National Indian Health Board

Regulation Review and Impact Analysis Report v. 4.02

as of February 28, 2014

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

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

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

In addition to this cover page, the report consists of three tables –

- Table A provides a status report on the RRIAR itself, listing the regulations included in the RRIAR to date, and the components of the analysis provided under each. The regulations are organized in four sections: I. Medicaid; II. Medicare; III. Health Reform; and IV. Other.
- Table B lists key regulations issued by CMS, due dates for comments, a synopsis of the CMS action, and a summary of the analysis, if any, prepared by NIHB.
- Table C identifies the recommendations made by NIHB pertaining to each regulation, if any, and evaluates the extent to which the recommendations made by NIHB were incorporated into subsequent CMS actions.

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

Regulations with pending due dates for public comments –

- 63.c. Certification of Compliance for Health Plans (CMS-0037-P; **comments due 3/3/2014**)
- 48.b. Medical Loss Ratio Rebate Calculation Report and Notices (CMS-10418; **comments due 3/5/2014**)
- 50.s. State-Based Marketplace Annual Report (CMS-10507; **comments due 3/5/2014**)
- 82.h. HIPAA Eligibility Transaction System Partner Agreement (CMS-10157; **comments due 3/5/2014**)
- 11.u. CY 2015 Policy and Technical Changes to Parts C and D (CMS-4159-P; **comments due 3/7/2014**)
- 11.y. Notice of Changes to Medicare Parts C and D Payment Policies (CMS/no ref. #; **comments due 3/7/2014**)
- 11.v. MA Chronic Care Improvement Program and QI Reporting Tools (CMS-4159-P; **comments due 3/11/2014**)
- 50.v. Medical Expenditure Panel Survey--Insurance Component (AHRQ/OMB 0935-0110; **comments due 3/11/2014**)
- 184.c. CLIA Budget Workload Reports (CMS-102 and CMS-105; **comments due 3/11/2014**)
- 50.e. Initial Plan Data Collection to Support QHP Certification (CMS-10433; **comments due 3/12/2014**)
- 23.f. 1932(a) State Plan Amendment Template and Requirements (CMS-10120; **comments due 3/17/2014**)
- 23.g. Imposition of Cost Sharing Charges Under Medicaid (CMS-R-53; **comments due 3/17/2014**)
- 165.d. Application for Hospital Insurance (CMS-18F5; **comments due 3/17/2014**)
- 11.x. Medication Therapy Management Program Improvements (CMS-10396; **comments due 3/18/2014**)
- 16.e. Community First Choice Option (CMS-10462; **comments due 3/18/2014**)
- 92.q. ACA Advance Notice of Rescission (DoL/OMB 1210-0141; **comments due 3/21/2014**)
- 184.b. CLIA Application Form (CMS-1460-ANPRM; **comments due 3/26/2014**)
- 3.k. Methodology for Medicare Fee Schedule for DMEPOS (CMS-1460-ANPRM; **comments due 3/28/2014**)
- 11.t. Appeals of Quality Bonus Payment Determinations (CMS-10246; **comments due 3/31/2014**)

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

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

- 50.o. State Health Insurance Exchange Incident Report (CMS-10496; **comments due 3/31/2014**)
- 92.i. ACA Notice of Rescission (TD 9491/OMB 1545-2180; **comments due 3/31/2014**)
- 92.k. ACA Notice of Patient Protection (REG-120399-10/OMB 1545-2181; **comments due 3/31/2014**)
- 92.n. Rules for Group Health Plans Related to Grandfather Status (REG-118412-10/OMB 1545-2178P; **comments due 3/31/2014**)
- 92.r. ACA Patient Protection Notice (DoL/ OMB 1210-0142; **comments due 3/31/2014**)
- 188. Emergency Preparedness Requirements (CMS-3178-P; **comments due 3/31/2014**)
- 65. Health Care Reform Insurance Web Portal Requirements (CMS-10320; **comments due 4/1/2014**)
- 25.q. Hospital Conditions of Participation (CMS-R-48; **comments due 4/4/2014**)
- 29.g. Payment Collections Operations Contingency Plan (CMS-10515; **comments due 4/4/2014**)
- 1.i. Public Health Agency/Registry Readiness for Meaningful Use (CMS-10499; **comments due 4/8/2014**)
- 147.c. Quarterly CHIP Statement of Expenditures and Budget Report (CMS-21 and CMS 21B; **comments due 4/15/2014**)
- 32.c. Bundled Payments for Care Improvement 2014 Winter Period (CMS-5504-N4; **comments due 4/18/2014**)
- 82.i. HIPAA Covered Entity and Associate Pre-Audit Survey (HHS OS-21435-60D; **comments due 4/25/2014**)
- 91.c. Waiting Period Limitation (REG-122706-12, DoL/RIN 1210-AB61, CMS-9952-P2; **comments due 4/25/2014**)
- 110.i. Self-Referral Disclosure Protocol (CMS-10328; **comments due 4/25/2014**)
- 1.h. Voluntary 2015 Edition EHR Certification Criteria, et al. (HHS/RIN 0991-AB92; **comments due 4/28/2014**)
- 31.x. MEC and Other Rules on the Shared Responsibility Payment (REG-141036-13; **comments due 4/28/2014**)
- 11.z. Medicare Health Outcomes Survey (CMS-10203; **comments due 4/29/2014**)
- 190. Frontier Community Health Integration Project Demo (CMS-5511-N; **comments due 5/5/2014**)

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

- 184.a. Clinical Laboratory Improvement Amendments Regulations (CMS-R-26; comments submitted 1/6/2014 by ANTHC)
- 31.v. Instructions for the Application for Indian-Specific Exemptions (CMS/no ref. #; comments submitted 1/13/2014 by TTAG)
- 31.w. Cost-Sharing Reductions for Contract Health Services (Draft) (CCIIO/no ref. #; comments submitted 1/14/2014 by TTAG)
- 50.t. QHP Quality Rating System Measures and Methodology (CMS-3288-NC; comments submitted 1/21/2014 by TTAG)
- 39.c. Basic Health Program: Proposed Funding Methodology for 2015 (CMS-2380-PN; comments submitted 1/22/2014 by TTAG)
- 7.ee. 2015 Letter to Issuers in FFMs (CCIIO/no ref. #, comments submitted 2/25/2014 by TTAG)

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

- 54. ESI Coverage Verification (CMS RIN 0938-ZB09; approved by OMB 4/26/2012 but not yet published)
- 164.b. Medicare Secondary Payer and "Future Medicals" (CMS-6047-P; sent to OMB 8/1/2013)
- 180. Flu Vaccination Standard for Certain Providers and Suppliers (CMS-3213-F; sent to OMB 9/27/2013)
- 3.j. Prior Authorization Process for Certain DMEPOS Items (CMS-6050-P; sent to OMB 12/24/2013)
- 81. Efficiency, Transparency, and Burden Reduction (CMS-3267-F; sent to OMB 1/9/2014)
- 16.b. Medicaid HCBS Waivers (CMS-2249-F2; approved by OMB 1/14/2014 but not yet published)
- 112.b. IHS Reimbursement Rates for CY 2014 (IHS RIN 0917-ZA28; sent to OMB 1/22/2014)
- 185.b. Revisions to HHS OIG Civil Monetary Penalty Rules (HHS OIG RIN 0936-AA04; sent to OMB 2/5/2014)
- 185.c. Revisions to HHS OIG Exclusion Authorities (HHS OIG RIN 0936-AA04; sent to OMB 2/5/2014)
- 39.b. Basic Health Program (CMS-2380-F; sent to OMB 2/7/2014)
- 39.c. Basic Health Program: Federal Funding Methodology for 2015 (CMS-2380-FN; sent to OMB 2/11/2014)
- 92.u. Marketplace and Insurance Market Standards for 2015/2016 (CMS-9949-P; sent to OMB 2/11/2014)

- 89.e. Notice of Benefit and Payment Parameters for 2015 (CMS-9954-F; sent to OMB 2/24/2014)

Recent (final) rules issued –

- 48.e. Computation of MLR (TD 9651; issued 1/7/2014)
- 82.e. CLIA Program and HIPAA Privacy Rule (CMS-2319-F; issued 2/5/2014)
- 31.f. Employer Shared Responsibility (TD 9655; issued 2/13/2014)
- 91.b. Waiting Period Limitation and Coverage Requirements (REG-122706-12, DoL/RIN 1210-AB56, CMS-9952-F; issued 2/24/2014)

Contacts: Eugene Gessow <EGessow@nihb.org>; Elizabeth McCormick <EMcCormick@nihb.org>

