. To determine the nature and extent of the noncompliance and the appropriate amount by which an overpayment may be reduced, the HHS secretary must collect relevant information regarding the arrangements and financial relationships at issue from disclosing parties. The HHS secretary also can collect supporting documentation, such as contracts, leases, communications, invoices, or other documents bearing on the actual or potential violation(s). Most of the information and documentation required for submission to CMS in accordance with the SRDP is information that health care providers of services and suppliers keep as part of customary and usual business practices.	
2019-014 (See also pre-2017 RRIAR #118.)	**Hospital Wage Index Occupational Mix Survey** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10079 OCN: 0938-0907	Published: 9/11/2019 Due Date: 10/11/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Hospital Wage Index Occupational Mix Survey; *Use*: Section 304(c) of Public Law 106-554 mandates an occupational mix adjustment to the wage index, requiring the collection of data every 3 years on the occupational mix of employees for each short-term, acute care hospital participating in the Medicare program. The proposed data collection that is included in this submission complies with this statutory requirement. The purpose of the occupational mix adjustment is to control for the effect of hospital employment choices on the wage index. For example, hospitals may choose to employ different combinations of registered nurses, licensed practical nurses, nursing aides, and medical assistants for the purpose of providing nursing care to their patients. The varying labor costs associated with these choices reflect hospital management decisions rather than geographic differences in the costs of labor.	
2019-	**Frequently Asked**	Published:	This guidance answers FAQs to clarify the requirements for prospective upstream non-	

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015	**Questions (FAQs) Regarding Enhanced Direct Enrollment (EDE) Participation Requirements for Non-Issuer Users of Primary EDE Entity Environments Serving Consumers in States with Federally-Facilitated Exchanges (FFEs) and State-Based Exchanges on the Federal Platform (SBE-FPs)** ACTION: Guidance AGENCY: CCIIO/CMS, HHS FILE CODE: NA RIN: NA	9/11/2019 Due Date: None	issuer users of an enhanced direct enrollment (EDE) environment discussed in the document titled "Third-party Auditor Operational Readiness Reviews for the Enhanced Direct Enrollment Pathway and Related Oversight Requirements" (EDE Guidelines). Any prospective hybrid, non-issuer upstream EDE Entity, as clarified in this guidance, planning to participate in EDE for PYs 2019 and 2020 must notify CMS as soon as possible of its intent to submit an audit consistent with the processes detailed in this document.	
2019-016 (See also pre-2017 RRIAR #60.c. and #60.n.)	**Health Insurance Common Claims Form** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-1500/1490S OCN: 0938-1197	Published: 9/12/2019 Due Date: 11/12/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Health Insurance Common Claims Form and Supporting Regulations at 42 CFR part 424, subpart C (CMS-1500 and CMS-1490S); *Use*: The CMS-1500 and the CMS-1490S forms are used to deliver information to CMS in order for CMS to reimburse for provided services. Medicare Administrative Contractors use the data collected on the CMS-1500 and the CMS-1490S to determine the proper amount of reimbursement for Part B medical and other health services (as listed in section 1861(s) of the Social Security Act) provided by physicians and suppliers to beneficiaries. The CMS-1500 is submitted by physicians/suppliers for all Part B Medicare. Serving as a common claim form, other third-party payers (commercial and nonprofit health insurers) and other Federal programs (e.g., TRICARE, RRB, and Medicaid) can use the CMS-1500. The CMS-1490S (Patient's Request for Medical Payment) was explicitly developed for easy use by beneficiaries who file their own claims.	
2019-017 (See also pre-	**Independent Diagnostic Testing Facilities (IDTFs) Site Investigation Form** ACTION: Request for Comment	Published: 9/12/2019 Due Date: 11/12/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Independent Diagnostic Testing Facilities (IDTFs) Site Investigation Form Revisions; *Use*: The data collection is used by Medicare contractors and/or their subcontractors on site visits to verify compliance with required IDTF performance standards. If a subcontractor is used, the subcontractor collects the information from the IDTF through an interview and forwards it to the Medicare contractor for evaluation.	

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2017 RRIAR #121.i.)	AGENCY: CMS, HHS FILE CODE: CMS-10221 OCN: 0938-1029		The collection and verification of this information defends and protects Medicare beneficiaries from illegitimate IDTFs. These procedures also protect the Medicare Trust Fund against fraud. The data collected also ensure that applicants have the necessary credentials to provide the health care services for which they intend to bill Medicare.	
2019-018 (See also pre-2017 RRIAR #2.e.)	**Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10237 OCN: 0938-0935	Published: 9/12/2019 Due Date: 11/12/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Applications for Part C Medicare Advantage, 1876 Cost Plans, and Employer Group Waiver Plans to Provide Part C Benefits; *Use*: This information collection includes the process for organizations wishing to provide health care services under MA plans. These organizations must complete an application annually (if required), file a bid, and receive final approval from CMS. The MA application process has two options for applicants that include (1) request for new MA product or (2) request for expanding the service area of an existing product. CMS utilizes the application process as the means to review, assess, and determine if applicants are compliant with the current requirements for participation in the MA program and to make a decision related to contract award. This collection process is the only mechanism for organizations to complete the required MA application process. The application process is open to all health plans that want to participate in the MA program. The application is distinct and separate from the bid process, and CMS issues a determination on the application prior to bid submissions, or before the first Monday in June.	
2019-019 (See also pre-2017 RRIAR #72.c.)	**Physician Certifications/ Recertifications in Skilled Nursing Facilities Manual Instructions** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-R-5 OCN: 0938-0454	Published: 9/12/2019 Due Date: 11/12/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Physician Certifications/Recertifications in Skilled Nursing Facilities Manual Instructions; *Use*: Section 1814(a) of the Social Security Act (the Act) requires specific certifications to receive Medicare payments for certain services. Before the enactment of the Omnibus Budget Reconciliation Act of 1989, section 1814(a)(2) of the Social Security Act required that, in the case of post-hospital extended care services, a physician certify that the services are or were required because the individual needs or needed, on a daily basis, skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services that, as a practical matter, an SNF can provide only on an inpatient basis. The physician certification requirements were included in the law to ensure that patients require a level of care covered by the Medicare program and because the physician serves a key figure in determining the utilization of health services. In addition, it set forth	

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			qualification requirements that a nurse practitioner or clinical nurse specialist must meet in order to sign certification or recertification statements (these requirements later were revised in the Balanced Budget Act of 1997). Effective with items and services furnished on or after January 1, 2011, section 3108 of the Affordable Care Act added physician assistants to the existing authority for nurse practitioners and clinical nurse specialists.	
2019-020 (See also pre-2017 RRIAR #191.a.)	**Healthcare Common Procedure Coding System (HCPCS)** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10224 OCN: 0938-1042	Published: 9/12/2019 Due Date: 11/12/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Healthcare Common Procedure Coding System (HCPCS)—Level II Code Modification Request Process; *Use*: In October 2003, the HHS secretary delegated authority under the Health Insurance Portability and Accountability Act (HIPAA) to CMS to maintain and distribute HCPCS Level II Codes. As stated in 42 CFR 414.40(a), CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. CMS has maintained and distributed the HCPCS code set via modifications of codes, modifiers, and descriptions as a direct result of data received from applicants. Thus, information collected in the application is significant to codeset maintenance.	
2019-021 (See also pre-2017 RRIAR #134.h.)	**Home Office Cost Statement** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-287-19 OCN: 0938-0202	Published: 9/12/2019 Due Date: 11/12/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Home Office Cost Statement; *Use*: Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not in itself certified by Medicare. The relationship of the home office is that of a related organization to participating providers (See 42 CFR 413.17). When a provider claims costs on its cost report allocated from a home office, the Home Office Cost Statement constitutes the documentary support required of the provider to receive payment for home office costs in the cost report. Each contractor servicing a provider in a chain must receive a detailed Home Office Cost Statement as a basis for reimbursing the provider for cost allocations from a home office or chain organization. Form CMS-287-19 is needed to determine the reasonable cost incurred by a provider in furnishing medical services to Medicare beneficiaries and reimbursement due to or from the provider.	
2019-022 (See also pre-2017 RRIAR #175.b.)	**Medicaid Drug Use Review (DUR) Program** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-R-153 OCN: 0938-0659	Published: 9/16/2019 Due Date: 10/16/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Medicaid Drug Use Review (DUR) Program; *Use*: States must provide for a review of drug therapy before each prescription is filled or delivered to a Medicaid patient. This review includes screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse/misuse. Pharmacists must make a reasonable effort to obtain, record, and maintain Medicaid patient profiles. These profiles must reflect at least the patient name, address, telephone number, date of birth/age, gender, history, e.g., allergies, drug reactions, list of medications, and pharmacist comments relevant to the drug therapy of the individual.	

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			States must conduct RetroDUR, which provides for the ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, or inappropriate or medically unnecessary care. Annual reports are submitted to CMS for the purposes of monitoring compliance and evaluating the progress of state DUR programs. The information submitted by states is reviewed and results are compiled by CMS in a format intended to provide information, comparisons, and trends related to state experiences with DUR. States benefit from the information and can enhance their programs each year based on state-reported innovative practices compiled by CMS from the DUR annual reports.	
2019-023 (See also pre-2017 RRIAR #121.d.)	**Notification of FLS and CMS of Co-Located Medicare Providers** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10088 OCN: 0938-0897	Published: 9/17/2019 Due Date: 11/18/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Notification of FLS and CMS of Co-Located Medicare Providers; *Use*: Many long-term care hospitals (LTCHs) are co-located with other Medicare providers (acute care hospitals, inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), or inpatient psychiatric facilities (IPFs)), which could lead to potential gaming of the Medicare system based on inappropriate patient shifting. In regulations at 42 CFR 412.22(e)(3) and (h)(6) CMS requires LTCHs to notify Medicare administrative contractors (MACs) and CMS of co-located providers. Under §§ 412.22(e)(3) and (h)(6), an LTCH or a satellite of an LTCH that occupies space in a building used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must notify its MAC and CMS in writing of its co-location within 60 days of its first cost reporting period that began on or after October 1, 2002.	
2019-024 (See also pre-2017 RRIAR #121.c.)	**Medicare Participation Agreement for Physicians and Suppliers** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-460 OCN: 0938-0373	Published: 9/17/2019 Due Date: 10/17/2019	*Type of Information Collection Request*: Reinstatement of a previously approved collection; *Title*: Medicare Participation Agreement for Physicians and Suppliers; *Use*: Section 1842(h) of the Social Security Act permits physicians and suppliers to voluntarily participate in Medicare Part B by agreeing to take assignment on all claims for services to beneficiaries. The law also requires that the HHS secretary provide specific benefits to the physicians, suppliers and other individuals who choose to participate. Form CMS-460 is the agreement by which the physician or supplier elects to participate in Medicare. By signing the agreement to participate in Medicare, the physician or supplier agrees to accept the Medicare-determined payment for Medicare-covered services as payment in full and to charge the Part B beneficiary no more than the applicable deductible or coinsurance for the covered services.	
2019-025	**Medicaid Program Face-to-Face Requirements for Home Health Services and Supporting Regulations**	Published: 9/23/2019 Due Date: 11/22/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP); *Use*: 42 CFR 440.70(f) and (g) require that physicians (or for medical equipment, authorized non-physician practitioners (NPPs), including nurse practitioners, clinical nurse	

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	ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10609 OCN: 0938-1319		specialists and physician assistants) document that a face-to-face encounter occurred with the Medicaid beneficiary prior to the physician making a certification that home health services are required. The burden associated with this requirement is the time and effort to complete this documentation. The burden also includes writing, typing, or dictating the face-to-face documentation and signing/dating the documentation.	
2019-026 (See also pre-2017 RRIAR #11.d.)	**Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10142 OCN: 0938-0944	Published: 9/23/2019 Due Date: 11/22/2019	*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*: Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and implementing regulations, Medicare Advantage organizations (MAO) and prescription drug plans (PDP) are required to submit an actuarial pricing "bid" for each plan offered to Medicare beneficiaries for approval by CMS. The MAOs and PDPs use the Bid Pricing Tool (BPT) software to develop their actuarial pricing bid.	
2019-027	**Medicaid Program; State Disproportionate Share Hospital Allotment Reductions** ACTION: Final Rule AGENCY: CMS, HHS FILE CODE: CMS-2394-F RIN: 0938-AS84	Published: 9/25/2019 Effective Date: 11/25/2019	The ACA requires aggregate reductions to state Medicaid disproportionate share hospital (DSH) allotments annually beginning with fiscal year (FY) 2020. This final rule delineates the methodology to implement the annual allotment reductions.	
2019-028	**QHP Issuers Data Collection for Notices for Plan or Display Errors Special Enrollment Periods** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10595 OCN: 0938-1301	Published: 9/25/2019 Due Date: 10/25/2019	*Type of Information Collection Request*: Extension without change of a currently approved collection; *Title*: QHP Issuers Data Collection for Notices for Plan or Display Errors Special Enrollment Periods; *Use*: In the HHS Notice of Benefit and Payment Parameters for 2017 (CMS-9937-F), CMS finalized 45 CFR 156.1256, which requires qualified health plan (QHP) issuers, in the case of a material plan or benefit display error included in 45 CFR 155.420(d)(12), to notify their enrollees of the error and the eligibility of their enrollees for a special enrollment period (SEP) within 30 calendar days after the issuer is informed by an Federally-Facilitated Exchange (FFE) that the error is corrected, if directed to do so by the FFE. This requirement provides notification to QHP enrollees of errors that might have impacted their QHP selection and enrollment and any associated monthly or annual costs, as well as the availability of an SEP under § 155.420(d)(12) for the enrollee to select a different QHP, if desired. CMS is renewing this information collection request (ICR) in connection with standards regarding Plan or Display Errors SEPs. CMS has changed the	

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			title of the package to reflect its subject matter better. The burden estimate for the ICR included in this package reflects the time and effort for QHP issuers to provide notifications to enrollees on the ICRs regarding Plan or Display Errors SEPs.	
2019-029 (See also pre-2017 RRIAR #11.m.)	**Collection of Diagnostic Data in the Abbreviated RAPS Format from Medicare Advantage Organizations for Risk Adjusted Payments** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10062 OCN: 0938-0878	Published: 9/25/2019 Due Date: 11/25/2019	*Type of Information Collection Request*: Extension without change of a currently approved collection; *Title*: Collection of Diagnostic Data in the Abbreviated RAPS Format from Medicare Advantage Organizations for Risk Adjusted Payments; *Use*: The 1997 Balanced Budget Act (BBA) and later legislation required CMS to adjust per-beneficiary payments with a risk adjustment methodology using diagnoses to measure relative risk due to health status instead of only demographic characteristics such as age, sex, and Medicaid eligibility. The purpose of risk adjustment is to pay plan sponsors accurately based on the health status and diagnoses of their Medicare enrollees. Section 1853 (a)(3) of the Social Security Act as enacted by Section 4001 of Subtitle A of the BBA required the HHS secretary to implement a risk adjustment methodology that accounted for variations in per capita costs based on health status and other demographic factors for payment to Medicare+Choice (now Medicare Advantage) organizations by January 1, 2000. The BBA also required that Medicare+Choice organizations submit data for use in developing risk adjusted payments.	
2019-030 (See also pre-2017 RRIAR #16.d.)	**Elimination of Cost-Sharing for Full Benefit Dual-Eligible Individuals Receiving Home and Community-Based Services** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10344 OCN: 0938-1127	Published: 9/25/2019 Due Date: 11/25/2019	*Type of Information Collection Request*: Extension without change of a currently approved collection; *Title*: Elimination of Cost-Sharing for Full Benefit Dual-Eligible Individuals Receiving Home and Community-Based Services; *Use*: Each month, CMS deems individuals automatically eligible for the full Medicare Part D Low-Income Subsidy (LIS), based on data from state Medicaid agencies and the Social Security Administration (SSA). The SSA sends a monthly file of Supplementary Security Income-eligible beneficiaries to CMS. Similarly, the state Medicaid agencies submit Medicare Modernization Act files to CMS that identify full subsidy beneficiaries. CMS deems the beneficiaries as having full subsidy and auto-assigns these beneficiaries to benchmark Part D plans. Part D plans receive premium amounts based on the monthly assessments.	
2019-031 (See also pre-2017 RRIAR #63.b.)	**Electronic Funds Transfer Authorization Agreement** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-588 OCN: 0938-0626	Published: 9/25/2019 Due Date: 11/25/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Electronic Funds Transfer Authorization Agreement; *Use*: Section 1815(a) of the Social Security Act provides the authority for the HHS secretary to pay providers/suppliers of Medicare services at such time or times as the secretary determines appropriate (but no less frequently than monthly). Under Medicare, CMS, acting for the Secretary, contracts with fiscal intermediaries and carriers to pay claims submitted by providers/suppliers that furnish services to Medicare beneficiaries. Under CMS payment policy, Medicare providers/suppliers have the option of receiving payments electronically.	