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

National Indian Health Board

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RRIAR Ref. #	Short Title/ Current Status of Regulation/ Title/ Agency	File Code	Dates (Issue, Due, File, Subsequent Action)[1]	In Table B-- • Is the summary of Agency action included? • Is the NIHB analysis included?	In Table C-- • Is the list of NIHB recommendations included? • Has the Agency taken subsequent action? • Is an analysis of subsequent Agency action included?
			SECTION I: MEDICAID (AND DUAL MEDICAID AND MEDICARE)	Beginning on page 1 of 45	
			SECTION II: MEDICARE	Beginning on page 9 of 45	
			SECTION III: HEALTH REFORM	Beginning on page 26 of 45	
			SECTION IV: OTHER	Beginning on page 42 of 45	
			SECTION I: MEDICAID (AND DUAL MEDICAID AND MEDICARE)		
1.g.	**Revision to the Definition of Common Meaningful Use Data Set** **ACTION: Interim Final Rule** **NOTICE:** 2014 Edition Electronic Health Record Certification Criteria: Revision to the Definition of "Common Meaningful Use Data Set" **AGENCY:** HHS	HHS RIN 0991-AB91	Issue Date: 11/4/2013 Due Date: 1/3/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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1.h.	**Voluntary 2015 Edition EHR Certification Criteria, et al.** **ACTION: Proposed Rule** **NOTICE:** Voluntary 2015 Edition Electronic Health Record (EHR) Certification Criteria; Interoperability Updates and Regulatory Improvements **AGENCY:** HHS	HHS RIN 0991-AB92	Issue Date: 2/26/2014 **Due Date: 4/28/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
1.i.	**Public Health Agency/Registry Readiness for Meaningful Use** **ACTION: Request for Comment** **NOTICE:** Public Health Agency/Registry Readiness to Support Meaningful Use **AGENCY:** CMS	CMS-10499	Issue Date: 2/7/2014 **Due Date: 4/8/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
16.b.	**Medicaid HCBS Waivers** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicaid; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment; Setting Requirements **AGENCY:** CMS	CMS-2249-~~P2~~F2	Issue Date: 5/3/2012 Due Date: ~~6/4/2012~~ 7/2/2012 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued due date extension 5/3/2012; Final Rule approved by OMB 1/13/2014	• Summary of Agency action: √ • NIHB analysis of action: None.	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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16.d.	**Elimination of Cost-Sharing for Dual-Eligibles Receiving HCBS** **ACTION: Request for Comment** **NOTICE:** Elimination of Cost-Sharing for Full Benefit Dual-Eligible Individuals Receiving Home and Community-Based Services **AGENCY:** CMS	CMS-10344	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/20/2013 Due Date: 1/21/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
16.e.	**Community First Choice Option** **ACTION: Request for Comment** **NOTICE:** Community First Choice Option **AGENCY:** CMS	CMS-10462	Issue Date: 1/17/2014 **Due Date: 3/18/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
23.e.	**State Children's Health Insurance Program** **ACTION: Request for Comment** **NOTICE:** State Children's Health Insurance Program and Supporting Regulations **AGENCY:** CMS	CMS-R-308	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 1/23/2014 Due Date: 2/24/2014	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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23.f.	**1932(a) State Plan Amendment Template and Requirements** **ACTION: Request for Comment** **NOTICE:** 1932(a) State Plan Amendment Template, State Plan Requirements, and Supporting Regulations **AGENCY:** CMS	CMS-10120	Issue Date: 12/6/2013 Due Date: 2/4/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 2/14/2014 **Due Date: 3/17/2014**	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
23.g.	**Imposition of Cost Sharing Charges Under Medicaid** **ACTION: Request for Comment** **NOTICE:** Imposition of Cost Sharing Charges Under Medicaid and Supporting Regulations **AGENCY:** CMS	CMS-R-53 (OMB approval sought under CMS-10398; **see 23.a.**)	Issue Date: 1/27/2014 Due Date: ~~2/26/2014~~ NIHB File Date: Date of Subsequent Agency Action, if any: Issued withdrawal 2/7/2014; re-issued request 2/14/2014 **Due Date: 3/17/2014**	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
28.e.	**FMAP Notice for FY 2015** **ACTION: Notice** **NOTICE:** Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2014, Through September 30, 2015 **AGENCY:** HHS	HHS (no reference number)	Issue Date: 1/21/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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41.d.	**New Safe Harbors** **ACTION: Notice** **NOTICE:** Solicitation of New Safe Harbors and Special Fraud Alerts **AGENCY:** HHS OIG	OIG-122-N	Issue Date: 12/27/2013 Due Date: 2/25/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
44.e.	**Multi-Payer Advanced Primary Care Practice Demonstration** **ACTION: Request for Comment** **NOTICE:** Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Provider Survey **AGENCY:** CMS	CMS-10485	Issue Date: 7/12/2013 Due Date: 9/10/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 1/29/2014 Due Date: 2/28/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
46.d.	**Preliminary DSH Allotments for FY 2014** **ACTION: Request for Comment** **NOTICE:** Medicaid Program; Preliminary Disproportionate Share Hospital (DSH) Allotments for Fiscal Year (FY) 2014 and the Preliminary Institutions for Mental Diseases Disproportionate Share Hospital Limits for FY 2014 **AGENCY:** CMS	CMS-2389-N	Issue Date: 2/28/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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147.c.	**Quarterly CHIP Statement of Expenditures and Budget Report** **ACTION: Request for Comment** **NOTICE:** Quarterly Children's Health Insurance Program (CHIP) Statement of Expenditures for the Title XXI Program (CMS-21) and State Children's Health Insurance Program Budget Report for the Title XXI Program State Plan Expenditures (CMS-21B) **AGENCY:** CMS	CMS-21 and CMS 21B	Issue Date: 2/14/2014 **Due Date: 4/15/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
157.b.	**Medicare Secondary Payer and Certain Civil Money Penalties** **ACTION: Advanced Notice of Proposed Rule Making** **NOTICE:** Medicare Program; Medicare Secondary Payer and Certain Civil Money Penalties **AGENCY:** CMS	CMS-6061-ANPRM	Issue Date: 12/11/2013 Due Date: 2/10/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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157.c.	**Right of Appeal for Medicare Secondary Payer Determination** **ACTION: Proposed Rule** **NOTICE:** Medicare Program; Right of Appeal for Medicare Secondary Payer Determination Relating to Liability Insurance (Including Self-Insurance), No Fault Insurance, and Workers' Compensation Laws and Plans **AGENCY:** CMS	CMS-6055-P	Issue Date: 12/27/2013 Due Date: 2/25/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
171.	**Medicaid Emergency Psychiatric Demonstration Evaluation** **ACTION: Request for Comment** **NOTICE:** Medicaid Emergency Psychiatric Demonstration (MEPD) Evaluation **AGENCY:** CMS	CMS-10487	Issue Date: 7/26/2013 Due Date: 9/24/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 12/6/2013 Due Date: 1/6/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
175.b.	**Medicaid Drug Use Review Program** **ACTION: Request for Comment** **NOTICE:** Medicaid Drug Use Review Program **AGENCY:** CMS	CMS-R-153	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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175.c.	**Submitting Drug Identifying Information to Medicaid Programs** **ACTION: Request for Comment** **NOTICE:** Medicaid Payment for Prescription Drugs--Physicians and Hospital Outpatient Departments Collecting and Submitting Drug Identifying Information to State Medicaid Programs **AGENCY:** CMS	CMS-10215	Issue Date: 12/27/2013 Due Date: 2/25/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
176.	**EPSDT Participation Report** **ACTION: Request for Comment** **NOTICE:** Annual EPSDT Participation Report **AGENCY:** CMS	CMS-416	Issue Date: 8/9/2013 Due Date: 10/8/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 12/6/2013 Due Date: 1/6/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
180.	**Flu Vaccination Standard for Certain Providers and Suppliers** **ACTION: Request for Comment** **NOTICE:** Influenza Vaccination Standard for Certain Participating Providers and Suppliers **AGENCY:** CMS	CMS-3213-F	Issue Date: [Pending at OMB as of 9/27/2013] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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188.	**Emergency Preparedness Requirements** **ACTION: Proposed Rule** **NOTICE:** Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers **AGENCY:** CMS	CMS-3178-P	Issue Date: 12/27/2013 **Due Date: ~~2/25/2014~~ 3/31/2014** NIHB File Date: Date of Subsequent Agency Action, if any: Issued due date extension 2/21/2014	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
190.	**Frontier Community Health Integration Project Demo** **ACTION: Proposed Rule** **NOTICE:** Medicare and Medicaid Programs; Solicitation for Proposals for the Frontier Community Health Integration Project Demonstration **AGENCY:** CMS	CMS-5511-N	Issue Date: 2/4/2014 **Due Date: 5/5/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
			SECTION II: MEDICARE		
3.i.	**Pass-Through Payment for New Categories of Devices** **ACTION: Request for Comment** **NOTICE:** Recognition of Pass-Through Payment for Additional (New) Categories of Devices Under the Outpatient Prospective Payment System and Supporting Regulations **AGENCY:** CMS	CMS-10052	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/20/2013 Due Date: 1/21/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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3.j.	**Prior Authorization Process for Certain DMEPOS Items** **ACTION: Proposed Rule** **NOTICE:** Prior Authorization Process for Certain Durable Medical Equipment, Prosthetic, Orthotics, and Supplies Items **AGENCY:** CMS	CMS-6050-P	Issue Date: [Pending at OMB as of 12/24/2013] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
3.k.	**Methodology for Adjusting Medicare Payments for DMEPOS** **ACTION: ANPRM** **NOTICE:** Medicare Program; Methodology for Adjusting Payment Amounts for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Using Information From Competitive Bidding Programs **AGENCY:** CMS	CMS-1460-ANPRM	Issue Date: 2/26/2014 **Due Date: 3/28/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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4.d.	**Medicare Hospital OPPS, Ambulatory Surgical Center Payment System, et al.** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; EHR Incentive Program; Provider Reimbursement Determinations and Appeals **AGENCY:** CMS	CMS-1601-~~P~~FC	Issue Date: 7/19/2013 Due Date: ~~9/6/2013~~ 9/16/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction/due date extension 9/6/2013; issued Final Rule 12/10/2013 Due Date: 1/27/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
5.a.	**PACE Information Request** **ACTION: Request for Comment** **NOTICE:** Medicare and Medicaid; Programs of All-Inclusive Care for the Elderly (PACE) **AGENCY:** CMS	CMS-R-244	Issue Date: 7/30/2010 Due Date: 9/28/2010 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 10/8/2010; issued extension 10/4/2013; issued extension 12/20/2013 Due Date: 11/8/2010; 12/3/2013; 1/21/2014	• Summary of Agency action: √ • NIHB analysis of action: None. • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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5.b.	**PACE State Plan Amendment Preprint** **ACTION: Request for Comment** **NOTICE:** State Plan Amendment Preprint **AGENCY:** CMS	CMS-10227	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/13/2013 Due Date: 1/13/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.d.	**Bid Pricing Tool** **ACTION: Request for Comment** **NOTICE:** BPT for Medicare Advantage and Prescription Drug Plans **AGENCY:** CMS	CMS-10142	Issue Date: 10/5/2012 Due Date: 12/4/2012 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 1/17/2013; issued revision 10/4/2013; issued revision 12/20/2013 Due Date: 2/19/2013; 12/3/2013; 1/21/2014	• Summary of Agency action: √ • NIHB analysis of action: [To be entered.] • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.f.	**Plan Benefit Package and Formulary Submission** **ACTION: Request for Comment** **NOTICE:** PBP and Formulary Submission for Medicare Advantage and Prescription Drug Plans **AGENCY:** CMS	CMS-R-262	Issue Date: 10/5/2012 Due Date: 12/4/2012 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 1/17/2013; issued revision 11/1/2013; issued revision 1/17/2014 Due Date: 2/19/2013; 12/31/2013; 2/18/2014	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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11.s.	**Medicare Prescription Drug Benefit Program** **ACTION: Request for Comment** **NOTICE:** Medicare Prescription Drug Benefit Program **AGENCY:** CMS	CMS-10141	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 12/13/2013 Due Date: 1/13/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.t.	**Appeals of Quality Bonus Payment Determinations** **ACTION: Request for Comment** **NOTICE:** Appeals of Quality Bonus Payment Determinations **AGENCY:** CMS	CMS-10346	Issue Date: 12/6/2013 Due Date: 2/4/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/28/2014 **Due Date: 3/31/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.u.	**CY 2015 Policy and Technical Changes to Parts C and D** **ACTION: Proposed Rule** **NOTICE:** Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs **AGENCY:** CMS	CMS-4159-P	Issue Date: 1/10/2014 **Due Date: 3/7/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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11.v.	**MA Chronic Care Improvement Program and QI Reporting Tools** **ACTION: Request for Comment** **NOTICE:** Medicare Advantage Chronic Care Improvement Program (CCIP) and Quality Improvement (QI) Project Reporting Tools **AGENCY:** CMS	CMS-10209	Issue Date: 1/10/2014 **Due Date: 3/11/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.w.	**Final Marketing Provisions for Medicare Parts C and D** **ACTION: Request for Comment** **NOTICE:** Medicare Advantage and Prescription Drug Program: Final Marketing Provisions **AGENCY:** CMS	CMS-10260	Issue Date: 1/29/2014 Due Date: 2/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.x.	**Medication Therapy Management Program Improvements** **ACTION: Request for Comment** **NOTICE:** Medication Therapy Management Program Improvements **AGENCY:** CMS	CMS-10396	Issue Date: 1/17/2014 **Due Date: 3/18/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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11.y.	**Notice of Changes to Medicare Parts C and D Payment Policies** **ACTION: Notice** **NOTICE:** Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter **AGENCY:** CMS	CMS (no reference number)	Issue Date: 2/21/2014 **Due Date: 3/7/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
11.z.	**Medicare Health Outcomes Survey** **ACTION: Request for Comment** **NOTICE:** Medicare Health Outcomes Survey (HOS) **AGENCY:** CMS	CMS-10203	Issue Date: 2/28/2014 **Due Date: 4/29/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
25.g.	**PPS for Acute and Long-Term Care Hospitals, et al.** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare Program; Hospital IPPS for Acute Care Hospitals and the Long-Term Care Hospital PPS and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital CoP **AGENCY:** CMS	CMS-1599-~~PF~~ CMS-1455-F	Issue Date: 5/10/2013 Due Date: 6/25/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction 6/27/2013; issued Final Rule 8/19/2013; issued correction 10/3/2013; issued correction 1/2/2014; issued correction 1/10/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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25.m.	**Geographic Classification Review Board Procedures** **ACTION: Request for Comment** **NOTICE:** Medicare Geographic Classification Review Board (MGCRB) Procedures and Supporting Regulations **AGENCY:** CMS	CMS-R-138	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued reinstatement 12/13/2013 Due Date: 1/13/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
25.n.	**Inpatient Rehab Facilities Quality Reporting Program Evaluation** **ACTION: Request for Comment** **NOTICE:** Inpatient Rehabilitation Facilities Quality Reporting Program: Program Evaluation **AGENCY:** CMS	CMS-10503	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
25.o.	**Conditions of Participation for Critical Access Hospitals** **ACTION: Request for Comment** **NOTICE:** Conditions of Participation for Critical Access Hospitals (CAH) and Supporting Regulations **AGENCY:** CMS	CMS-10239	Issue Date: 12/20/2013 Due Date: 2/18/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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25.p.	**Medicare/Medicaid Psychiatric Hospital Survey Data** **ACTION: Request for Comment** **NOTICE:** Medicare/Medicaid Psychiatric Hospital Survey Data **AGENCY:** CMS	CMS-724	Issue Date: 12/27/2013 Due Date: 2/25/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
25.q.	**Hospital Conditions of Participation** **ACTION: Request for Comment** **NOTICE:** Hospital Conditions of Participation and Supporting Regulations **AGENCY:** CMS	CMS-R-48	Issue Date: 1/31/2014 **Due Date: 4/4/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
32.c.	**Bundled Payments for Care Improvement 2014 Winter Period** **ACTION: Notice** **NOTICE:** Medicare Program; Bundled Payments for Care Improvement Models 2, 3, and 4 2014 Winter Open Period **AGENCY:** CMS	CMS-5504-N4	Issue Date: 2/14/2014 **Due Date: 4/18/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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52.i.	**Home Health PPS Rate Update: Physician Narrative Requirement** **ACTION: Request for Comment** **NOTICE:** Medicare Program--Home Health Prospective Payment System Rate Update for CY 2010: Physician Narrative Requirement and Supporting Regulation **AGENCY:** CMS	CMS-10311	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/20/2013 Due Date: 1/21/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
52.j.	**Moratoria on Enrollment of Ambulances and HHAs** **ACTION: Notice** **NOTICE:** Medicare, Medicaid, and CHIP: Announcement of New and Extended Temporary Moratoria on Enrollment of Ambulances and Home Health Agencies in Designated Geographic Locations **AGENCY:** CMS	CMS-6046-N	Issue Date: 2/4/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
58.	**Medicare Hospital Conditions of Participation** **ACTION: Final Rule** **NOTICE:** Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation **AGENCY:** CMS	CMS-3244-F	Issue Date: 5/16/2012 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued correcting amendment 2/25/2014	• Summary of Agency action: √ • NIHB analysis of action: None. • Summary of Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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70.b.	**Revisions to Medicare Payment Policies Under PFS, et al.** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for 2014 **AGENCY:** CMS	CMS-1600-~~P~~FC	Issue Date: 7/19/2013 Due Date: 9/6/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued Final Rule 12/10/2013 Due Date: 1/27/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
70.c.	**Policy on FOA Disclosure of Payments to Medicare Physicians** **ACTION: Notice** **NOTICE:** Modified Policy on Freedom of Information Act Disclosure of Amounts Paid to Individual Physicians Under the Medicare Program **AGENCY:** CMS	CMS-0041-N	Issue Date: 1/17/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
72.b.	**Medicare PPS and Consolidated Billing for SNFs for FY 2014** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare Program; PPS and Consolidated Billing for Skilled Nursing Facilities for FY 2014 **AGENCY:** CMS	CMS-1446-~~P~~F	Issue Date: 5/6/2013 Due Date: 7/1/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued Final Rule 8/6/2013; issued correction 10/3/2013; issued correction 1/2/2014; issued correction 1/10/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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78.c.	**Hospice Request for Certification** **ACTION: Request for Comment** **NOTICE:** Hospice Request for Certification and Supporting Regulations **AGENCY:** CMS	CMS-417	Issue Date: 11/1/2013 Due Date: 12/31/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 1/29/2014 Due Date: 2/28/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
78.d.	**Hospice Quality Reporting Program Evaluation** **ACTION: Request for Comment** **NOTICE:** Hospice Quality Reporting Program: Program Evaluation **AGENCY:** CMS	CMS-10504	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
78.e.	**Hospice Conditions of Participation** **ACTION: Request for Comment** **NOTICE:** Hospice Conditions of Participation **AGENCY:** CMS	CMS-10277	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 1/29/2014 Due Date: 2/28/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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81.	**Efficiency, Transparency, and Burden Reduction** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare and Medicaid Programs; Part II--Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction **AGENCY:** CMS	CMS-3267-~~P~~F	Issue Date: 2/7/2013 Due Date: 4/8/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 1/9/2014	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
110.g.	**Procedures for Advisory Opinions on Physician Referrals** **ACTION: Request for Comment** **NOTICE:** Procedures for Advisory Opinions Concerning Physicians' Referrals and Supporting Regulations **AGENCY:** CMS	CMS-R-216	Issue Date: 11/8/2013 Due Date: 1/7/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 1/17/2014 Due Date: 2/18/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
110.h.	**Hospital Disclosures Regarding Physician Ownership** **ACTION: Request for Comment** **NOTICE:** Disclosures Required of Certain Hospitals and Critical Access Hospitals Regarding Physician Ownership **AGENCY:** CMS	CMS-10225	Issue Date: 12/13/2013 Due Date: 2/11/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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110.i.	**Self-Referral Disclosure Protocol** **ACTION: Request for Comment** **NOTICE:** Self-Referral Disclosure Protocol **AGENCY:** CMS	CMS-10328	Issue Date: 2/24/2014 **Due Date: 4/25/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
113.	**Additional Medicare Tax** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Rules Relating to Additional Medicare Tax **AGENCY:** IRS	~~REG-130074-11~~ TD 9645	Issue Date: 12/5/2012 Due Date: 3/5/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction 1/30/2013; issued Final Rule 11/29/2013; issued correction 1/22/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
121.g.	**Health Insurance Benefit Agreement** **ACTION: Request for Comment** **NOTICE:** Health Insurance Benefit Agreement **AGENCY:** CMS	CMS-1561	Issue Date: 11/1/2013 Due Date: 12/31/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 1/17/2014 Due Date: 2/18/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
121.h.	**Medicare Enrollment Application: Part A Institutional Providers** **ACTION: Request for Comment** **NOTICE:** Medicare Enrollment Application: Part A Institutional Providers **AGENCY:** CMS	CMS-855A	Issue Date: 11/15/2013 Due Date: 1/14/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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126.b.	**Evaluation of the Rural Community Hospital Demo** **ACTION: Request for Comment** **NOTICE:** Evaluation of the Rural Community Hospital Demonstration **AGENCY:** CMS	CMS-10508	Issue Date: 11/15/2013 Due Date: 1/14/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Date of Subsequent Agency Action, if any: Issued new request 1/23/2014 Due Date: 2/24/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
132.e.	**Outpatient/Ambulatory Surgery Experience of Care Survey** **ACTION: Request for Comment** **NOTICE:** Outpatient and Ambulatory Surgery Experience of Care Survey **AGENCY:** CMS	CMS-10500	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 12/27/2013 Due Date: 1/27/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
134.f.	**Outpatient Rehab Facility/CMHC Cost Report** **ACTION: Request for Comment** **NOTICE:** Outpatient Rehabilitation Facility, Community Mental Health Center Cost Report and Supporting Regulations **AGENCY:** CMS	CMS-2088-92	Issue Date: 10/23/2013 Due Date: 12/23/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 1/2/2014 Due Date: 2/3/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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151.a.	**Request for Employment Information** **ACTION: Request for Comment** **NOTICE:** Request for Employment Information **AGENCY:** CMS	CMS-R-297	Issue Date: 4/4/2013 Due Date: 6/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 7/26/2013; issued revision 1/2/2014 Due Date: 8/26/2013; 2/3/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
164.b.	**Medicare Secondary Payer and "Future Medicals"** **ACTION: Proposed Rule** **NOTICE:** Medicare Secondary Payer and "Future Medicals" **AGENCY:** CMS	CMS-6047	Issue Date: [Pending at OMB as of 8/1/2013] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action
165.c.	**Application for Medicare Part B Enrollment** **ACTION: Request for Comment** **NOTICE:** Application for Enrollment in Medicare the Medical Insurance Program **AGENCY:** CMS	CMS-40B	Issue Date: 10/23/2013 Due Date: 12/23/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 1/2/2014 Due Date: 2/3/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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165.d.	**Application for Hospital Insurance** **ACTION: Request for Comment** **NOTICE:** Application for Hospital Insurance and Supporting Regulations **AGENCY:** CMS	CMS-18F5	Issue Date: 12/6/2013 Due Date: 2/4/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/14/2014 **Due Date: 3/17/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
184.a.	**Clinical Laboratory Improvement Amendments Regulations** **ACTION: Request for Comment** **NOTICE:** Clinical Laboratory Improvement Amendments (CLIA) Regulations **AGENCY:** CMS	CMS-R-26	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 12/6/2013 Due Date: 1/6/2014 ANTHC File Date: 1/6/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• ANTHC recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:
184.b.	**CLIA Application Form** **ACTION: Request for Comment** **NOTICE:** Clinical Laboratory Improvement Amendments (CLIA) Application Form and Supporting Regulations **AGENCY:** CMS	CMS-116	Issue Date: 12/13/2013 Due Date: 2/11/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 2/24/2014 **Due Date: 3/26/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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184.c.	**CLIA Budget Workload Reports** **ACTION: Request for Comment** **NOTICE:** Clinical Laboratory Improvement Amendments of 1988 (CLIA) Budget Workload Reports and Supporting Regulations **AGENCY:** CMS	CMS-102 and CMS-105	Issue Date: 1/10/2014 **Due Date: 3/11/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
			SECTION III: HEALTH REFORM		
6.g.	**Policy Sales to Medicare Beneficiaries Losing Coverage Due to High Risk Pool Closures** **ACTION: Guidance** **NOTICE:** The Sale of Individual Market Policies to Medicare Beneficiaries Under 65 Losing Coverage Due to High Risk Pool Closures **AGENCY:** CMS	CMS (no reference number)	Issue Date: 1/10/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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7.bb.	**Program Integrity; Amendments to the HHS Notice of Benefit and Payment Parameters** **ACTION: Final Rule** **NOTICE:** Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 **AGENCY:** CMS	CMS-9957-F2 CMS-9964-F3 **See also 7.s., 89.a., and 89.b.**	Issue Date: 10/30/2013 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction 12/31/2013	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
7.ee.	**2015 Letter to Issuers in FFMs** **ACTION: Guidance** **NOTICE:** Draft 2015 Letter to Issuers in the Federally-Facilitated Marketplaces **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 2/4/2014 Due Date: 2/25/2014 TTAG File Date: 2/25/2014; NIHB and TSGAC also filed comments 2/15/2014 Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• TTAG recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:
7.ff.	**Enrollment and Termination Policies for Marketplace Issuers** **ACTION: Guidance** **NOTICE:** Affordable Exchanges Guidance: Bulletins on Enrollment and Termination Policies and Processes for FFM and SPM Issuers **AGENCY:** CCIIO	CCIIO (no reference number) **See also 7.aa. and 7.dd.**	Issue Date: 2/6/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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29.g.	**Payment Collections Operations Contingency Plan** **ACTION: Request for Comment** **NOTICE:** Payment Collections Operations Contingency Plan **AGENCY:** CMS	CMS-10515	Issue Date: 12/27/2013 Due Date: 1/27/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 1/31/2014 **Due Date: 4/4/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
29.h.	**Verification of Income for Tax Credits and Cost Sharing** **ACTION: Guidance** **NOTICE:** Verification of Household Income and Other Qualifications for the Provision of Affordable Care Act Premium Tax Credits and Cost-Sharing Reductions **AGENCY:** HHS	HHS (no reference number)	Issue Date: 12/31/2013 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
31.f.	**Employer Shared Responsibility** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Shared Responsibility for Employers Regarding Health Coverage **AGENCY:** IRS	~~REG-138006-12~~ TD 9655	Issue Date: 1/2/2013 Due Date: 3/18/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction 3/15/2013; issued Final Rule 2/12/2014	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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31.t.	**Amendments to Excepted Benefits** **ACTION: Proposed Rule** **NOTICE:** Amendments to Excepted Benefits **AGENCY:** IRS/DoL/CMS	REG-143172-13 DoL RIN 1210-AB60 CMS-9946-P	Issue Date: 12/24/2013 Due Date: 2/24/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
31.u.	**Options Available for Consumers with Cancelled Policies** **ACTION: Guidance** **NOTICE:** Options Available for Consumers with Cancelled Policies **AGENCY:** CCIIO	CCIIO (no reference number) **See also 7.dd.**	Issue Date: 12/19/2013 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued clarification 1/3/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
31.v.	**Instructions for the Application for Indian-Specific Exemptions** **ACTION: Guidance** **NOTICE:** Instructions for the Application for Exemption for American Indians and Alaska Natives and Other Individuals who are Eligible to Receive Services from an Indian Health Care Provider **AGENCY:** CMS	CMS (no reference number) **See also 31.q.**	Issue Date: 1/10/2014 Due Date: 1/13/2014 TTAG File Date: 1/13/2014 Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • TTAG analysis of action: √	• TTAG recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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31.w.	**Q&A on Cost-Sharing Reductions for Contract Health Services** **ACTION: Guidance** **NOTICE:** Question and Answer on Cost-Sharing Reductions for Contract Health Services **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 1/8/2014 Due Date: 1/14/2014 TTAG File Date: 1/14/2013 Date of Subsequent Agency Action, if any: Issued Final Guidance 2/18/2014	• Summary of Agency action: √ • TTAG analysis of action: √ • Summary of subsequent Agency action: √	• TTAG recommendations included: √ • Subsequent Agency action: √ • Analysis of Agency action: √
31.x.	**MEC and Other Rules on the Shared Responsibility Payment** **ACTION: Proposed Rule** **NOTICE:** Minimum Essential Coverage and Other Rules Regarding the Shared Responsibility Payment for Individuals **AGENCY:** IRS	REG-141036-13	Issue Date: 1/27/2014 **Due Date: 4/28/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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39.b.	**Basic Health Program** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity **AGENCY:** CMS	CMS-2380-~~P~~F	Issue Date: 9/25/2013 Due Date: 11/25/2013 NIHB File Date: 11/22/2013; ANTHC, TSGAC, and TTAG also filed comments 11/22/2013 Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 2/7/2014	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:
39.c.	**Basic Health Program: Federal Funding Methodology for 2015** **ACTION: ~~Proposed~~ Final Methodology** **NOTICE:** Basic Health Program: ~~Proposed~~ Final Federal Funding Methodology for Program Year 2015 **AGENCY:** CMS	CMS-2380-~~P~~FN	Issue Date: 12/23/2013 Due Date: 1/22/2014 TTAG File Date: 1/22/2014; TSGAC also filed comments 1/22/2014 Date of Subsequent Agency Action, if any: Sent Final Methodology to OMB 2/11/2014	• Summary of Agency action: √ • NIHB analysis of action: √	• TTAG recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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39.d.	**Basic Health Program Report for Exchange Premium** **ACTION: Request for Comment** **NOTICE:** Basic Health Program Report for Health Insurance Exchange Premium **AGENCY:** CMS	CMS-10510	Issue Date: 12/23/2013 Due Date: 1/2/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction 12/27/2013	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
48.b.	**Medical Loss Ratio Rebate Calculation Report and Notices** **ACTION: Request for Comment** **NOTICE:** Annual MLR and Rebate Calculation Report and MLR Rebate Notices **AGENCY:** CMS	CMS-10418	Issue Date: 12/4/2012 Due Date: 2/4/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 2/22/2013; issued revision 11/22/2013; issued revision 1/31/2014 **Due Date:** 3/25/2013; 1/21/2014; **3/5/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
48.e.	**Computation of MLR** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Computation of, and Rules Relating to, Medical Loss Ratio **AGENCY:** IRS	~~REG-126633-12~~ TD 9651	Issue Date: 5/13/2013 Due Date: 8/12/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued Final Rule 1/7/2014	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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50.e.	**Initial Plan Data Collection to Support QHP Certification** **ACTION: Request for Comment** **NOTICE:** Initial Plan Data Collection to Support Qualified Health Plan Certification and Other Financial Management and Exchange Operations **AGENCY:** CMS	CMS-10433	Issue Date: 11/21/2012 Due Date: 12/21/2012 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 11/1/2013; issued revision 2/10/2014 **Due Date:** 12/31/2013; **3/12/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
50.o.	**State Health Insurance Exchange Incident Report** **ACTION: Request for Comment** **NOTICE:** State Health Insurance Exchange Incident Report **AGENCY:** CMS	CMS-10496	Issue Date: 8/21/2013 Due Date: 9/20/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/20/2013; issued extension 2/28/2014 **Due Date:** 2/18/2014; **3/31/2014**	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
50.q.	**Third Party Payments of Premiums for QHPs** **ACTION: Guidance** **NOTICE:** FAQ: Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces **AGENCY:** CCIIO	CCIIO (no reference number) **See also 50.r.**	Issue Date: 11/4/2013 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued clarification 2/7/2014	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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50.s.	**State-Based Marketplace Annual Report** **ACTION: Request for Comment** **NOTICE:** State-Based Marketplace Annual Report (SMAR) **AGENCY:** CMS	CMS-10507	Issue Date: 11/15/2013 Due Date: 1/14/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 1/31/2014 **Due Date: 3/5/2014**	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
50.t.	**QHP Quality Rating System Measures and Methodology** **ACTION: Request for Comment** **NOTICE:** Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology **AGENCY:** CMS	CMS-3288-NC	Issue Date: 11/22/2013 Due Date: 1/21/2014 TTAG File Date: 1/21/2014 Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• TTAG recommendations included: √ • Subsequent Agency action: • Analysis of Agency action:
50.v.	**Medical Expenditure Panel Survey--Insurance Component** **ACTION: Request for Comment** **NOTICE:** Medical Expenditure Panel Survey--Insurance Component **AGENCY:** AHRQ	AHRQ (OMB 0935-0110)	Issue Date: 1/10/2014 **Due Date: 3/11/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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50.w.	**Retroactive Advance Payments of PTCs and CSRs Due to Exceptional Circumstances** **ACTION: Request for Comment** **NOTICE:** CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 2/27/2014 Due Date: None TTAG File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• TTAG recommendations included: • Subsequent Agency action: • Analysis of Agency action:
54.	**ESI Coverage Verification** **ACTION: Notice** **NOTICE:** Employer-Sponsored Coverage Verification: Preliminary Informational Statement **AGENCY:** CMS	CMS RIN 0938-ZB09	Issue Date: [Approved by OMB 4/26/2012] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
63.c.	**Certification of Compliance for Health Plans** **ACTION: Proposed Rule** **NOTICE:** Administrative Simplification: Certification of Compliance for Health Plans **AGENCY:** CMS	CMS-0037-P	Issue Date: 1/2/2014 **Due Date: 3/3/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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65.	**Health Care Reform Insurance Web Portal Requirements** **ACTION: Request for Comment** **NOTICE:** Health Care Reform Insurance Web Portal Requirements **AGENCY:** CMS	CMS-10320	Issue Date: 8/15/2012 Due Date: 9/13/2012 TTAG File Date: 9/13/2012; ANTHC also filed comments 9/13/2013 Date of Subsequent Agency Action, if any: Issued revision 2/3/2014 **Due Date: 4/1/2014**	• Summary of Agency action: √ • TTAG analysis of action: √ • Summary of subsequent Agency action: √	• TTAG recommendations included: √ • Subsequent Agency action: √ • Analysis of Agency action: **TBE**
89.e.	**Notice of Benefit and Payment Parameters for 2015** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015 **AGENCY:** CMS	CMS-9954-~~P~~F	Issue Date: 12/2/2013 Due Date: 12/26/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 2/24/2014	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
91.b.	**Waiting Period Limitation and Coverage Requirements** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under ACA **AGENCY:** IRS/DoL/CMS	REG-122706-12 DoL (RIN 1210-AB56) CMS-9952-~~P~~F	Issue Date: 3/21/2013 Due Date: 5/20/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued Final Rule 2/24/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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91.c.	**Waiting Period Limitation** **ACTION: Proposed Rule** **NOTICE:** Ninety-Day Waiting Period Limitation **AGENCY:** IRS/DoL/CMS	REG-122706-12 DoL (RIN 1210-AB61) CMS-9952-P2	Issue Date: 2/24/2014 **Due Date: 4/25/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
92.h.	**Disclosure and Recordkeeping for Grandfathered Health Plans** **ACTION: Request for Comment** **NOTICE:** Affordable Care Act Grandfathered Health Plan Disclosure, Recordkeeping Requirement, and Change in Carrier Disclosure **AGENCY:** DoL	DoL (OMB 1210-0140)	Issue Date: 5/22/2013 Due Date: 7/22/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 11/29/2013 Due Date: 1/2/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
92.i.	**ACA Notice of Rescission** **ACTION: Request for Comment** **NOTICE:** Affordable Care Act Notice of Rescission **AGENCY:** Treasury	TD 9491 (OMB 1545-2180)	Issue Date: 6/27/2013 Due Date: 8/20/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/27/2014 **Due Date: 3/31/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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