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2019-032 (See also pre-2017 RRIAR #121.a.)	**Medicare Enrollment Application for Clinics/Group Practices and Other Suppliers** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-855B OCN: 0938-XXXX	Published: 9/25/2019 Due Date: 11/25/2019	*Type of Information Collection Request*: New collection; *Title*: Medicare Enrollment Application for Clinics/Group Practices and Other Suppliers; *Use*: Form CMS-855B, the Medicare enrollment application for suppliers serves to gather information from the supplier that tells CMS the name of the supplier, whether the supplier meets certain qualifications needed to become a Medicare health care provider or supplier, where the supplier practices or renders services, and other information necessary to establish correct claims payments. Form CMS-855B includes an attachment for opioid treatment programs (OTPs). This attachment is used only to capture the OTP personnel and consists of limited data fields (name, Social Security number, national provider identifier, and license number) in response to the "SUPPORT for Patients and Communities Act" signed into law on October 24, 2018.	
2019-033	**Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care** ACTION: Final Rule AGENCY: CMS, HHS FILE CODE: CMS-3346-F, CMS-3334-F, & CMS-3295-F RIN: 0938-AT23	Published: 9/30/2019 Effective Date: 11/29/2019	This final rule reforms Medicare regulations identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers. This final rule also eliminates or reduces requirements that impede quality patient care or that divert resources away from furnishing high quality patient care. Additionally, this final rule updates fire safety standards for Medicare and Medicaid participating end-stage renal disease (ESRD) facilities by adopting the 2012 edition of the Life Safety Code and the 2012 edition of the Health Care Facilities Code. Finally, this final rule updates the requirements that hospitals and critical access hospitals (CAHs) must meet to participate in the Medicare and Medicaid programs.	
2019-034	**Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access**	Published: 9/30/2019 Effective Date: 11/29/2019	This final rule revises the discharge planning requirements that hospitals (including short-term acute-care hospitals, long-term care hospitals (LTCHs), rehabilitation hospitals, psychiatric hospitals, children's hospitals, and cancer hospitals), critical access hospitals (CAHs), and home health agencies (HHAs) must meet in order to participate in the Medicare and Medicaid programs. This final rule also implements discharge planning	

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	Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care ACTION: Final Rule AGENCY: CMS, HHS FILE CODE: CMS-3317-F & CMS-3295-F RIN: 0938-AS59		requirements that will give patients and their family access to information to help them to make informed decisions about their post-acute care, while addressing their goals of care and treatment preferences. It also updates one provision regarding patient rights in hospitals.	
2019-035	**Hospital Survey for Specified Covered Outpatient Drugs (SCODs)** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10709 OCN: 0938-XXXX	Published: 9/30/2019 Due Date: 11/29/2019	*Type of Information Collection Request*: New collection; *Title*: Hospital Survey for Specified Covered Outpatient Drugs (SCODs); *Use*: In the CY 2018 OPPS/ASC payment system final rule, CMS finalized a policy to adjust payment for separately payable outpatient drugs acquired by eligible hospitals at discounted rates under the HRSA 340B program from average sales price (ASP) plus 6% to ASP minus 22.5%. According to 42 U.S.C. 256b, eligible hospitals include Medicare disproportionate share hospital (DSH) adjustment of greater than 11.75%, children's hospitals, critical access hospitals, cancer hospitals, rural referral centers and sole community hospitals. On December 27, 2018, the U.S. District Court for the District of Columbia ruled that the HHS secretary exceeded his statutory authority to adjust payment rates under the hospital outpatient prospective payment system (OPPS) for separately payable, 340B-acquired drugs. CMS believes that it is important to begin obtaining acquisition costs for specified covered outpatient drugs to set payment rates based on cost for 340B-acquired drugs when they are furnished by certain covered entity hospitals. CMS will use the acquisition cost data hospitals submit in response to this survey will to help determine payment amounts for drugs acquired under the 340B program.	
2019-036	**Opportunity for States to Participate in a Wellness Program Demonstration Project to Implement Health-Contingent Wellness Programs in the Individual Market**	Published: 9/30/2019 Due Date: None	This bulletin announces an opportunity for states to apply to participate in a wellness program demonstration project. Participating States can implement nondiscriminatory health-contingent wellness programs in the individual market, as described in section 2705(l) of the Public Health Service Act (PHS Act). This bulletin outlines the participation requirements; the criteria HHS, in consultation with DoL and Treasury, will use to evaluate applications; instructions on application submissions and appeals; and potential future opportunities for additional states to apply.	

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Ref. #	**Short Title/Current Status/Agency/File Code**	**Dates (Issued/ Due/ Action)**	**Brief Summary of Proposed Agency Action**	**NIHB Analysis**
	ACTION: Guidance AGENCY: CCIIO/CMS, HHS FILE CODE: NA RIN: NA			
2019-037	**Executive Order on Protecting and Improving Medicare for Our Nation's Seniors** ACTION: Executive Order AGENCY: White House FILE CODE: NA RIN: NA	Published: 10/3/2019 Due Date: None	This executive order seeks to "protect and improve Medicare by building on those aspects of the program that work well, including the market-based approaches in the current system." Under this executive order: • Within 1 year, the HHS secretary shall propose regulations and implement other administrative actions to promote Medicare Advantage (MA) plans; • Within 1 year, the HHS secretary shall propose regulations to provide beneficiaries with improved access to providers and plans by adjusting network adequacy requirements for MA plans; • Within 1 year, the HHS secretary shall propose reforms to the Medicare program to enable providers to spend more time with patients, in part by proposing regulations that would (1) eliminate billing requirements, conditions of participation, supervision requirements, benefit definitions, and other licensure requirements and (2) ensure appropriate reimbursement for time spent with patients; • Within 1 year, the HHS secretary shall propose regulatory and sub-regulatory changes to the Medicare program to encourage innovation for patients by (1) streamlining the approval, coverage, and coding process for new drugs and medical devices and (2) modifying the Value-Based Insurance Design payment model to remove any disincentives for MA plans to cover items and services not covered by fee-for-service (FFS) Medicare if those items and service can reduce costs and improve the quality of care; • The HHS secretary shall ensure that Medicare payments and policies encourage competition and a diversity of sites for patients to access care; • Within 1 year, the HHS secretary shall propose regulations that would provide Medicare beneficiaries with improved quality care and cost data, as well as use Medicare claims data to give health care providers additional information regarding practice patterns for services that might pose undue risks to patients or that are outside recommended standards of care; • The HHS secretary shall propose regulatory or sub-regulatory changes to the Medicare program, to take effect by January 1, 2021, and shall propose such changes annually thereafter, to combat fraud, waste, and abuse in the Medicare program;	

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Ref. #	**Short Title/Current Status/Agency/File Code**	**Dates (Issued/ Due/ Action)**	**Brief Summary of Proposed Agency Action**	**NIHB Analysis**
			• Within 180 days, the HHS secretary shall recommend approaches to transition toward market-based pricing in FFS Medicare; • Within 1 year, the HHS secretary shall propose regulatory changes to the Medicare program to reduce the burden on providers and eliminate regulations that create inefficiencies or otherwise undermine patient outcomes; and • Within 180 days, the HHS secretary, in coordination with the Social Security commissioner, shall revise current rules or policies to preserve the Social Security retirement insurance benefits of beneficiaries who choose not to receive benefits under Medicare Part A, and propose other administrative improvements to Medicare enrollment processes; and • Within 1 year, the HHS secretary shall identify and remove unnecessary barriers to private contracts that allow Medicare beneficiaries to obtain the care of their choice and facilitate the development of market-driven prices.	
2019-038 (See also pre-2017 RRIAR #11.f.)	**Contract Year 2021 Plan Benefit Package (PBP) Software and Formulary Submission** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-R-262 OCN: 0938-0763	Published: 10/4/2019 Due Date: 12/3/2019	*Type of Information Collection Request*: Revision with change of a currently approved collection; *Title*: Contract Year 2021 Plan Benefit Package (PBP) Software and Formulary Submission; *Use*: Under the Medicare Modernization Act (MMA), Medicare Advantage (MA) and prescription drug plan (PDP) organizations must submit plan benefit packages for all Medicare beneficiaries residing in their service area. The plan benefit package submission consists of the Plan Benefit Package (PBP) software, formulary file, and supporting documentation, as necessary. MA and PDP organizations use the PBP software to describe their plan benefit packages, including information on premiums, cost-sharing, authorization rules, and supplemental benefits. They also generate a formulary to describe their list of drugs, including information on prior authorization, step therapy, tiering, and quantity limits. CMS requires that MA and PDP organizations submit a completed PBP and formulary as part of the annual bidding process. During this process, organizations prepare their proposed plan benefit packages for the upcoming contract year and submit them to CMS for review and approval. CMS uses these data to review and approve the benefit packages that the plans will offer to Medicare beneficiaries. CMS also uses these data to populate data on Medicare Plan Finder, which allows beneficiaries to access and compare MA plans and PDPs.	
2019-039	**Administrative Simplification HIPAA Compliance Review** ACTION: Request for Comment	Published: 10/4/2019 Due Date: 12/3/2019	*Type of Information Collection Request*: New collection; *Title*: Administrative Simplification HIPAA Compliance Review; *Use*: CMS has authority for administering and enforcing compliance with the Administrative Simplification non-privacy HIPAA rules. Federal regulations at 45 CFR 160.310 require that a covered entity provide records and compliance reports to the HHS secretary in cooperation with a compliance review. These regulations provide that a covered entity must permit HHS, or its delegated entity, access	