National Indian Health Board

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92.k.	**ACA Notice of Patient Protection ACTION: Request for Comment NOTICE:** Affordable Care Act Notice of Patient Protection **AGENCY:** IRS	REG-120399-10 (OMB 1545-2181)	Issue Date: 9/4/2013 Due Date: 11/4/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/27/2014 **Due Date: 3/31/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
92.n.	**Rules for Group Health Plans Related to Grandfather Status ACTION: Request for Comment NOTICE:** Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act **AGENCY:** IRS	REG-118412-10 (OMB 1545-2178)	Issue Date: 10/29/2013 Due Date: 12/30/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 2/27/2014 **Due Date: 3/31/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
92.q.	**ACA Advance Notice of Rescission ACTION: Request for Comment NOTICE:** Affordable Care Act Advance Notice of Rescission **AGENCY:** DoL	DoL (OMB 1210-0141)	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/19/2014 **Due Date: 3/21/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

TABLE A: REGULATIONS INCLUDED TO DATE IN RRIAR TABLES B AND C UPDATED THROUGH 2/28/2014

RRIAR Ref. #	Short Title/ Current Status of Regulation/ Title/ Agency	File Code	Dates (Issue, Due, File, Subsequent Action)[1]	In Table B-- • Is the summary of Agency action included? • Is the NIHB analysis included?	In Table C-- • Is the list of NIHB recommendations included? • Has the Agency taken subsequent action? • Is an analysis of subsequent Agency action included?
92.r.	**ACA Patient Protection Notice** **ACTION: Request for Comment** **NOTICE:** Affordable Care Act Patient Protection Notice **AGENCY:** DoL	DoL (OMB 1210-0142)	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/28/2014 **Due Date: 3/31/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
92.s.	**Rate Increase Disclosure and Review Reporting Requirements** **ACTION: Request for Comment** **NOTICE:** Rate Increase Disclosure and Review Reporting Requirements **AGENCY:** CMS	CMS-10379	Issue Date: 12/27/2013 Due Date: 2/25/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
92.t.	**ACA Implementation: Market Reform and Mental Health Parity** **ACTION: Guidance** **NOTICE:** Affordable Care Act Implementation FAQs: Market Reform Provisions and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 1/9/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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92.u.	**Marketplace and Insurance Market Standards for 2015/2016** **ACTION: Proposed Rule** **NOTICE:** Marketplace and Insurance Market Standards for 2015/2016 **AGENCY:** CMS	CMS-9949-P	Issue Date: [Pending at OMB as of 2/11/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
92.v.	**Q&A on Outreach by Medicaid MCOs to Former Enrollees** **ACTION: Guidance** **NOTICE:** Question and Answer on Outreach by Medicaid Managed Care Contractors and Health Insurance Issuers to Former Enrollees **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 2/21/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
99.c.	**Evaluation of Wellness and Prevention Programs** **ACTION: Request for Comment** **NOTICE:** Prospective Evaluation of Evidence-Based Community Wellness and Prevention Programs **AGENCY:** CMS	CMS-10509	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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112.b.	**IHS Reimbursement Rates for CY 2014** **ACTION: Notice** **NOTICE:** Reimbursement Rates for Calendar Year 2014 **AGENCY:** IHS	IHS RIN 0917-ZA28	Issue Date: [Pending at OMB as of 1/22/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
135.d.	**LTCH Quality Reporting Program Evaluation** **ACTION: Request for Comment** **NOTICE:** Long Term Care Hospital Quality Reporting Program: Program Evaluation **AGENCY:** CMS	CMS-10502	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
145.a.	**Health Insurance Providers Fee** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Health Insurance Providers Fee **AGENCY:** IRS	~~REG-118315-12~~ TD 9643	Issue Date: 3/4/2013 Due Date: 6/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction 3/22/2013; issued Final Rule 11/29/2013; issued correction 1/22/2014	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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145.b.	**Report of Health Insurance Provider Information** **ACTION: Request for Comment** **NOTICE:** Report of Health Insurance Provider Information **AGENCY:** IRS	Form 8963	Issue Date: 11/21/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 1/29/2014 Due Date: 2/28/2014	• Summary of Agency action: √ • NIHB analysis of action: √ • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
			SECTION IV: OTHER		
82.e.	**CLIA Program and HIPAA Privacy Rule** **ACTION: Final Rule** **NOTICE:** CLIA Program and HIPAA Privacy Rule; Patients' Access to Test Reports **AGENCY:** CMS	CMS-2319-F	Issue Date: 2/5/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
82.h.	**HIPAA Eligibility Transaction System Partner Agreement** **ACTION: Request for Comment** **NOTICE:** HIPAA Eligibility Transaction System (HETS) Trading Partner Agreement (TPA) **AGENCY:** CMS	CMS-10157	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued reinstatement 1/31/2014 **Due Date: 3/5/2014**	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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RRIAR Ref. #	Short Title/ Current Status of Regulation/ Title/ Agency	File Code	Dates (Issue, Due, File, Subsequent Action)[1]	In Table B-- • Is the summary of Agency action included? • Is the NIHB analysis included?	In Table C-- • Is the list of NIHB recommendations included? • Has the Agency taken subsequent action? • Is an analysis of subsequent Agency action included?
82.i.	**HIPAA Covered Entity and Associate Pre-Audit Survey** **ACTION: Request for Comment** **NOTICE:** HIPAA Covered Entity and Business Associate Pre-Audit Survey **AGENCY:** HHS OCR	HHS OS-21435-60D	Issue Date: 2/24/2014 **Due Date: 4/25/2014** NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
153.j.	**CMS/VA Computer Matching Program** **ACTION: Notice** **NOTICE:** Privacy Act of 1974: CMS Computer Matching Program Match No. 2013-01; HHS Computer Matching Program Match No. 1312 **AGENCY:** CMS	CMS (no reference number)	Issue Date: 12/5/2013 Due Date: 30 days (approx. 1/6/2014) NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
153.k.	**CMS/SSA/IRS Computer Matching Program** **ACTION: Notice** **NOTICE:** Privacy Act of 1974, CMS Computer Match No. 2013-03, HHS Computer Match No. 1314, SSA Computer Match No. 1048, IRS Project No. 241 **AGENCY:** CMS	CMS (no reference number)	Issue Date: 1/28/2014 Due Date: 30 days (approx. 2/27/2014) NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

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RRIAR Ref. #	Short Title/ Current Status of Regulation/ Title/ Agency	File Code	Dates (Issue, Due, File, Subsequent Action)[1]	In Table B-- • Is the summary of Agency action included? • Is the NIHB analysis included?	In Table C-- • Is the list of NIHB recommendations included? • Has the Agency taken subsequent action? • Is an analysis of subsequent Agency action included?
185.a.	**Healthcare Fraud Prevention Partnership: Data Sharing** **ACTION: Request for Comment** **NOTICE:** Healthcare Fraud Prevention Partnership (HFPP): Data Sharing and Information Exchange **AGENCY:** CMS	CMS-10501	Issue Date: 10/23/2013 Due Date: 12/23/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 1/10/2014 Due Date: 2/10/2014	• Summary of Agency action: √ • NIHB analysis of action: • Summary of subsequent Agency action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
185.b.	**Revisions to HHS OIG Civil Monetary Penalty Rules** **ACTION: Request for Comment** **NOTICE:** Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Office of the Inspector General's Civil Monetary Penalty Rules **AGENCY:** HHS OIG	HHS OIG RIN 0936-AA04	Issue Date: [Pending at OMB as of 2/5/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
185.c.	**Revisions to HHS OIG Exclusion Authorities** **ACTION: Request for Comment** **NOTICE:** Revisions to the Office of Inspector General's Exclusion Authorities **AGENCY:** HHS OIG	HHS OIG RIN 0936-AA05	Issue Date: [Pending at OMB as of 2/5/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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186.	**DSW Resource Center Core Competencies Survey** **ACTION: Request for Comment** **NOTICE:** Direct Service Workforce (DSW) Resource Center (RC) Core Competencies (CC) Survey Instrument **AGENCY:** CMS	CMS-10512	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action:	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:
189.	**Annual Update of the HHS Poverty Guidelines** **ACTION: Notice** **NOTICE:** Annual Update of the HHS Poverty Guidelines **AGENCY:** HHS	HHS (no reference number)	Issue Date: 1/22/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:	• Summary of Agency action: √ • NIHB analysis of action: √	• NIHB recommendations included: • Subsequent Agency action: • Analysis of Agency action:

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National Indian Health Board

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
1.g.	**Revision to the Definition of Common Meaningful Use Data Set** **ACTION: Interim Final Rule** **NOTICE:** 2014 Edition Electronic Health Record Certification Criteria: Revision to the Definition of "Common Meaningful Use Data Set" **AGENCY:** HHS	HHS RIN 0991-AB91	Issue Date: 11/4/2012 Due Date: 1/3/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This interim final rule with comment period revises one paragraph in the Common Meaningful Use (MU) Data Set definition at 45 CFR 170.102 to allow more flexibility with respect to the representation of dental procedures data for electronic health record (EHR) technology testing and certification. http://www.gpo.gov/fdsys/pkg/FR-2013-11-04/pdf/2013-26290.pdf **SUMMARY OF NIHB ANALYSIS:** I/T/Us might have an interest in the revision to the definition pertaining to dental procedures and EHRs.	
1.h.	**Voluntary 2015 Edition EHR Certification Criteria, et al.** **ACTION: Proposed Rule** **NOTICE:** Voluntary 2015 Edition Electronic Health Record (EHR) Certification Criteria; Interoperability Updates and Regulatory Improvements **AGENCY:** HHS	HHS RIN 0991-AB92	Issue Date: 2/26/2014 **Due Date: 4/28/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This notice of proposed rulemaking introduces the beginning of the more frequent approach by the HHS Office of National Coordinator for Health Information Technology (ONC) to health information technology certification regulations. Under this approach, ONC intends to update certification criteria editions every 12 to 18 months to provide smaller, more incremental regulatory changes and policy proposals. This approach gives stakeholders greater and earlier visibility into our regulatory direction before they must comply, provides more time for public input on policy proposals under consideration for future rulemakings, and enables certification processes to more quickly adopt newer industry standards that can enhance interoperability. **The 2015 Edition EHR certification criteria outlined in this proposed rule would remain voluntary.** No EHR technology developer that has certified its EHR technology to the 2014 Edition would need to recertify to the 2015 Edition for its customers to participate in the Medicare and Medicaid EHR Incentive Programs (EHR Incentive Programs). Furthermore, eligible professionals, eligible hospitals, and critical access hospitals that participate in the EHR Incentive Programs would not need to "upgrade" to EHR technology certified to 2015 Edition to have EHR technology that meets the Certified EHR Technology (CEHRT) definition. Instead, **the 2015 Edition EHR**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					certification criteria would accomplish three policy objectives. They would: 1) enable a more efficient and effective response to stakeholder feedback; 2) incorporate "bug fixes" to improve on 2014 Edition EHR certification criteria in ways designed to make rules clearer and easier to implement; and 3) reference newer standards and implementation specifications that reflect ONC commitment to promoting innovation and enhancing interoperability. This proposed rule also includes specific revisions to the ONC HIT Certification Program. These proposals focus on: improving regulatory clarity; simplifying the certification of EHR Modules designed for purposes other than achieving meaningful use; and discontinuing the use of the Complete EHR definition starting with the 2015 Edition. **SUMMARY OF NIHB ANALYSIS:** Although this proposed rule would make the certification criteria voluntary for 2015, it offers an opportunity to comment on criteria likely to become mandatory in the future.	
1.i.	**Public Health Agency/Registry Readiness for Meaningful Use** **ACTION: Request for Comment** **NOTICE:** Public Health Agency/Registry Readiness to Support Meaningful Use **AGENCY:** CMS	CMS-10499	Issue Date: 2/7/2014 **Due Date: 4/8/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Public Health Agency/Registry Readiness to Support Meaningful Use; *Use*: The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs provide incentives for the meaningful use of Certified Electronic Health Record Technology (CEHRT). CMS defined meaningful use as a set of objectives and measures in either Stage 1 or Stage 2, depending on how long an eligible provider has participated in the program. **Both Stage 1 (3 objectives) and Stage 2 (5 objectives) of meaningful use contain objectives and measures that require eligible providers to determine the readiness of public health agencies and registries to receive electronic data from CEHRT.** Public comments on the notice of proposed rulemaking for Stage 2 of meaningful use (77 FR 13697) asserted that the burden for each individual eligible provider to determine the readiness of multiple public health agencies and registries would decrease to almost zero if CMS maintained a database on the readiness of public health agencies and registries. **In the final rule for Stage 2 of meaningful use (77 FR 53967), CMS agreed that the burden on eligible providers, public health agencies, and registries would decrease greatly and established that it would create such a database,** which would serve as the definitive information source for determining public health agency and registry readiness to receive electronic data associated with the public health meaningful use objectives. CMS will make the information publicly available on its	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					Web site (www.cms.gov/EHRincentiveprograms) to provide a centralized repository of this information to eligible providers and eliminate multiple individual inquiries to multiple public health agencies and registries. http://www.gpo.gov/fdsys/pkg/FR-2014-02-07/pdf/2014-02673.pdf **SUMMARY OF NIHB ANALYSIS:**	
3.i.	**Pass-Through Payment for New Categories of Devices** **ACTION: Request for Comment** **NOTICE:** Recognition of Pass-Through Payment for Additional (New) Categories of Devices Under the Outpatient Prospective Payment System and Supporting Regulations **AGENCY:** CMS	CMS-10052	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/20/2013 Due Date: 1/21/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension without change of a currently approved collection; *Title*: Recognition of Pass-Through Payment for Additional (New) Categories of Devices Under the Outpatient Prospective Payment System and Supporting Regulations; *Use*: Interested parties such as hospitals, device manufacturers, pharmaceutical companies, and physicians apply for transitional pass-through payment for certain items used with services covered in the outpatient prospective payment system (OPPS). After CMS receives all requested information, it evaluates the information to determine if justification exists for the creation of an additional category of medical devices for transitional pass-through payments. CMS might request additional information related to the proposed new device category, as needed. CMS advises the applicant of its decision and updates the OPPS during its next scheduled quarterly payment update cycle to reflect any newly approved device categories. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/20/2013 issued an extension of this PRA request with no changes. http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30334.pdf	
3.j.	**Prior Authorization Process for Certain DMEPOS Items**	CMS-6050-P	Issue Date: [Pending at OMB as of		**SUMMARY OF AGENCY ACTION:** This proposed rule would establish a prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items subject to frequent unnecessary utilization.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	ACTION: Proposed Rule **NOTICE:** Prior Authorization Process for Certain Durable Medical Equipment, Prosthetic, Orthotics, and Supplies Items **AGENCY:** CMS		12/24/2013] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF NIHB ANALYSIS:**	
3.k.	**Methodology for Adjusting Medicare Payments for DMEPOS** **ACTION: ANPRM** **NOTICE:** Medicare Program; Methodology for Adjusting Payment Amounts for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Using Information From Competitive Bidding Programs **AGENCY:** CMS	CMS-1460-ANPRM	Issue Date: 2/26/2014 **Due Date: 3/28/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This advance notice of proposed rulemaking (ANPRM) solicits public comments on different methodologies CMS might consider using with regard to applying information from the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding programs to adjust Medicare fee schedule payment amounts or other Medicare payment amounts for DMEPOS items and services furnished in areas not included in these competitive bidding programs. In addition, CMS also requests comments on a different matter regarding ideas for potentially changing the payment methodologies used under the competitive bidding programs for certain durable medical equipment and enteral nutrition. **SUMMARY OF NIHB ANALYSIS:**	
4.d.	**Medicare Hospital OPPS, Ambulatory Surgical Center Payment System, et**	CMS-1601-~~P~~FC	Issue Date: 7/19/2013		**SUMMARY OF AGENCY ACTION:** This proposed rule would revise the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for CY 2014 to implement applicable statutory	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	al. **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Hospital Value-Based Purchasing Program; Organ Procurement Organizations; Quality Improvement Organizations; Electronic Health Records (EHR) Incentive Program; Provider Reimbursement Determinations and Appeals **AGENCY:** CMS		Due Date: ~~9/6/2013~~ 9/16/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction/due date extension 9/6/2013; issued Final Rule 12/10/2013 Due Date: 1/27/2014		requirements and changes arising from continuing experience with these systems. In this proposed rule, CMS describes the proposed changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. In addition, this proposed rule would update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program, the ASC Quality Reporting (ASCQR) Program, and the Hospital Value-Based Purchasing (VBP) Program. This proposed rule also would change the conditions for coverage (CfCs) for organ procurement organizations (OPOs); revise the Quality Improvement Organization (QIO) regulations; change the Medicare fee-for-service Electronic Health Record (EHR) Incentive Program; and make changes relating to provider reimbursement determinations and appeals. http://www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16555.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 9/6/2013 issued a document (CMS-1601-CN) to correct technical errors that appeared in the proposed rule published in the 7/19/2013 FR. This document also extends the comment period for 10 days for the technical corrections set forth in this correcting document. http://www.gpo.gov/fdsys/pkg/FR-2013-09-06/pdf/2013-21849.pdf CMS on 12/10/2013 issued a final rule with comment period that revises the Medicare hospital outpatient prospective payment system (OPPS) and the Medicare ambulatory surgical center (ASC) payment system for CY 2014 to implement applicable statutory requirements and changes arising from continuing CMS experience with these systems. In this final rule with comment period, CMS describes the changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system. **In addition, this final rule with comment period updates and refines the requirements for the Hospital Outpatient Quality Reporting (OQR) Program, the ASC Quality Reporting (ASCQR) Program, and the Hospital Value-Based Purchasing (VBP) Program**. In addition, this final rule with comment period makes changes to the conditions for	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					coverage (CfCs) for organ procurement organizations (OPOs); the Quality Improvement Organization (QIO) regulations; the Medicare fee-for-service Electronic Health Record (EHR) Incentive Program; and provider reimbursement determinations and appeals. CMS will consider comments on the payment classification assigned to HCPCS codes identified in Addenda B, AA, and BB of this final rule with comment period with the "NI" comment indicator and on other areas specified throughout this rule. http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf	
5.a.	**PACE Information Request** **ACTION: Request for Comment** **NOTICE:** Medicare and Medicaid; Programs of All-Inclusive Care for the Elderly (PACE) **AGENCY:** CMS	CMS-R-244	Issue Date: 7/30/2010 Due Date: 9/28/2010 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 10/8/2010; issued extension 10/4/2013; issued extension 12/20/2013 Due Date: 11/8/2010;		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Programs for All-inclusive Care of the Elderly (PACE) and Supporting Regulations; *Use*: The PACE organizations must demonstrate their ability to provide quality community-based care for the frail elderly who meet their state nursing home eligibility standards using capitated payments from Medicare and the state. The model of care includes as core services the provision of adult day health care and multidisciplinary team case management, with controlled access to and allocation of all health services. Participants receive physician, therapeutic, ancillary, and social support services in their residence or onsite at the adult day health center. The PACE programs must provide all Medicare and Medicaid covered services, including hospital, nursing home, home health, and other specialized services. Financing of this model occurs through prospective capitation of both Medicare and Medicaid payments. The information collection requirements ensure that only appropriate organizations become PACE organizations and that CMS has the information necessary to monitor the care provided to the frail, vulnerable population served. **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 10/8/2010 issued an extension of this PRA request. CMS on 10/4/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			12/3/2013; 1/21/2014		CMS on 12/20/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30334.pdf	
5.b.	**PACE State Plan Amendment Preprint** **ACTION: Request for Comment** **NOTICE:** State Plan Amendment Preprint **AGENCY:** CMS	CMS-10227	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/13/2013 Due Date: 1/13/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension without change 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 preprint packet described as "Enclosures #3, 4, 5, 6, and 7." CMS uses the information, collected from the state on a one-time basis, to determine if the state has properly elected to cover PACE services as a state plan option. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/13/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-13/pdf/2013-29726.pdf CMS-10227 and a Supporting Statement for this PRA request are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1239083.html.	
6.g.	**Policy Sales to Medicare Beneficiaries Losing Coverage Due to High Risk Pool Closures** **ACTION: Guidance** **NOTICE:** The Sale of Individual Market Policies to	CMS (no reference number)	Issue Date: 1/10/2014 Due Date: None NIHB File Date:		**SUMMARY OF AGENCY ACTION:** This bulletin sets forth circumstances under which the HHS Secretary has determined that issuers can sell individual market health insurance policies to certain Medicare beneficiaries younger than age 65 who lose state high risk pool coverage. As this bulletin explains, for sales to these individuals, HHS will not enforce the anti-duplication provisions of section 1882(d)(3)(A) of the Social Security Act (the Act) from 1/10/2014 to 12/31/2015. http://www.cms.gov/Medicare/Health-Plans/Medigap/Downloads/Sale-of-Individual-Market-Policies-to-Certain-Medicare-Beneficiaries.pdf	

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	Medicare Beneficiaries Under 65 Losing Coverage Due to High Risk Pool Closures **AGENCY:** CMS		Date of Subsequent Agency Action, if any:		**SUMMARY OF NIHB ANALYSIS:**	
7.bb.	**Program Integrity; Amendments to the HHS Notice of Benefit and Payment Parameters** **ACTION: Final Rule** **NOTICE:** Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 **AGENCY:** CMS	CMS-9957-F2 CMS-9964-F3 **See also 7.s., 89.a., and 89.b.**	Issue Date: 10/30/2013 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction 12/31/2013		**SUMMARY OF AGENCY ACTION:** This final rule implements provisions of ACA. Specifically, this final rule outlines financial integrity and oversight standards with respect to Affordable Insurance Exchanges, qualified health plan (QHP) issuers in Federally-facilitated Exchanges (FFEs), and States with regard to the operation of risk adjustment and reinsurance programs. It also establishes additional standards for special enrollment periods, survey vendors that might conduct enrollee satisfaction surveys on behalf of QHP issuers, and issuer participation in an FFE, and makes certain amendments to definitions and standards related to the market reform rules. These standards, which include financial integrity provisions and protections against fraud and abuse, are consistent with Title I of ACA. This final rule also amends and adopts as final interim provisions set forth in the Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 interim final rule, published in the Federal Register on March 11, 2013, related to risk corridors and cost-sharing reduction reconciliation. http://www.gpo.gov/fdsys/pkg/FR-2013-10-30/pdf/2013-25326.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/31/2013 issued a document (CMS-9957-CN; 9964-CN) that corrects an error that appeared in the final rule published in the 10/30/2013 FR. On page 65095, CMS added subpart M "Oversight and Program Integrity Standards for State Exchanges" to the regulations text at 45 CFR ` 155. Although subpart M applies to all Exchanges, including Small Business Health Options Program (SHOP) Exchanges, as a result of an oversight, CMS inadvertently omitted cross-referencing new subpart M at § 155.705(a) of the regulations in part 155, subpart H--Exchange Functions: Small Business Health Options Program. Accordingly, CMS has revised § 155.705(a) so that the regulations in part 155 consistently reflect its policy that all Exchanges, including SHOP Exchanges, must carry out the required functions of an Exchange set forth at	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					subpart M. CMS has correcting § 155.705(a) by adding a cross reference to subpart M, so that the provision reads, "Exchange functions that apply to SHOP". The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, K, and M of this part, except: …" http://www.gpo.gov/fdsys/pkg/FR-2013-12-31/pdf/2013-31319.pdf	
7.ee.	**2015 Letter to Issuers in FFMs** **ACTION: Guidance** **NOTICE:** Draft 2015 Letter to Issuers in the Federally-Facilitated Marketplaces **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 2/4/2014 Due Date: 2/25/2014 TTAG File Date: 2/25/2014; NIHB and TSGAC also filed comments 2/15/2014 Date of Subsequent Agency Action, if any:	TTAG response: NIHB response: TSGAC response:	**SUMMARY OF AGENCY ACTION:** This draft Letter to Issuers in the Federally-Facilitated Marketplaces (Letter) provides issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in a Federally-Facilitated Marketplace (FFM) and/or Federally-Facilitated Small Business Health Options Program (FF-SHOP) with operational and technical guidance to help them successfully participate in the Marketplaces. Unless otherwise specified, references to the Marketplaces or FFMs include the FF-SHOP. As indicated in previous guidance, states that perform plan management functions in an FFM have some flexibility in assessing compliance with certification standards and adjusting processes. Throughout this Letter, CMS identifies the areas in which states performing plan management functions in an FFM have flexibility to follow an approach different from that articulated in this guidance. CMS notes that the policies articulated in this Letter apply to QHP issuers starting in the 2015 certification year and beyond, until or unless subsequent guidance or regulations supersedes them. In the future, CMS intends to issue similar letters and other guidance to provide operational updates to QHP issuers but does not intend to issue these letters on more than an annual basis. CMS welcomes comments on this proposed guidance. However, to the extent that this guidance merely summarizes policies proposed through other rulemaking processes not yet finalized, such as the rulemaking process for the HHS Notice of Benefit and Payment Parameters for 2015 (2015 Payment Notice), CMS notes that issuers have already had or will have an opportunity to comment on those underlying policies through these ongoing rulemaking processes. CMS does not seek any additional comments on the substance of the underlying policies proposed in un-finalized rulemakings through the comment process for this Letter. Please send comments on other aspects of this Letter to FFEcomments@cms.hhs.gov by 2/25/2014. Comments will prove most helpful if commenters organize them by subsections of this document. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-	See Table C.