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Ref. #	**Short Title/Current Status/Agency/File Code**	**Dates (Issued/ Due/ Action)**	**Brief Summary of Proposed Agency Action**	**NIHB Analysis**
	AGENCY: CMS, HHS FILE CODE: CMS-10662 OCN: 0938-xxxx		during normal business hours to its facilities, books, records, and other information necessary to determine compliance, as well as provide that if the HHS secretary determines that "exigent circumstances exist, such as when documents may be hidden or destroyed," the covered entity must permit access at any time without notice. CMS requires this information collection to retrieve information necessary to conduct a compliance review as described in CMS-0014-N (68 FR 60694). Covered entities will submit these forms to the CMS Program Management National Standards Group.	
2019-040	**Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations** ACTION: Proposed Rule AGENCY: CMS, HHS FILE CODE: CMS-1720-P RIN: 0938-AT64	Published: 10/17/2019 Due Date: 12/31/2019	This proposed rule would address any undue regulatory impact and burden of the physician self-referral law. This proposed rule would implement exceptions to the physician self-referral law for certain value-based compensation arrangements between or among physicians, providers, and suppliers. It also would create a new exception for certain arrangements under which a physician receives limited remuneration for items or services actually provided by the physician; create a new exception for donations of cybersecurity technology and related services; and amend the existing exception for EHR items and services. In addition, this proposed rule provides guidance for physicians and health care providers and suppliers whose financial relationships are governed by the physician self-referral statute and regulations.	This proposed rule would address any undue regulatory impact and burden of the physician self-referral law—or "Stark Law." This rulemaking follows a history of rulemakings related to the physician self-referral law. The proposed rule would create new, permanent exceptions to the Stark Law for value-based arrangements. CMS is soliciting comments about the role of price transparency in the context of the Stark Law and whether to require cost-of-care information at the point of a referral for an item or service.
2019-041 (See also pre-2017 RRIAR #5.b.)	**PACE State Plan Amendment Preprint** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10227 OCN: 0938-1027	Published: 10/18/2019 Due Date: 12/17/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: PACE State Plan Amendment Preprint; *Use*: If a state elects to offer PACE as an optional Medicaid benefit, it must complete a State Plan Amendment (SPA) preprint packet described as "Enclosures 3, 4, 5, 6, and 7." CMS will review the information provided to determine if the state has properly elected to cover PACE services as a State Plan option.	
2019-042 (See also	**Testing Experience and Functional Tools: Functional Assessment Standardized Items (FASI) Based on the CARE Tool**	Published: 10/18/2019 Due Date: 12/17/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Testing Experience and Functional Tools: Functional Assessment Standardized Items (FASI) Based on the CARE Tool; *Use*: In 2012, CMS funded a project entitled, Technical Assistance to States for Testing Experience and Functional Tools (TEFT) Grants. This project will include two collections of individual-level data using the TEFT FASI Item Set.	

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Ref. #	**Short Title/Current Status/Agency/File Code**	**Dates (Issued/ Due/ Action)**	**Brief Summary of Proposed Agency Action**	**NIHB Analysis**
pre-2017 RRIAR #210.)	ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10243 OCN: 0938-1037		The first data collection effort will collect data that can be analyzed to evaluate the reliability and validity of the FASI items when used with the five waiver populations: elderly adults; younger adults with physical disabilities; and adults of any age with intellectual or developmental disabilities, with severe mental illness, or with traumatic brain injury. States will conduct functional assessments in client homes using the TEFT FASI Item Set. States will conduct the second data collection to demonstrate their use of the FASI data elements.	
2019-043 (See also pre-2017 RRIAR #11.k.)	**Implementation of the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10316 OCN: 0938-1113	Published: 10/18/2019 Due Date: 12/17/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Implementation of the Medicare Prescription Drug Plan (PDP) and Medicare Advantage (MA) Plan Disenrollment Reasons Survey; *Use*: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides a requirement to collect and report performance data for Part D prescription drug plans (PDPs). Specifically, the MMA requires CMS to conduct consumer satisfaction surveys regarding the Medicaid Advantage (MA) and PDP contracts. CMS developed the Disenrollment Survey to capture the reasons for disenrollment at a time as close as possible to the actual date of disenrollment. Through this survey, CMS seeks to: (1) obtain information about beneficiary expectations relative to provided benefits and services (for both MA plans and PDPs) and (2) determine the reasons that prompt beneficiaries to disenroll voluntarily.	
2019-044	**Applicable Integrated Plan Coverage Decision Letter** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10716 OCN: 0938-xxxx	Published: 10/18/2019 Due Date: 12/17/2019	*Type of Information Collection Request*: New collection; *Title*: Applicable Integrated Plan Coverage Decision Letter; *Use*: The Bipartisan Budget Act (BBA) of 2018 directed the establishment of procedures to unify Medicare and Medicaid grievance and appeals procedures to the extent feasible for dual-eligible special needs plans (D-SNPs), beginning in 2021. Under implementing regulations, applicable integrated plans as defined at 42 CFR 422.561 must issue form CMS-10716 when a declining a request for either a medical service or payment covered under the Medicare or Medicaid benefit. The notice explains why the plan denied the service or payment and informs the plan enrollees of their appeal rights.	
2019-045 (See also pre-2017 RRIAR	**Organ Procurement Organization's (OPOs) Health Insurance Benefits Agreement and Supporting Regulations** ACTION: Request for Comment	Published: 10/18/2019 Due Date: 11/18/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Organ Procurement Organization's (OPOs) Health Insurance Benefits Agreement and Supporting Regulations; *Use*: The Medicare and Medicaid final conditions for coverage for organ procurement organizations (OPOs) require OPOs to sign agreements with CMS to receive reimbursement and perform their services. The information provided on this form serves as a basis for continuing the agreements with CMS and the OPOs for participation in the Medicare and Medicaid.	

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Ref. #	**Short Title/Current Status/Agency/File Code**	**Dates (Issued/ Due/ Action)**	**Brief Summary of Proposed Agency Action**	**NIHB Analysis**
#138.a.)	AGENCY: CMS, HHS FILE CODE: CMS-576A OCN: 0938-0512			
2019-046 (See also pre-2017 RRIAR #7.q.)	**Cooperative Agreement to Support Navigators in Federally-Facilitated Exchanges** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10463 OCN: 0938-1215	Published: 10/23/2019 Due Date: 12/23/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Cooperative Agreement to Support Navigators in Federally-Facilitated Exchanges; *Use*: Section 1311(i) of the ACA requires Exchanges to establish a Navigator grant program. Navigators assist consumers by providing education about, and facilitating selection of, qualified health plans (QHPs) within the Exchanges, as well as perform other required duties. As a condition of award, Navigator grant awardees must agree to cooperate with any federal evaluation of the program and provide required weekly, monthly, quarterly, annual, and final (at the end of the cooperative agreement period) reports in a form prescribed by CMS, as well as any additional reports as required.	
2019-047 (See also pre-2017 RRIAR #92.hh.)	**Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10527 OCN: 0938-1254	Published: 10/24/2019 Due Date: 11/25/2019	*Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Annual Eligibility Redetermination, Product Discontinuation and Renewal Notices; *Use*: Section 1411(f)(1)(B) of the ACA directs the HHS secretary to establish procedures to redetermine the eligibility of individuals on a periodic basis in appropriate circumstances. Section 1321(a) of the ACA provides authority for the HHS secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, qualified health plans (QHPs), and other components of title I of the ACA. Under section 2703 of the Public Health Service Act (PHS Act), as added by the ACA, and sections 2712 and 2741 of the PHS Act, enacted by the HIPAA, health insurance issuers in the group and individual markets must guarantee the renewability of coverage unless an exception applies. The final rule titled "Patient Protection and Affordable Care Act; Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs; Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges" (79 FR 52994) provides that an Exchange can choose to conduct the annual redetermination process for a plan year (1) in accordance with the existing procedures described in 45 CFR 155.335; (2) in accordance with procedures described in guidance issued by the Secretary for the coverage year; or (3) using an alternative proposed by the Exchange and approved by the HHS secretary. The final rule also amends the requirements for product renewal and re-enrollment (or non-renewal) notices sent by QHP issuers in the Exchanges and specifies content for these notices.	
2019-048 (See	**End Stage Renal Disease Application and Survey and Certification Report**	Published: 10/28/2019 Due Date: 12/27/2019	*Type of Information Collection Request*: Reinstatement with change of a previously approved collection; *Title*: End Stage Renal Disease Application and Survey and Certification Report; *Use*: Part I of this form is a facility identification and screening measurement used to initiate the certification and recertification of ESRD facilities. Part II	