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					issuer-letter-2-4-2014.pdf CMS provided an overview and answer questions on the ACA Tribal Outreach Call on 2/11/2014. **SUMMARY OF NIHB ANALYSIS:** On February 4, 2014, the Center for Consumer Information and Insurance Oversight (CCIIO) in the Centers for Medicare and Medicaid Services (CMS) of the federal Department of Health and Human Services (HHS) released a "Draft 2015 Letter to Issuers in the Federally-facilitated Marketplaces" (2015 Issuer Letter). Comments are due back to CCIIO by February 25, 2014. On February 11, 2014, there was a national "All Tribes Call" hosted by CMS to explain the document and answer questions. During the call, CMS staff responded to questions from tribal representatives and indicated that issuers complied with the 2014 standards pertaining to Essential Community Providers (ECP) and specifically the requirement under the Safe Harbor Standard to offer contracts to all Indian Health Care Providers in a Qualified Health Plan's (QHP) service area. CMS staff stated that issuers "attested" to having offered contracts to all IHCPs in their service areas. CMS staff further indicated that all but five states have taken on the (first line) responsibility for certifying QHPs. (As indicated in the Issuer Letter, it is CMS that retains the authority to actually certify the QHPs.) In the other five states, CMS certified the plans as being compliant on the requirement for QHPs to offer contracts to IHCPs, again by issuers attesting to complying with this provision. Tribal representatives indicated to CMS staff that the experience in the field has been different from what CMS was reporting. Namely, in general, issuers have not been uniformly offering contracts to IHCPs. A tribal representative from Washington State reviewed in detail the experience with QHPs operating in the State's Marketplace. CMS representatives responded that it would be beneficial to have further discussions on the issue of issuer compliance with this requirement. Comments by tribal representatives will, among other topics, focus on the need for increased oversight to ensure QHP compliance with the CMS-established standards.  Analysis of 2015 CCIIO Issuer Letter	

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7.ff.	**Enrollment and Termination Policies for Marketplace Issuers** **ACTION: Guidance** **NOTICE:** Affordable Exchanges Guidance: Bulletins on Enrollment and Termination Policies and Processes for FFM and SPM Issuers **AGENCY:** CCIIO	CCIIO (no reference number) **See also 7.aa. and 7.dd.**	Issue Date: 2/6/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** CMS has finalized a series of processes and policies regarding enrollment and termination for issuers participating in Marketplaces using the CMS system, including Federally-Facilitated Marketplaces (FFMs) and State Partnership Marketplaces (SPMs). This set of guidance covers a variety of topics related to the ability of consumers or issuers to make changes to information or plan selections based on changes in life circumstances or as the result of receiving a special enrollment period. New functionality in the FFM will allow consumers to make certain changes to their application. The attached guidance represents a series of bulletins and FAQs related to consumer changes where new functionality is available. This guidance outlines interim processes for situations where functionality is not yet available, such as special enrollment periods (SEPs). This guidance works in conjunction with previously issued guidance, including the 12/12/2013 Interim Final Rule (link below); the FFM Enrollment Operational Policy and Guidance draft issued on 10/3/2013 (link below); and all previously released bulletins except where otherwise indicated. This guidance includes the following bulletins: • Bulletin #2: Functionality for Consumer-Initiated Application and Enrollment Changes; • Bulletin #3: Special Enrollment Periods: Effective Dates and Processes; • Bulletin #4: Enrollee-Initiated Terminations; • Bulletin #5: Flexibility During the Initial Open Enrollment Period to Change Plans Offered by the Same Issuer at the Same Metal Level; and • Bulletin #6: Clarifications of the Instructions Presented in the December 12, 2013, Interim Final Rule and Bulletin #001. http://www.healthreformgps.org/wp-content/uploads/provider-networks-2-11.pdf The 12/12/2013 Interim Final Rule is available at http://www.gpo.gov/fdsys/pkg/FR-2013-12-17/pdf/2013-29918.pdf. The FFM Enrollment Operational Policy and Guidance draft is available at http://www.cms.gov/CCIIO/Resources/Regulations-and-	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					Guidance/Downloads/ENR_OperationsPolicyandGuidance_5CR_100313.pdf. According to a February 7, 2014, *Washington Post* article: In a 14-page memo sent to health insurers on 2/6/2014, CMS announced it will temporarily allow consumers who have obtained coverage through the new online Marketplace to switch health plans before 3/31/2014, provided they remain with the same insurer and generally the same level of coverage. Specifically, the memo states that consumers can switch health plans if they want to "move to a plan with a more inclusive provider network" or fit within "other isolated circumstances," which CMS did not define. CMS will allow consumers more flexibility and a longer opportunity to obtain a new health plan if they can prove that HealthCare.gov displayed inaccurate information about the benefits that their current plan offers, according to the memo. In addition, the memo states that CMS has added to HealthCare.gov a "Report a Life Change" button, which will allow consumers to adjust their health plans if they have added members to their family, moved, gotten released from prison, or undergone other changes that affect the coverage they want. The memo also indicates that consumers, during open enrollment periods this year and in the future, might have the ability to switch health plans by refusing to pay their premium to prompt their insurer to cancel their policy. In that circumstance, consumers can apply for a new health plan, the memo states. The *Post* article is available at http://www.washingtonpost.com/national/health-science/administration-will-allow-people-to-switch-obamacare-plans-to-a-limited-degree/2014/02/07/56c8bfd2-9015-11e3-b227-12a45d109e03_story.html. **SUMMARY OF NIHB ANALYSIS:** Details on effective dates for coverage for individuals eligible for Special Enrollment Periods (SEPs): • If eligible for a Special Enrollment Period due to loss of minimum essential coverage (MEC), an individual can enroll in a Marketplace plan at any time during a month, with the coverage taking effect on the 1st of the following month (i.e., not required to enroll by the 15th of the month). • For most other SEPs, an individual must enroll by the 15th of the month, etc. For instance, individuals with a status as an Indian must enroll by the 15th of the month for coverage to take effect by the 1st of the following month.	

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					• For births and adoptions, coverage takes effect on the day of the birth or adoption. • For future loss of MEC as much as 60 days in the future, an individual can enroll for coverage that will become effective on the 1st of the month following the loss of coverage.	
11.d.	**Bid Pricing Tool** **ACTION: Request for Comment** **NOTICE:** BPT for Medicare Advantage and Prescription Drug Plans **AGENCY:** CMS	CMS-10142	Issue Date: 10/5/2012 Due Date: 12/4/2012 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 1/17/2013; issued revision 10/4/2013; issued revision 12/20/2013 Due Date: 2/19/2013; 12/3/2013; 1/21/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: **Bid Pricing Tool** (BPT) for Medicare Advantage (MA) Plans and **Prescription Drug Plans** (PDP); *Use*: Medicare Advantage organizations (MAO) and Prescription Drug Plans (PDP) must submit an actuarial pricing "bid" for each plan offered to Medicare beneficiaries for approval by the Centers for Medicare & Medicaid Services (CMS). MAOs and PDPs use the Bid Pricing Tool (BPT) software to develop their actuarial pricing bid, with the information provided in the BPT used as the basis for the plan's enrollee premiums and CMS payments for each contract year. The tool collects data such as medical expense development, administrative expenses, profit levels, and projected plan enrollment information. CMS reviews and analyzes the information provided in the BPT and decides whether to approve the plan pricing proposed by each organization. CMS is requesting to continue its use of the BPT for the collection of information for CY 2014 through CY 2016. **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/17/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-01-17/pdf/2013-00858.pdf CMS on 10/4/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf CMS on 12/20/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30334.pdf	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
11.f.	**Plan Benefit Package and Formulary Submission** **ACTION: Request for Comment** **NOTICE:** PBP and Formulary Submission for Medicare Advantage and Prescription Drug Plans **AGENCY:** CMS	CMS-R-262	Issue Date: 10/5/2012 Due Date: 12/4/2012 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 1/17/2013; issued revision 11/1/2013; issued revision 1/17/2014 Due Date: 2/19/2013; 12/31/2013; 2/18/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Plan **Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP)**; *Use*: Medicare Advantage (MA) and Prescription Drug Plan (PDP) organizations must submit plan benefit packages—which consist of the Plan Benefit Package (PBP) software, formulary file, and supporting documentation, as necessary—for all Medicare beneficiaries residing in their service area. MA and PDP organizations use the PBP software to describe their organization's plan benefit packages, including information on premiums, cost sharing, authorization rules, and supplemental benefits, as well as **generate a formulary** to describe their list of drugs, including information on prior authorization, step therapy, tiering, and quantity limits. In addition, CMS uses the PBP and formulary data to review and approve the plan benefit packages proposed by each MA and PDP organization. **SUMMARY OF NIHB ANALYSIS:** A link to a detailed list of changes to the PBP software appears below. In addition, if issues with the current formulary development process or the use of the formulary have occurred, this PRA request might provide an opportunity to comment on them. The changes proposed are to be implemented and effective by CY 2014. http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-262.html **SUMMARY OF SUBSEQUENT AGENCY ACTION:** Based on operational changes and policy clarifications to Medicare and continued input and feedback by the industry, CMS has made the necessary changes to the plan benefit package submission. http://www.gpo.gov/fdsys/pkg/FR-2013-01-17/pdf/2013-00858.pdf CMS on 11/1/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-11-01/pdf/2013-26107.pdf CMS on 1/17/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-17/pdf/2014-00915.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
11.s.	**Medicare Prescription Drug Benefit Program** **ACTION: Request for Comment** **NOTICE:** Medicare Prescription Drug Benefit Program **AGENCY:** CMS	CMS-10141	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 12/13/2013 Due Date: 1/13/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Medicare Prescription Drug Benefit Program; *Use*: Part D plans use the information to comply with the eligibility and associated Part D participating requirements. CMS uses the information to approve contract applications, monitor compliance with contract requirements, make proper payment to plans, and ensure disclosure of correct information to potential and current enrollees. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/13/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-13/pdf/2013-29726.pdf Several documents related to CMS-10141 (listed below) are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS1210554.html. • Attachment 1a: Compensation Certification • Attachment 2a: Description of Compensation Structure for Plans Using Contracted Marketing Organizations • Attachment 3: Writing Agents Information Sheet • Attachment 4: Compensation Structure for Writing Agents by Contract/PBP Number • Supporting Statement	
11.t.	**Appeals of Quality Bonus Payment Determinations** **ACTION: Request for Comment**	CMS-10346	Issue Date: 12/6/2013 Due Date: 2/4/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Appeals of Quality Bonus Payment Determinations; *Use*: Section 1853(o) of the Social Security Act (the Act) requires CMS to make quality bonus payments (QBPs) to Medicare Advantage (MA) organizations that achieve performance rating scores of at least 4 stars under a 5-star rating system. While CMS	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Appeals of Quality Bonus Payment Determinations **AGENCY:** CMS		NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/28/2014 **Due Date: 3/31/2014**		has applied a Star Rating system to MA organizations for a number of years, prior to the QBP program, it used these Star Ratings only to provide additional information for beneficiaries to consider in making their Part C and D plan elections. Beginning in 2012, the Star Ratings CMS assign for purposes of QBPs directly affect the monthly payment amount MA organizations receive under their contracts. Additionally, section 1854(b)(1)(C)(v) of the Act, as added by ACA, requires CMS to change the share of savings that MA organizations must provide to enrollees as the beneficiary rebate specified at § 422.266(a) based on the level of a Star Rating for quality performance. While the statute does not specify an administrative review process for appealing low QBP Star Ratings, CMS has implemented an appeals process in accordance with its authority to establish MA program standards by regulation at section 1856(b)(1) of the Act. Under this process, MA organizations can seek review of their QBP Star Rating determinations. This review process also applies to the determinations CMS made where the Star Rating sets the QBP status of an MA organization at ineligible for rebate retention. The reconsideration official and potentially the hearing officer will consider the information collected from MA organizations in reviews of CMS determinations of eligibility for a QBP. While the statute does not specify an administrative review process for appealing low QBP Star Ratings, CMS has implemented an appeals process in accordance with its authority to establish MA program standards by regulation at section 1856(b)(1) of the Act. Under this process, MA organizations can seek review of their QBP Star Rating determinations. This review process also applies to the determinations CMS made where the Star Rating sets the QBP status of an MA organization at ineligible for rebate retention. The reconsideration official and potentially the hearing officer will consider the information collected from MA organizations in reviews of CMS determinations of eligibility for a QBP. http://www.gpo.gov/fdsys/pkg/FR-2013-12-06/pdf/2013-29144.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/28/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-28/pdf/2014-04327.pdf	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
11.u.	**CY 2015 Policy and Technical Changes to Parts C and D** **ACTION: Proposed Rule** **NOTICE:** Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs **AGENCY:** CMS	CMS-4159-P	Issue Date: 1/10/2014 **Due Date: 3/7/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This proposed rule would revise Medicare Advantage (MA) program (Part C) regulations and prescription drug benefit program (Part D) regulations to implement statutory requirements; strengthen beneficiary protections; exclude plans that perform poorly; improve program efficiencies; and clarify program requirements. This proposed rule also includes several provisions designed to improve payment accuracy. http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf **SUMMARY OF NIHB ANALYSIS:**	
11.v.	**MA Chronic Care Improvement Program and QI Reporting Tools** **ACTION: Request for Comment** **NOTICE:** Medicare Advantage Chronic Care Improvement Program (CCIP) and Quality Improvement (QI) Project Reporting Tools **AGENCY:** CMS	CMS-10209	Issue Date: 1/10/2014 **Due Date: 3/11/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Medicare Advantage Chronic Care Improvement Program (CCIP) and Quality Improvement (QI) Project Reporting Tools; *Use*: Medicare Advantage Organizations (MAOs) must have an ongoing quality improvement (QI) program that meets CMS requirements and includes at least one chronic care improvement program (CCIP) and one QI Project. Every MAO must have a QI program that monitors and identifies areas where implementing appropriate interventions would improve patient outcomes and patient safety. CMS uses the information collected using the CCIP and QIP reporting tools for oversight, monitoring, compliance, and auditing activities necessary to ensure high-quality, value-based health care for Medicare beneficiaries. http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00195.pdf **SUMMARY OF NIHB ANALYSIS:**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
11.w.	**Final Marketing Provisions for Medicare Parts C and D** **ACTION: Request for Comment** **NOTICE:** Medicare Advantage and Prescription Drug Program: Final Marketing Provisions **AGENCY:** CMS	CMS-10260	Issue Date: 1/29/2014 Due Date: 2/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Medicare Advantage and Prescription Drug Program: Final Marketing Provisions; *Use*: CMS requires Medicare Advantage (MA) organizations and Part D sponsors to use standardized documents to satisfy disclosure requirements mandated by section 1851(d)(3)(A) of the Social Security Act (Act) for MA organizations and section 1860D-1(c) of the Act for Part D sponsors. MA organizations and Part D sponsors must disclose plan information, including: **service area, benefits, access, grievance and appeals procedures, and quality improvement and quality assurance requirements** by September 30 of each year. MA organizations and Part D sponsors use this information to comply with the disclosure requirements. CMS will use the approved standardized documents to ensure disclosure of correct information to current and potential enrollees. http://www.gpo.gov/fdsys/pkg/FR-2014-01-29/pdf/2014-01775.pdf **SUMMARY OF NIHB ANALYSIS:** This PRA request involves a revision to current reporting requirements pertaining to marketing materials used by Medicare Advantage and Part D plans. The plans report on service areas, benefits, etc. No comments recommended.	
11.x.	**Medication Therapy Management Program Improvements** **ACTION: Request for Comment** **NOTICE:** Medication Therapy Management Program Improvements **AGENCY:** CMS	CMS-10396	Issue Date: 1/17/2014 **Due Date: 3/18/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Medication Therapy Management Program Improvements; *Use*: Medicare beneficiaries or their authorized representatives, caregivers, and health care providers will use information collected by Part D medication therapy management programs (as required by the standardized format for the comprehensive medication review summary) to improve medication use and achieve better health care outcomes. http://www.gpo.gov/fdsys/pkg/FR-2014-01-17/pdf/2014-00916.pdf **SUMMARY OF NIHB ANALYSIS:**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
11.y.	**Notice of Changes to Medicare Parts C and D Payment Policies** **ACTION: Notice** **NOTICE:** Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter **AGENCY:** CMS	CMS (no reference number)	Issue Date: 2/21/2014 **Due Date: 3/7/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** In accordance with section 1853(b)(2) of the Social Security Act (the Act), this notice announces planned changes in the Medicare Advantage (MA) capitation rate methodology and risk adjustment methodology applied under Part C of the Act for calendar year (CY) 2015. This notice also contains the following information: preliminary estimates of the national per capita MA growth percentage and other MA payment methodology changes for CY 2015, changes in payment methodology for CY 2015 for Part D benefits, and annual adjustments for CY 2015 to the Medicare Part D benefit parameters for the defined standard benefit. For 2015, CMS will announce the MA capitation rates on the first Monday in April 2014, in accordance with the timetable established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Interested parties can submit comments or questions electronically to the following address: AdvanceNotice2015@cms.hhs.gov. CMS might make comments public, so submitters should not include any confidential or personal information. To receive consideration prior to the April 7, 2014, release of the final Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, interested parties must submit comments by 6 p.m. ET on Friday, March 7, 2014. http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2015.pdf A CMS press release on this notice is available at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-02-21-02.html. A *Politico* article on this notice is available at http://go.politicoemail.com/?qs=2f3fd5d0ab4340c4e932460059903a0b9bc3096058df55cd2ed6d55887eac92e. **SUMMARY OF NIHB ANALYSIS:** In relation to "remote access technologies" (e.g., **telehealth services**) under Medicare Advantage plans, CMS indicated: • **Improved Coordination of Care:** CMS intends to expand plans' ability to use	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					technologies that enable health care providers to deliver care to beneficiaries in remote locations. The use of remote access technologies as a care delivery option for Medicare Advantage enrollees may improve access to and timeliness of needed care, increase communications between providers and beneficiaries, and enhance care coordination.	
11.z.	**Medicare Health Outcomes Survey** **ACTION: Request for Comment** **NOTICE:** Medicare Health Outcomes Survey (HOS) **AGENCY:** CMS	CMS-10203	Issue Date: 2/28/2014 **Due Date: 4/29/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of currently approved collection; *Title*: Medicare Health Outcomes Survey (HOS); *Use*: CMS uses data collected through the Medicare Health Outcomes Survey (HOS) to hold Medicare managed care contracts accountable for the quality of care they deliver to beneficiaries. This reporting requirement allows CMS to obtain the information necessary for proper oversight of the Medicare Advantage program. http://www.gpo.gov/fdsys/pkg/FR-2014-02-28/pdf/2014-04328.pdf **SUMMARY OF NIHB ANALYSIS:**	
16.b.	**Medicaid HCBS Waivers** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicaid; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment; Setting Requirements **AGENCY:** CMS	CMS-2249-~~P2~~F2	Issue Date: 5/3/2012 Due Date: ~~6/4/2012~~ 7/2/2012 NIHB File Date: None Date of Subsequent Agency		**SUMMARY OF AGENCY ACTION:** This proposed rule would revise Medicaid regulations to define and describe State plan home and community-based services (HCBS) under the Social Security Act (the Act) as added by the Deficit Reduction Act of 2005 and amended by ACA. This rule would offer States new flexibility in providing necessary and appropriate services to elderly and disabled populations. In particular, this rule would not require the eligibility link between HCBS and institutional care that exists under the Medicaid HCBS waiver program. This rule would describe Medicaid coverage of the optional State plan benefit to furnish HCBS and receive Federal matching funds. This proposed rule also would amend Medicaid regulations consistent with the requirements of ACA, which amended the Act to provide authority for a 5-year duration for certain demonstration projects or waivers, at the discretion of the HHS Secretary, when they involve individuals dually eligible for Medicaid and Medicare benefits. In	No comments filed.