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Ref. #	**Short Title/Current Status/Agency/File Code**	**Dates (Issued/ Due/ Action)**	**Brief Summary of Proposed Agency Action**	**NIHB Analysis**
also pre-2017 RRIAR #71.o.)	ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-3427 OCN: 0938-0360		is completed by the Medicare/Medicaid state survey agency to determine facility compliance with ESRD conditions for coverage.	
2019-049 (See also pre-2017 RRIAR #3.c. and #3.d.)	**Durable Medical Equipment Medicare Administrative Contractor Certificate of Medical Necessity and Supporting Documentation Requirements** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-484, 846, 847, 848, 849, 10125, and 10126 OCN: 0938-0679	Published: 10/28/2019 Due Date: 12/27/2019	*Type of Information Collection Request*: Extension without change of a currently approved collection; *Title*: Durable Medical Equipment Medicare Administrative Contractor Certificate of Medical Necessity and Supporting Documentation Requirements; *Use*: The certificates of medical necessity (CMNs) collect information required to help determine the medical necessity of certain items. CMS requires CMNs where a vulnerability to the Medicare program might exist. Each initial claim for these items must have an associated CMN for the beneficiary. Suppliers complete the administrative information (e.g., patient name and address, items ordered, etc.) on each CMN. Suppliers also must provide a narrative description of the items ordered and all related accessories, their charge for each of these items, and the Medicare fee schedule allowance (where applicable). Suppliers then send each CMN to the treating physician or other clinicians (e.g., physician assistant, LPN, etc.) who completes questions pertaining to the medical condition of the beneficiary and signs the CMN. The physician or other clinician returns the CMN to the supplier, which submits the CMN electronically to CMS, along with a claim for reimbursement.	
2019-050 (See also pre-2017 RRIAR #7.jjj.)	**Establishment of Exchanges and Qualified Health Plans** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10400 OCN: 0938-1156	Published: 10/28/2019 Due Date: 11/27/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Establishment of Exchanges and Qualified Health Plans; *Use*: As directed by the final rule titled Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (77 FR 18310) (Exchange rule), each Exchange assumed responsibilities related to the certification and offering of qualified health plans (QHPs). Under 45 CFR 156.280(e)(5)(ii), each QHP issuer that offers non-excepted abortion services must submit to the state insurance commissioner a segregation plan describing how the QHP issuer establishes and maintains separate payment accounts for any QHP covering non-excepted abortion services, and pursuant to § 156.280(e)(5)(iii), each QHP issuer must annually attest to compliance with ACA section 1303 and applicable regulations. This segregation plan is used to verify that the financial and other systems of the QHP issuer fully conform to the segregation requirements required by the ACA.	
2019-051 (See also pre-	**The PACE Organization Application Process** ACTION: Request for Comment AGENCY: CMS, HHS	Published: 10/29/2019 Due Date: 12/30/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: The PACE Organization Application Process in 42 CFR part 460; *Use*: The Programs of All-Inclusive Care for the Elderly (PACE) consist of pre-paid, capitated plans that provide comprehensive health services to frail, older adults in the community who are eligible for nursing home care according to state standards. This information collection is mandated under sections 1894(f) and 1934(f) of the Social Security Act and at 42 CFR part 460,	

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Ref. #	**Short Title/Current Status/Agency/File Code**	**Dates (Issued/ Due/ Action)**	**Brief Summary of Proposed Agency Action**	**NIHB Analysis**
2017 RRIAR #5.e.)	FILE CODE: CMS-10631 OCN: 0938-1326		subpart B, which addresses the PACE organization (PO) application and waiver process. An entity wishing to become a PO must submit an application to CMS describing how the entity meets all the requirements in the PACE program. The application must include an assurance from the State Administering Agency (SAA) of the state in which the PO is located. CMS recently issued a final PACE rule (CMS-4168-F), effective August 2, 2019, to update and modernize the PACE program. In addition to codifying the current automated processes for the submission and review of both initial and service area expansion PO applications, this rule modifies existing regulatory provisions and requirements. As a result, certain attestations associated with the application are no longer applicable, and others need require updates to reflect updated regulatory requirements. CMS also has made minor changes to certain document upload requirements for clarification purposes based on experience reviewing applications.	
2019-052	**Proposed Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Process and Requirements for a Potential National Model** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-10708 OCN: 0938-xxxx	Published: 10/29/2019 Due Date: 12/30/2019	*Type of Information Collection Request*: New collection; *Title*: Proposed Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Process and Requirements for a Potential National Model; *Use*: CMS seeks approval to potentially expand the RSNAT Prior Authorization Model nationally if the HHS secretary determines that the expansion criteria are met. If such a national model moves forward, CMS would use this information collection to determine proper payment for repetitive, scheduled non-emergent ambulance transports. The information required would include all medical documents and information to show that the number and level of transports requested are reasonable and necessary for the beneficiary and meet other Medicare requirements.	
2019-053 (See also pre-2017 RRIAR #176.)	**Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report** ACTION: Request for Comment AGENCY: CMS, HHS FILE CODE: CMS-416 OCN: 0938-0354	Published: 10/31/2019 Due Date: 12/30/2019	*Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report; *Use*: The collected baseline data is used to assess the effectiveness of state early and periodic screening, diagnostic, and treatment (EPSDT) programs in reaching eligible children (by age group and basis of Medicaid eligibility). This assessment is coupled with state results in attaining the participation goals set for the state. The information gathered from this report permits federal and state managers to evaluate the effectiveness of the EPSDT law on the basic aspects of the program.	

National Indian Health Board

RRIAR INDEX: HEALTH REFORM
UPDATED THROUGH 10/31/2019

RRIAR Index: Health Reform[1]

From left to right in the table, the term is listed (*e.g.*, "Indian-specific ACA provisions"); the subtopic is listed (*e.g.*, "Cost-sharing reductions"); and the RRIAR entry number is shown (*e.g.*, "7.a."). For years prior to 2017, 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 and underlined (*e.g.*, "(16)"). For 2017 and subsequent years, the page number for the summary entry is shown in purple. 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 Purple = Summary Entry							
	2012 (v.2.12)	**2013 (v.3.12)**	**2014 (v.4.12)**	**2015 (v.5.12)**	**2016 (v.6.10)**	**2017 (v.7.01)**	**2018 (v.8.01)**	**2019 (v.9.10)**
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), 111.c.	31.w. (133/14), 31.x. (135/16)	7.ww. (26), 7.xx. (27), 27.n. (97), 89.h. (203/35)	50.h. (152)		2018-017 (21), 2018-038 (37)	2019-001 (4), 2019-002 (5)

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

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

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

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

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RRIAR INDEX: HEALTH REFORM
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RRIAR Index: Health Reform[1]

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Referrals		(240/102)		89.l. (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. (149), 50.h. (152)			
Employer mandate				31.ccc. (136/26)	31.iii. (124/6)			
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.ll. (218/54)	7.kkk. (32), 7.lll. (34/7), 7.iiii. (55)	2017-022 (17)		
Exemption from tax penalty		31.e. (94/40), 31.g. (103/44), 31.q. (47)	7.mm. (42), 31.v. (133/13)	7.ww. (26), 89.h. (203/35)	31.q. (117)		2018-038 (37)	
Fees	116. (154)	89.a. (194/79)		145.c. (279)				
Implementation of section 402 of IHCIA			50.q. (173), 50.r. (175), 50.x. (179/30)				2018-038 (37)	
Indian addendum	7.b. (21/22)	50.c. (135/54), 111.a. (237/94),	7.ee. (29/4)	7.vv. (24/9), 89.h. (203/35)	7.lll. (34/2)			

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Issuer regulations (Indian-specific concerns)	7.a. (18/16), 7.b. (21/22), 7.g. (29/76)	111.b. (238/96) 7.n. (23/1), 89.a. (194/79), 89.b. (195/87), 111.a. (237/94)	7.ee. (29/4), 50.t. (176/29), 65. (199/36), 92.u. (242/49), 92.cc. (255)	7.vv. (24/9), 31.pp. (119/21), 89.h. (203/35), 92.ll. (218/54),	7.lll. (34/2), 31.lll. (126/7), 168. (344/65)	2017-022 (17)		2019-001 (4), 2019-002 (5)
Premium sponsorship	7.a. (18/16), 7.b. (21/22), 7.g. (29/76), 29.a. (70/112)	50.d. (136/61), 111.a. (237/94), 111.b. (238/96)	7.b. (3), 7.ee. (29/4), 50.q. (173), 50.r. (175), 50.x. (179/30), 65. (199/36)	7.vv. (24/9)	7.lll. (34/2)			
Tribal consultation			64.a. (196/31), 64.b (198/33)	64.c. (173/30)				
Tribal employer/organization participation in FEHBP			174.c. (315/63), 174.d. (317)		174.g. (347)			
Tobacco use (ceremonial)		50.d. (136/61), 50.f. (64), 50.h. (68), 92.a. (202/91)			50.f. (149), 50.h. (152)			
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.e. (138)	39.f. (132)			2019-003 (7)

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			39.d. (159)					
Consumer assistance grants					67.a. (175)			
Consumer Operated and Oriented Plan (CO-OP) Program	12.a. (44), 12.b. (46/94)	12.c. (58)		12.d. (64), 12.e. (65)	7.www. (43), 12.f. (79)			
Cost-sharing reductions	7.a. (18/16), 45. (87)	29.f. (89), 50.d. (136/61), 50.h. (68), 50.n. (146), 89.a. (194/79), 89.b. (195/87), 89.f. (201), 111.c. (240/102)	29.g. (107/12), 29.h. (108), 31.w. (133/14), 50.w (178),	27.n. (97), 89.k. (210/42), 89.l. (211/48), 92.uu. (225)	50.h. (152), 89.d. (203), 89.g. (205), 89.n. (211), 89.o. (213), 89.p. (214), 89.q. (214), 89.r. (215), 89.s. (216)			2019-001 (4), 2019-002 (5)
Early retiree reinsurance program		88.a. (193), 88.b. (194)						
Electronic funds transfers	63.a. (113)				63.b. (174)			
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. (107), 31.iii. (124/6)			
Excise tax				31.ss. (124/22), 31.aaa. (132/26)				
Notices		7.z. (36)			7.x. (28)			

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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)	29.t. (116)			
Self-funded, non-federal governmental plans			92.ee. (259)					
Employer tax credits			31.m. (127), 31.n. (128)					
Essential health benefits								
Excepted benefits		31.i. (107)	31.t. (131)	31.oo. (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)	92.iii. (234)			
Standards	7.g. (29/76), 31.a. (74/115), 45. (87), 50.b. (98)	31.d. (93)	92.aa. (253)		31.kkk. (126)			
Exchanges								
Federally-facilitated and state-partnership								
Benefit and payment parameters (**see Notice of Benefit and Payment**								

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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)					
Data matching				7.ggg. (36)	7.dddd. (49)			
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.ppp. (45), 92.oo. (220)	7.hhh. (29), 7.ttt. (41), 7.yyy. (46), 7.zzz. (47), 7.aaaa. (47), 7.bbbb. (48), 7.eeee. (50), 7.kkkk. (57), 31.jjj. (125), 50.h. (152), 92.hh. (223), 92.jjj. (235)			2019-001 (4)
Employer-sponsored insurance verification					31.jjj. (125), 54. (169)			
Enrollee satisfaction	7.a. (18/16)				7.xxx. (45), 168. (344/65)			
Establishment					7.mmm. (37), 7.nnn. (38)			
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)					

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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.lll. (34/2), 7.rrr. (40)			
Health insurance affordability programs (**see Cost-sharing reductions and Premium tax credits**)								
Inappropriate steering into individual market					7.cccc. (48)			
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. (32), 7.iiii. (55)			
Language access					7.uuu. (42), 7.ffff. (51)			
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.v. (22), 7.kk. (23)	7.q. (27)			2019-001 (4)
Out-of-pocket costs				7.ccc. (29/10)				
Outreach	7.a. (18/16), 7.g. (29/76)		7.pp. (46)		67.b. (176)			
Policy-based payments				7.qqq. (47)	7.sss. (41)			

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Program integrity		7.s. (30/11)						
Quality	100.a. (144)		100.b. (271)		7.xxx. (45)			
Special enrollment periods		31.h. (105)	6.h. (22), 7.ii. (38), 7.jj. (38), 29.i. (108)	7.yy. (27), 7.aaa. (28), 29.r. (107)	7.vvv. (43), 7.www. (43), 7.llll. (57)	2017-022 (17)		
Stand-alone dental plans		7.u. (32/12)			7.l. (26), 7.nnnn. (59)			
User fee					7.hhhh. (55)			2019-001 (4)
Web portal	7.g. (29/76)		65. (199/36)		7.ooo. (39)			
State-based								
General		7.dd. (40), 50.u. (150)	50.o. (172), 50.s. (175)	7.t. (20)	50.gg (155)			
Shared responsibility payment exemptions				50.cc. (157)				
State alternative applications		50.k. (143/73), 50.l. (144)						
Federal Employees Health Benefits Program (FEHBP)		174.a. (323), 174.b. (325)	174.c. (315/63), 174.d. (317), 174.e. (318)	174.f. (290)	174.g. (347)			
Health insurance market rules								
Regulations								
90-day waiting period	91.a. (138)		91.b. (231), 91.c. (231)					
Age curves		92.c. (205)						

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Appeals and external review	90. (138)	128.b. (261), 128.c. (261), 128.d. (262)		92.bbb. (232), 128.e. (263), 128.f. (263)	128.a. (284)			
Contraceptive services		31.i. (107)	31.y. (136), 31.ee. (144), 31.ff. (145)	31.dd. (108), 31.gg. (110), 31.ll. (112), 31.nn. (117), 31.xx. (128)	31.mmm. (129), 92.iii. (234)			
Cost-sharing limitations				89.j. (207)			2018-038 (37)	
Expatriate health plans					92.kkk. (236)			
General		92.a. (202/91)	92.u. (242/49), 92.dd. (257/52) 92.ff. (260)				2018-038 (37)	
Geographic rating areas		92.c. (205)						
Grandfathered health plans			92.h. (234), 92.n. (237)	92.bbb. (232)	92.e. (220)			
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.b. (217), 92.ddd. (231), 92.eee. (217), 92.ggg. (219), 92.yy. (212)			
Mental health parity/services	31.a. (74/115)		92.t. (241)	92.aaa. (231)	92.iii. (234), 92.mmm.			

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					(237), 92.qqq. (240)			
Netting payments					92.ooo. (239)			
Network/provider issues			92.w. (249/51), 92.cc. (255), 145.a. (301)	89.j. (207), 92.ll. (218/54) 145.c. (279), 145.d. (279)	92.fff. (233)		2018-038 (37)	
PACE Act				50.ee. (159), 92.zz. (231)				
Preventive services (**see Essential health benefits**)								
Product modification/withdrawal				92.vv. (225)				
Rate review		92.o. (213)	92.g. (232)	92.mm. (218), 92.nn. (219), 92.ss. (223)	92.s. (221), 92.ccc. (229), 92.lll. (236), 92.ppp. (240)			
Reference pricing			92.gg. (261)					
Same-sex spouses			92.z. (252)					
Stop-loss insurance	56. (106)							
Student insurance	51.a. (101)			51.b. (159)	51.c. (155), 51.d. (156), 51.e. (157)			
Transitional policy			92.x. (250), 92.aa. (253)		92.eee. (232)			
Unique plan identifiers	77.a. (125)			77.e. (190)				
Notices								

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Annual/lifetime limits		92.j. (210)		92.bbb. (232)	92.d. (219)			
COBRA election					92.nnn. (238)			
Coverage (Summary of Benefits and Coverage)		122.c. (254)		31.pp. (119/21), 31.uu. (126), 31.bbb. (133)	31.tt. (118), 31.ggg. (123), 31.hhh. (124), 31.lll. (126/7), 92.kk. (224)			2019-002 (5)
Enrollment opportunity		92.j. (210)		92.v. (215)				
Market discontinuation/renewal		92.f. (207)	92.y. (251)	92.ww. (227)	92.hhh. (234)			
Patient protection		92.j. (210)	92.k. (236), 92.r. (238)	92.bbb. (232)	92.d. (219)			
Pre-existing condition exclusion		122.b. (254)		92.bbb. (232)				
Rescission		92.j. (210)	92.i. (235), 92.q. (237)	92.bbb. (232)	92.d. (219)			
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.lll. (34/2)			
Marketplaces (see Exchanges)								
Medical loss ratio								

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General requirements	48.a. (96)	48.d. (131), 48.g. (133), 89.a. (194/79)	48.e. (169)	27.n. (97), 48.h. (145), 48.i. (145)	48.b. (141), 48.f. (144) 48.j. (145), 48.k. (145)			
Medicare Parts C and D		48.c. (131)						
Medicaid/CHIP								
Application of essential health benefits	31.a. (74/115)							
Community First Choice Option	16.a. (49/100)							
Eligibility/enrollment under ACA	7.a. (18/16), 7.c. (24/67), 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)							
Federally Qualified Health Center payments			159.b. (310/60)					
Minimum essential coverage		31.e. (94/40), 31.q. (47), 31.s. (117)	29.m. (113), 31.p. (130), 31.x. (135/16), 92.aa. (253)	31.rr. (123)	31.q. (117), 31.fff. (121)			
Multi-State Plan Program		111.a. (237/94), 111.b.		111.e. (240)	111.f. (247)			

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		(238/96), 111.c. (240/102), 111.d. (241)						
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. (208/18)			
2018					89.t. (216/23)			
2020								2019-001 (4)
Patient-Centered Outcomes Research Trust Fund	116. (154)							
Pre-Existing Condition Insurance Plan	6.a. (16/15), 6.b. (17)	6.c., (17), 6.d. (18), 6.e. (18), 6.f. (19)	6.g. (22), 6.h. (22)		6.i. (25)			
Premium tax credits								
General	29.a. (70/112)	29.b. (86), 29.c. (87), 29.f. (89),	29.g. (107/12), 29.h. (108), 29.j. (109),	29.q. (106), 92.uu. (225)	29.d. (107), 29.s. (109), 50.h. (152)			

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Relation to cost-sharing reduction eligibility		50.d. (136/61), 50.h. (68), 50.n. (146)	29.k. (110), 29.l. (113), 29.m. (113), 29.n. (115), 50.w. (178)	89.a. (/34)				
Prescription drug fee			198.a. (347), 198.b. (347)	198.c. (306)				
Qualified health plans								
Accreditation/certification	50.b. (98)	31.d. (93), 50.j. (142)		7.bbb. (29)	7.rrr. (40), 7.jjjj. (56), 31.hhh. (124)			
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. (119), 31.nnn. (130)	2017-022 (17)		
Casework standards					7.mmmm. (58)			
Enrollee satisfaction					168. (344/65)			
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.ddd. (33), 50.e. (147)	7.kkk. (32), 7.iiii. (55)	2017-022 (17)		
General	7.b. (21/22)	50.p. (147), 89.c. (198/89)	7.b. (3)					
Guaranteed availability			92.aa. (253)			2017-022 (17)		

National Indian Health Board

RRIAR INDEX: HEALTH REFORM
UPDATED THROUGH 10/31/2019

RRIAR Index: Health Reform[1]

From left to right in the table, the term is listed (*e.g.*, "Indian-specific ACA provisions"); the subtopic is listed (*e.g.*, "Cost-sharing reductions"); and the RRIAR entry number is shown (*e.g.*, "7.a."). For years prior to 2017, 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 and underlined (*e.g.*, "(16)"). For 2017 and subsequent years, the page number for the summary entry is shown in purple. 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 Purple = Summary Entry							
	2012 (v.2.12)	**2013 (v.3.12)**	**2014 (v.4.12)**	**2015 (v.5.12)**	**2016 (v.6.10)**	**2017 (v.7.01)**	**2018 (v.8.01)**	**2019 (v.9.10)**
Network adequacy					7.jjj. (31), 7.gggg. (53)	2017-022 (17)		
Quality improvement/rating system			50.t. (176/29)	92.tt. (224)				
State evaluation		50.i. (142)						
Third-party payments	7.a. (18/16), 7.b. (21/22), 7.g. (29/76), 29.a. (70/112)		50.q. (173), 50.x. (179/30), 50.y. (182)					
Reinsurance, risk corridors, and risk adjustment	7.a. (18/16), 27.a. (65/104)	27.b. (77), 27.d. (79), 27.e. (80)	27.c. (100), 27.f. (101), 27.g. (102), 27.h. (102), 27.j. (104)	27.i. (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)	27.u. (105), 27.v. (106), 27.w. (106), 27.x. (107), 48.k. (145)		2018-017 (21)	2019-001 (4)
Shared responsibility payments								
Employers		31.k. (108), 31.q. (47)	31.f. (120)	31.ccc. (136/26)	31.q. (117), 31.iii. (124/6)			
Exemptions		31.e. (94/40), 31.h. (105)	7.jj. (38), 7.ll. (41), 7.mm. (42), 7.nn. (43), 7.tt. (51),	50.cc. (157)	31.ooo. (130)			

National Indian Health Board

RRIAR INDEX: HEALTH REFORM
UPDATED THROUGH 10/31/2019

RRIAR Index: Health Reform[1]

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Individuals		31.g. (103/44), 31.r. (116)	29.m. (113), 31.v. (133/13), 31.bb. (139/18), 31.x. (135/16)					
Small Business Health Options Program (SHOP)								
Aggregation of premiums			50.z. (183)					
Direct Enrollment				50.bb. (156)	50.ff. (154)			
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), 50.dd. (159)	7.hhh. (29), 7.lll. (34/2), 50.f. (149), 50.g. (150), 50.aa. (154)			
State alternative applications		50.m. (145)						
Waivers for state innovation/section 1332 waivers	14.a. (49/98)			14.b. (66)	14.c. (82/4)			2019-004 (7)
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

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 FFMs	CCIIO
7.ff.	Guidance	Enrollment and Termination Policies for Marketplace Issuers	CCIIO
7.gg.	Guidance	Casework Guidance for Issuers in FFMs	CCIIO
7.hh.	Guidance	Guidance on Individuals “In Line” for FFM	CCIIO
7.ii.	Guidance	Guidance on Special Enrollment Periods for Complex Cases	CCIIO
7.jj.	Guidance	SEPs and Hardship Exemptions for Certain Individuals	CCIIO
7.kk.	Request for Comment	Standards for Navigators and Non-Navigator Personnel	CMS
7.ll.	Guidance	Filing Threshold Hardship Exemption	CCIIO
7.mm.	Guidance	Exemption for Individuals Eligible for Indian Provider Services	CCIIO
7.nn.	Guidance	Hardship Exemptions, Age Offs, and Catastrophic Coverage	CCIIO
7.oo.	Guidance	Information and Tips for Assisters: Working with AI/ANs	CCIIO
7.pp.	Guidance	Effort to Help Marketplace Enrollees Stay Covered	CCIIO
7.qq.	Guidance	Options for Paper-Based Marketplace Eligibility Appeals	CCIIO
7.rr.	Guidance	Termination of Enrollment in FFM Due to Death	CCIIO
7.ss.	Notice	Health Insurance Marketplace Public Use Files	CCIIO
7.tt.	Guidance	Hardship Exemptions for Persons Meeting Certain Criteria	CCIIO
7.uu.	Guidance	Guidance for Issuers on 2015 Reenrollment in the FFM	CCIIO
7.vv.	Guidance	2016 Letter to Issuers in FFMs	CCIIO
7.ww.	Guidance	Special Protections for AI/ANs	CMS
7.xx.	Guidance	AI/AN Trust Income and MAGI	CMS
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 FFMs	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

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.lll.	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
7.sss.	Guidance	April 2016 Transition of Issuers to Policy-Based Payments	CCIIO
7.ttt.	Guidance	Marketplace Eligibility Appeals--Paper-Based Processes	CCIIO
7.uuu.	Guidance	Ensuring Meaningful Access by Limited-English Speakers	CCIIO
7.vvv.	Guidance	Ending Special Enrollment Periods for Coverage in 2015	CCIIO
7.www.	Interim Final Rule	Amendments to SEPs and the CO-OP Program	CMS
7.xxx.	Guidance	Display of QRS Star Ratings and QHP Enrollee Survey Results	CCIIO
7.yyy.	Guidance	FAQs on Incarceration and the Marketplace	CCIIO
7.zzz.	Guidance	Effectuation of 2016 FFM Dental Enrollment Without APTCs	CCIIO
7.aaaa.	Guidance	FAQs on Auto Re-Enrollment for QHPs No Longer Available	CCIIO
7.bbbb.	Guidance	FAQs on Annual Income Threshold Adjustment	CCIIO
7.cccc.	Notice	Inappropriate Steering of Individuals to Individual Market	CMS
7.dddd.	Guidance	FAQs on Periodic Data Matching	CCIIO
7.eeee.	Guidance	Notice to States Regarding Marketplace Auto Re-Enrollment	CCIIO
7.ffff.	Guidance	FAQs on Language Access Tagline Requirements	CCIIO
7.gggg.	Guidance	Network Breadth Information for QHPs on Healthcare.gov	CCIIO
7.hhhh.	Guidance	FAQs on FFM User Fee Adjustment Submissions	CCIIO
7.iiii.	Notice	ECP Petition for 2018	CCIIO
7.jjjj.	Guidance	Agreement Between QHP Issuers and CMS	CCIIO
7.kkkk.	Guidance	FAQs on Crosswalk of Enrollees into the Plans of Other Issuers	CCIIO
7.llll.	Guidance	FAQs on Verification of Special Enrollment Periods	CCIIO
7.mmmm.	Guidance	FAQ on Safe Harbor for Issuers with Increased Enrollment in 2017	CCIIO
7.nnnn.	Guidance	FAQ on Health Insurance Marketplace Standards	CCIIO
2017-022	Final Rule	ACA Market Stabilization	CMS
10.b.	Final Rule	ACO Standards	CMS

RRIAR Number	Action	Short Title	Agency
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
2019-004	Notice	Request for Information Regarding State Relief and Empowerment Waivers	CMS
16.a.	Final Rule	New Medicaid Community First Choice Option	CMS
27.a.	Final Rule	Risk Adjustment Standards in ACA	CMS
27.b.	Guidance	HHS Risk Adjustment Model Algorithm	CCIIO
27.c.	Request for Comment	Reinsurance, Risk Corridors, and Risk Adjustment Standards	CMS
27.d.	Guidance	HHS-Developed Risk Adjustment Model Algorithm	CCIIO
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
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
27.u.	Guidance	Transitional Reinsurance Program Collections for 2015	CCIIO
27.v.	Notice	New System of Records (Risk Adjustment Data Validation)	CMS
27.w.	Request for Comment	Evaluation of Training--Stabilization Programs	CMS

RRIAR Number	Action	Short Title	Agency
27.x.	Guidance	Q&A on HHS-Operated Risk Adjustment Methodology	CCIIO
2018-017	Request for Comment	Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment	CMS
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
29.s.	Proposed Rule	Premium Tax Credit	IRS
29.t.	Proposed Rule	Information Reporting of Catastrophic Health Coverage	IRS
31.a.	Guidance	Essential Health Benefits Bulletin	CCIIO
31.b.	Interim Final Rule	Preventive Health Services	IRS/DoL/CMS
31.c.	Final Rule	Coverage of Certain Preventive Services Under ACA	IRS/DoL/CMS
31.d.	Final Rule	Standards on EHB, Actuarial Value, and Accreditation	CMS
31.e.	Final Rule	Exchanges: Eligibility for Exemptions and Minimum Essential Coverage Provisions	CMS
31.f.	Final Rule	Employer Shared Responsibility	IRS
31.g.	Final Rule	Shared Responsibility for Not Maintaining Essential Coverage	IRS
31.h.	Guidance	Hardship Exemption Criteria and Special Enrollment Periods	CCIIO

RRIAR Number	Action	Short Title	Agency
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
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

RRIAR Number	Action	Short Title	Agency
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	Summary of Benefits and Coverage and Uniform Glossary	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
31.fff.	Request for Comment	Minimum Essential Coverage Calculation Report and Notices	CMS
31.ggg.	Guidance	FAQs on ACA Implementation (SBC)	CCIIO
31.hhh.	Guidance	FAQs on SBC Related to Rate Filing and QHP Certification	CCIIO
31.iii.	Notice	Tribal Consultation on ACA Employer Shared Responsibility	IRS
31.jjj.	Request for Comment	EHBs in ABPs, Eligibility Notices, et al.	CMS
31.kkk.	Guidance	FAQs on Health Insurance Market Reforms (EHBs)	CCIIO
31.lll.	Guidance	Indian-Specific CSV Sample SBC Templates	CCIIO
31.mmm.	Notice	Coverage for Contraceptive Services	IRS/DoL/CMS
31.nnn.	Guidance	2018 Actuarial Value Calculator	CCIIO
31.ooo.	Guidance	Health Coverage Tax Credit Hardship Exemption	CCIIO
2019-002	Letter to CCIIO	Re-Review of Indian-Specific SBC Documents	TTAG
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.	Final Methodology	Basic Health Program: Federal Funding Methodology for 2017	CMS
2019-003	Proposed Methodology	Basic Health Program: Federal Funding Methodology for 2019 and 2020	CMS
45.	Guidance	Actuarial Value and Cost-Sharing	CMS
48.a.	Final Rule	Medical Loss Ratio Requirements	CMS

RRIAR Number	Action	Short Title	Agency
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
48.j.	Final Rule	Modification of Treatment of Certain Health Organizations	IRS
48.k.	Guidance	FAQ on MLR and Risk Corridors Data Submission Deadline	CCIIO
50.b.	Final Rule	EHB and QHP Standards	CMS
50.c.	Guidance	Model Qualified Health Plan Addendum (Indian Addendum)	CMS/IHS
50.d.	Request for Comment	Data Elements for Exchange Application	CMS
50.e.	Request for Comment	Initial Plan Data Collection to Support QHP Certification	CMS
50.f.	Request for Comment	Eligibility and Enrollment for Employees in SHOP	CMS
50.g.	Request for Comment	Eligibility and Enrollment for Small Businesses in SHOP	CMS
50.h.	Request for Comment	Eligibility for Insurance Affordability Programs and Enrollment	CMS
50.i.	Guidance	State Evaluation of Plan Management Activities	CCIIO
50.j.	Request for Comment	Recognized Accrediting Entities Data Collection	CMS
50.k.	Guidance	Model Eligibility Application	CCIIO
50.l.	Guidance	State Alternative Applications for Health Coverage	CCIIO
50.m.	Guidance	State Alternative Applications for Health Coverage Through SHOP	CCIIO
50.n.	Final Rule	Disclosures for Health Insurance Affordability Program Eligibility	Treasury
50.o.	Request for Comment	State Health Insurance Exchange Incident Report	CMS
50.p.	Guidance	QHP Webinar Series FAQs	CMS
50.q.	Guidance	Third Party Payments of Premiums for QHPs	CCIIO
50.r.	Guidance	Implementation of Section 402 of IHCIA	IHS
50.s.	Request for Comment	State-Based Marketplace Annual Report	CMS
50.t.	Request for Comment	QHP Quality Rating System Measures and Methodology	CMS
50.u.	Guidance	State-Based Marketplace Annual Reporting Tool	CCIIO
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

RRIAR Number	Action	Short Title	Agency
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
50.ff.	Guidance	State-Based SHOP Direct Enrollment Transition	CCIIO
50.gg.	Guidance	SBM No Cost Extensions in 2017	CCIIO
51.a.	Final Rule	Student Insurance Coverage	CMS
51.b.	Guidance	FAQ on Rate Review of Student Health Plans	CCIIO
51.c.	Guidance	Application of Market Reforms to Student Health Coverage	CCIIO
51.d.	Request for Comment	Student Health Insurance Coverage	CMS
51.e.	Guidance	FAQ on ACA Implementation (Student Health Insurance)	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
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

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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.	Final Rule	Notice of Benefit and Payment Parameters for 2017	CMS
89.n.	Guidance	Manual for Reconciliation of Advance Payment of CSRs	CCIIO
89.o.	Guidance	CSR Reconciliation Issuer to MIDAS Attestation	CCIIO
89.p.	Guidance	CSR Reconciliation Issuer to MIDAS Inbound Specification	CCIIO
89.q.	Guidance	Data Submission Deadline for CSR Reconciliation	CCIIO
89.r.	Guidance	Alternative Schedule for Payment for Reconciliation of CSRs	CCIIO
89.s.	Guidance	Discrepancy Resolution Process Inbound Specification (CSRs)	CCIIO
89.t.	Proposed Rule	Notice of Benefit and Payment Parameters for 2018	CMS
2019-001	Final Rule	Notice of Benefit and Payment Parameters for 2020	CMS
90.	Guidance	Adverse Benefit Determinations	CCIIO
91.a.	Guidance	Waiting Period Limitation Under Public Health Service Act	CCIIO
91.b.	Final Rule	Waiting Period Limitation and Coverage Requirements	IRS/DoL/CMS
91.c.	Final Rule	Waiting Period Limitation	IRS/DoL/CMS
92.a.	Final Rule	Health Insurance Market Rules	CMS
92.b.	Request for Comment	Compliance with Individual and Group Market Reforms	CMS
92.c.	Guidance	Age Curves, Geographical Rating Areas, and State Reporting	CMS
92.d.	Request for Comment	Patient Protection Notices and Disclosure Requirements	CMS
92.e.	Request for Comment	Disclosure and Recordkeeping for Grandfathered Health Plans	CMS
92.f.	Guidance	Model Language for Individual Market Renewal Notices	CMS
92.g.	Request for Comment	Reporting for Grants to Support Health Insurance Rate Review	CMS
92.h.	Request for Comment	Disclosure and Recordkeeping for Grandfathered Health Plans	DoL
92.i.	Request for Comment	ACA Notice of Rescission	Treasury
92.j.	Request for Comment	Enrollment Opportunity Notice Relating to Lifetime Limits	Treasury
92.k.	Request for Comment	ACA Notice of Patient Protection	IRS

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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
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

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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
92.eee.	Guidance	Extension of Transitional Policy Through CY 2017	CCIIO
92.fff.	Guidance	FAQs on the 2017 Moratorium on Health Insurance Provider Fee	CCIIO
92.ggg.	Guidance	Evaluation of EDGE Data Submissions for 2015	CCIIO
92.hhh.	Guidance	Updated Renewal and Product Discontinuation Notices	CCIIO
92.iii.	Guidance	FAQs on ACA Implementation (Parity and Women's Health)	CCIIO
92.jjj.	Guidance	Marketplace Eligibility Redetermination for 2017	CCIIO
92.kkk.	Proposed Rule	Rules for Expatriate Health Plans, et al.	IRS/DoL/CMS
92.lll.	Request for Comment	Health Insurance Enforcement and Consumer Protections Grants	CMS
92.mmm.	Guidance	NQTLs Requiring Analysis to Determine Parity Compliance	CCIIO
92.nnn.	Guidance	FAQs on ACA Implementation (COBRA Model Election Notice)	CCIIO
92.ooo.	Guidance	Netting of Payments and Charges	CCIIO
92.ppp.	Guidance	Issuer Posting of Rate Filing Information	CCIIO
92.qqq.	Guidance	FAQs on ACA Implementation (Market Reforms and Parity)	CCIIO
2018-037	Notice	Reducing Regulatory Burdens Imposed by the ACA	CMS
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

RRIAR Number	Action	Short Title	Agency
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
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
174.g.	Proposed Rule	FEHBP: Access for Employees of Certain Indian Tribal Employers	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