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Action, if any: Issued due date extension 5/3/2012; Final Rule approved by OMB 1/13/2014		addition, this rule would provide an additional limited exception to the general requirement that payment for services under a State plan go directly to the individual practitioner providing a service when the Medicaid program serves as the primary source of reimbursement for a class of individual practitioners. This exception would allow payments to other parties to benefit the providers by ensuring health, welfare, and training. Finally, this rule would amend Medicaid regulations to provide home and community-based setting requirements of ACA for the Community First Choice State plan option. **SUMMARY OF NIHB ANALYSIS:** None.	
16.d.	**Elimination of Cost-Sharing for Dual-Eligibles Receiving HCBS** **ACTION: Request for Comment** **NOTICE:** Elimination of Cost-Sharing for Full Benefit Dual-Eligible Individuals Receiving Home and Community-Based Services **AGENCY:** CMS	CMS-10344	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/20/2013 Due Date: 1/21/2014		**SUMMARY OF AGENCY ACTION:** *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*: This provision eliminates Part D cost-sharing for full benefit dual-eligible beneficiaries who receive home and community based services. To implement this provision, States must identify the affected beneficiaries in their monthly Medicare Modernization Act Phase Down reports. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/20/2013 issued an extension of this PRA request with no changes. http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30334.pdf	
16.e.	**Community First Choice Option** **ACTION: Request for**	CMS-10462	Issue Date: 1/17/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Community First Choice Option; *Use*: This project will evaluate the implementation and progress of the Community First Choice (CFC) Option. The results of	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Comment **NOTICE:** Community First Choice Option **AGENCY:** CMS		**Due Date: 3/18/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		the study will appear in the final Report to Congress delivered by the HHS Secretary in 2015. This project will assist CMS and Congress in their understanding of: State CFC implementation plans, the effectiveness of the CFC Option on individuals receiving home- and community-based attendant care, and State spending on long-term services and supports. Researchers will request data from States approved for CFC via a data form and semi-structured interviews. Information obtained will improve understanding of CFC program design, the targeted patient population, and intended outcomes. **At this time, CMS has approved only a California program.** To provide comparative information to the HHS Secretary, researchers also will collect data from States that have decided not to pursue the CFC option. Researchers will analyze data and develop them into a report to Congress evaluating the effectiveness of the CFC option, the impact of the program on the physical and emotional health of participants, and the cost of community-based services versus those provided in institutional settings. http://www.gpo.gov/fdsys/pkg/FR-2014-01-17/pdf/2014-00916.pdf **SUMMARY OF NIHB ANALYSIS:** California Tribes and tribal health organizations might want to comment on this research and survey to ensure adequate consideration of AI/AN and I/T/U issues.	
23.e.	**State Children's Health Insurance Program** **ACTION: Request for Comment** **NOTICE:** State Children's Health Insurance Program and Supporting Regulations **AGENCY:** CMS	CMS-R-308	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: State Children's Health Insurance Program and Supporting Regulations; *Use*: States must submit title XXI plans and amendments for approval by the HHS Secretary. CMS uses the plan and its subsequent amendments to determine if the state has met the requirements of title XXI. Advocacy groups, beneficiaries, applicants, other governmental agencies, provider groups, research organizations, health care corporations, and health care consultants will use the information provided in the state plan and state plan amendments. States will use the information collected to assess state plan performance, health outcomes, the amount of substitution of private coverage that occurs as a result of the subsidies, and the effect of the subsidies on access to coverage. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Issued extension 1/23/2014 Due Date: 2/24/2014		**SUMMARY OF NIHB ANALYSIS:** This PRA request might provide an opportunity to recommend potential changes to better capture I/T/U- and AI/AN-related information. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/23/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-23/pdf/2014-01208.pdf No comments recommended, as CMS has made no changes to the current reporting requirements for states, the District of Columbia, and territories with regard to the CHIP State Plan and amendment processes.	
23.f.	**1932(a) State Plan Amendment Template and Requirements** **ACTION: Request for Comment** **NOTICE:** 1932(a) State Plan Amendment Template, State Plan Requirements, and Supporting Regulations **AGENCY:** CMS	CMS-10120	Issue Date: 12/6/2013 Due Date: 2/4/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 2/14/2014 **Due Date: 3/17/2014**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: 1932(a) State Plan Amendment Template, State Plan Requirements, and Supporting Regulations; *Use*: Section 1932(a)(1)(A) of the Social Security Act (the Act) grants states the authority to enroll Medicaid beneficiaries on a mandatory basis into managed care entities--managed care organizations (MCOs) and primary care case managers (PCCMs). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without violating provisions of section 1902 of the Act on statewideness, freedom of choice, or comparability. States can use the template to modify their state plans if they choose to implement the provisions of section 1932(a)(1)(A). http://www.gpo.gov/fdsys/pkg/FR-2013-12-06/pdf/2013-29144.pdf **SUMMARY OF NIHB ANALYSIS:** No comments recommended, as the protection for members of federally recognized tribes is maintained. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/14/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-14/pdf/2014-03290.pdf No comments recommended.	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
23.g.	**Imposition of Cost Sharing Charges Under Medicaid** **ACTION: Request for Comment** **NOTICE:** Imposition of Cost Sharing Charges Under Medicaid and Supporting Regulations **AGENCY:** CMS	CMS-R-53 (OMB approval sought under CMS-10398; **see 23.a.**)	Issue Date: 1/27/2014 Due Date: ~~2/26/2014~~ NIHB File Date: Date of Subsequent Agency Action, if any: Issued withdrawal 2/7/2014; re-issued revision 2/14/2014 **Due Date: 3/17/2014**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Imposition of Cost Sharing Charges Under Medicaid and Supporting Regulations; *Use*: This information collection seeks to ensure that states impose nominal cost sharing charges upon categorically and medically needy individuals as allowed by law and implementing regulations. States must identify in their state plan the service for which the charge occurs, the amount of the charge, the basis for determining the charge, the basis for determining whether an individual cannot pay the charge and the way in which the individual will get identified to providers, and the procedures for implementing and enforcing the exclusions from cost sharing. CMS has revised the template for this 30-day comment period before submission to OMB for approval under CMS-10398. In addition, CMS seeks to discontinue CMS-R-53 to avoid duplicating requirements and burden. http://www.gpo.gov/fdsys/pkg/FR-2014-01-27/pdf/2014-01465.pdf **SUMMARY OF NIHB ANALYSIS:** This notice of a revision to a previously approved data collection might provide an opportunity to ensure that states have the procedures in place to ensure AI/ANs receive the cost-sharing protections established in the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA § 5006 eliminates cost-sharing for AI/ANs who receive services from an Indian health care provider or through referral from an Indian health care provider. This notice indicates that "states must identify … the procedures for implementing and enforcing the exclusions from cost sharing" for all populations eligible for exclusions from cost-sharing. Although this notice does not reference AI/ANs directly, the ARRA protections for AI/ANs are in effect, and CMS last year published regulations that provide guidance on implementing the ARRA cost-sharing protections for AI/ANs under Medicaid. For AI/ANs to receive the cost-sharing protections, 1) eligible AI/ANs need to be identified as eligible for the protections and 2) providers and MCOs need to be made aware that the certain AI/ANs are to be provided the cost-sharing protections. It appears that these two things are not occurring consistently across the country. This PRA notice might provide an opportunity to stimulate the development of procedures by states that indicate how the ARRA protections will be consistently implemented.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					Tribes and tribal organizations might want to consider recommending that TTAG work with CMS and/or a designated state to establish model procedures for 1) identifying AI/ANs eligible for the ARRA protections and 2) communicating this information to providers and MCOs. For example, in previous comments to CMS, tribal representatives recommended that states a) use self-attestation of status for the protections or b) access an electronic database for the identification of AI/ANs who qualify for the ARRA protections. These items could be incorporated into a set of model procedures. TTAG comments on CMS-2334--initially published on 1/22/2013 and published in final form on 7/15/2013--might provide a guide for tribal comments on CMS-R-53. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/7/2014 issued a notice of withdrawal of this PRA request. According to CMS, it published this PRA request in error. http://www.gpo.gov/fdsys/pkg/FR-2014-02-07/pdf/2014-02660.pdf CMS on 2/14/2014 re-issued this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-14/pdf/2014-03297.pdf	
25.g.	**PPS for Acute and Long-Term Care Hospitals, et al.** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare Program; Hospital IPPS for Acute Care Hospitals and the Long-Term Care Hospital PPS and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital CoP	CMS-1599-~~P~~F CMS-1455-F	Issue Date: 5/10/2013 Due Date: 6/25/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction		**SUMMARY OF AGENCY ACTION:** This proposed rule would revise the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from continuing CMS experience with these systems. Some of the proposed changes would implement certain statutory provisions contained in ACA and other legislation. These proposed changes would apply to discharges occurring on or after 10/1/2013, unless otherwise specified in this proposed rule. This proposed rule also would update the rate-of-increase limits for certain IPPS-excluded hospitals that receive payments on a reasonable cost basis subject to these limits. The proposed updated rate-of-increase limits would apply to cost reporting periods beginning on or after 10/1/2013. In addition, this proposed rule would update the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) and implement certain statutory changes made by ACA. Generally, these proposed changes would apply to discharges	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	AGENCY: CMS		6/27/2013; issued Final Rule 8/19/2013; issued correction 10/3/2013; issued correction 1/2/2014; issued correction 1/10/2014		occurring on or after 10/1/2013, unless otherwise specified in this proposed rule. This proposed rule also includes a number of changes relating to direct graduate medical education (GME) and indirect medical education (IME) payments. This proposed rule would establish new requirements or revised requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities (IPFs)) that participate in Medicare. Further, this proposed rule would update policies relating to the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program. This proposed rule also would revise the conditions of participation (CoPs) for hospitals relating to the administration of vaccines by nursing staff, as well as the CoPs for critical access hospitals relating to the provision of acute care inpatient services. http://www.gpo.gov/fdsys/pkg/FR-2013-05-10/pdf/2013-10234.pdf **SUMMARY OF NIHB ANALYSIS:** None. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 6/27/2013 issued a document that corrects technical and typographical errors in the proposed rule (CMS-1599-P) that appeared in the 5/10/2013 FR (78 FR 27486). http://www.gpo.gov/fdsys/pkg/FR-2013-06-27/pdf/2013-15321.pdf CMS on 8/19/2013 issued a final rule. This final rule revises the Medicare hospital inpatient prospective payment systems (IPPS) for operating and capital-related costs of acute care hospitals to implement changes arising from continuing CMS experience with these systems. Some of the changes implement certain statutory provisions contained in ACA and other legislation. These changes will apply to discharges occurring on or after October 1, 2013, unless otherwise specified in this final rule. This final rule also updates the rate-of-increase limits for certain hospitals excluded from IPPS and paid on a reasonable cost basis subject to these limits. The updated rate-of-increase limits will apply to cost reporting periods beginning on or after October 1, 2013. This final rule also updates the payment policies and the annual payment rates for the Medicare prospective payment system (PPS) for inpatient hospital services provided by long-term care hospitals (LTCHs) and implements certain statutory changes applied to LTCH PPS by ACA. Generally, these updates and statutory changes will apply to discharges occurring on or after October 1, 2013, unless otherwise specified in this final	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					rule. In addition, this final rule makes a number of changes relating to direct graduate medical education (GME) and indirect medical education (IME) payments. This final rule establishes new requirements or revises requirements for quality reporting by specific providers (acute care hospitals, PPS-exempt cancer hospitals, LTCHs, and inpatient psychiatric facilities (IPFs)) that participate in Medicare. This final rule updates policies relating to the Hospital Value-Based Purchasing (VBP) Program and the Hospital Readmissions Reduction Program. In addition, this final rule revises the conditions of participation (CoPs) for hospitals relating to the administration of vaccines by nursing staff, as well as CoPs for critical access hospitals relating to the provision of acute care inpatient services. This final rule finalizes proposals issued in two separate proposed rules that included payment policies related to patient status: payment of Medicare Part B inpatient services; and admission and medical review criteria for payment of hospital inpatient services under Medicare Part A. http://www.gpo.gov/fdsys/pkg/FR-2013-08-19/pdf/2013-18956.pdf CMS on 10/3/2013 issued a document (CMS-1599 & 1455-CN2) that corrects technical and typographical errors in the final rule that appeared in the 8/19/2013 FR. http://www.gpo.gov/fdsys/pkg/FR-2013-10-03/pdf/2013-24211.pdf CMS on 1/2/2014 issued a document (CMS-1599 & 1455-CN3) that corrects technical errors in the final rules that appeared in the 8/19/2013 FR. This document corrects IPPS Table 2 and Table 3A and LTCH Table 12A in the final rules. http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31432.pdf CMS on 1/10/2014 issued a document (CMS-1599-CN4) that corrects technical errors in the correcting document that appeared in the 1/2/2014 FR. On page 61 of the correcting document, CMS inadvertently omitted some CFR part numbers from the heading and inadvertently omitted the applicability date from the DATES section.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00273.pdf	
25.m.	**Geographic Classification Review Board Procedures** **ACTION: Request for Comment** **NOTICE:** Medicare Geographic Classification Review Board (MGCRB) Procedures and Supporting Regulations **AGENCY:** CMS	CMS-R-138	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued reinstatement 12/13/2013 Due Date: 1/13/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Reinstatement without change of a currently approved collection; *Title*: Medicare Geographic Classification Review Board (MGCRB) Procedures and Supporting Regulations; *Use*: The information submitted by the hospitals serves to determine the validity of the hospital requests and the discretion used by the Medicare Geographic Classification Review Board (MGCRB) in reviewing and making decisions regarding hospital requests for geographic reclassification. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/13/2013 issued a reinstatement of this PRA request with no changes. http://www.gpo.gov/fdsys/pkg/FR-2013-12-13/pdf/2013-29726.pdf A Supporting Statement for this PRA request is available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-138.html.	
25.n.	**Inpatient Rehab Facilities Quality Reporting Program Evaluation** **ACTION: Request for Comment** **NOTICE:** Inpatient Rehabilitation Facilities Quality Reporting Program:	CMS-10503	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Inpatient Rehabilitation Facilities Quality Reporting Program: Program Evaluation; *Use*: Section 3004(a) of ACA mandated that CMS establish a quality reporting program for Inpatient Rehabilitation Facilities (IRFs). Specifically, section 3004(a) added section 1886(j)(7) to the Social Security Act (the Act) to establish a quality reporting program for IRFs. This program requires IRFs to submit quality data in a time, form and manner specified by the HHS Secretary. CMS seeks to explore how IRFs respond to the new quality reporting program (QRP) and its measures. CMS believes in the importance of understanding early trends in	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Program Evaluation **AGENCY:** CMS		Agency Action, if any:		outcomes, making adjustments as needed to enhance the effectiveness of QRP, seeking opportunities to minimize provider burden, and ensuring the meaningfulness of the program to providers. The methodology employed in the evaluation uses qualitative interviews (as opposed to quantitative statistical methods). In consultation with research experts, CMS has decided that using a rich, contextual approach to evaluate the process and success of QRP will prove most beneficial at this time. The information collected will help inform CMS about QRP-related experiences, such as program impact related to quality improvement, burden, process-related issues, and education. This information also will inform future measurement development for the IRF QRP, future steps related to data validation, and future monitoring and evaluation. http://www.gpo.gov/fdsys/pkg/FR-2013-11-22/pdf/2013-28049.pdf **SUMMARY OF NIHB ANALYSIS:**	
25.o.	**Conditions of Participation for Critical Access Hospitals** **ACTION: Request for Comment** **NOTICE:** Conditions of Participation for Critical Access Hospitals (CAH) and Supporting Regulations **AGENCY:** CMS	CMS-10239	Issue Date: 12/20/2013 Due Date: 2/18/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Conditions of Participation for Critical Access Hospitals (CAH) and Supporting Regulations; *Use*: At the outset of the CAH program, CMS-R-48 addressed all of the information collection requirements for all CAHs. As the CAH program has grown in scope of services and the number of providers, CMS has separated the burden associated with CAHs with distinct part units (DPUs) from the burden associated with CAHs without DPUs. Section 1820(c)(2)(E)(i) of the Social Security Act provides that a CAH can establish and operate a psychiatric or rehabilitation DPU. Each DPU can maintain as many as 10 beds and must comply with the hospital requirements specified in 42 CFR Subparts A, B, C, and D of part 482. Presently, 105 CAHs have rehabilitation or psychiatric DPUs. The burden associated with CAHs that have DPUs continues to fall under CMS-R-48, along with the burden for all 4,890 accredited and non-accredited hospitals. http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30337.pdf **SUMMARY OF NIHB ANALYSIS:** No comments recommended.	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
25.p.	**Medicare/Medicaid Psychiatric Hospital Survey Data** **ACTION: Request for Comment** **NOTICE:** Medicare/Medicaid Psychiatric Hospital Survey Data **AGENCY:** CMS	CMS-724	Issue Date: 12/27/2013 Due Date: 2/25/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Reinstatement without change of a previously approved collection; *Title*: Medicare/Medicaid Psychiatric Hospital Survey Data; *Use*: CMS-724 form collects data not collected elsewhere and assists CMS in program planning and evaluation and in maintaining an accurate database on providers participating in the psychiatric hospital program. http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30994.pdf **SUMMARY OF NIHB ANALYSIS:**	
25.q.	**Hospital Conditions of Participation** **ACTION: Request for Comment** **NOTICE:** Hospital Conditions of Participation and Supporting Regulations **AGENCY:** CMS	CMS-R-48	Issue Date: 1/31/2014 **Due Date: 4/4/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Hospital Conditions of Participation and Supporting Regulations; *Use*: CMS surveyors use the conditions of participation (CoP) and accompanying requirements specified in the supporting regulations as a basis for determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid. The requirements described in this information collection request apply to 4,890 accredited and non-accredited hospitals and an additional 101 critical access hospitals (CAHs) that have distinct part psychiatric or rehabilitation units (DPUs). http://www.gpo.gov/fdsys/pkg/FR-2014-01-31/pdf/2014-02065.pdf **SUMMARY OF NIHB ANALYSIS:**	
28.e.	**FMAP Notice for FY 2015** **ACTION: Notice** **NOTICE:** Federal Financial Participation in State	HHS (no reference number)	Issue Date: 1/21/2014 Due Date: None		**SUMMARY OF AGENCY ACTION:** HHS has calculated the Federal Medical Assistance Percentages (FMAPs), Enhanced Federal Medical Assistance Percentages (eFMAPs), and disaster-recovery FMAP adjustments for FY 2015 pursuant to the Social Security Act (the Act). These percentages will remain effective from October 1, 2014, through September 30, 2015. This notice announces the calculated FMAP and eFMAP rates that HHS will use in determining the amount of federal matching for state medical assistance	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2014, Through September 30, 2015 **AGENCY:** HHS		NIHB File Date: Date of Subsequent Agency Action, if any:		(Medicaid) and Children's Health Insurance Program (CHIP) expenditures, Temporary Assistance for Needy Families (TANF) Contingency Funds, Child Support Enforcement collections, Child Care Mandatory and Matching Funds of the Child Care and Development Fund, Foster Care Title IV-E Maintenance payments, and Adoption Assistance payments. This notice also announces the disaster-recovery FMAP adjustments that HHS will use in determining the amount of federal matching for state medical assistance (Medicaid) and title IV-E Foster Care and Adoption Assistance and Guardianship Assistance programs for qualifying States for FY 2015. http://www.gpo.gov/fdsys/pkg/FR-2014-01-21/pdf/2014-00931.pdf **SUMMARY OF NIHB ANALYSIS:**	
29.g.	**Payment Collections Operations Contingency Plan** **ACTION: Request for Comment** **NOTICE:** Payment Collections Operations Contingency Plan **AGENCY:** CMS	CMS-10515	Issue Date: 12/27/2013 Due Date: 1/27/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 1/31/2014 **Due Date: 4/4/2014**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Payment Collections Operations Contingency Plan; *Use*: Under sections 1401, 1411, and 1412 of ACA and 45 CFR part 155 subpart D, an Exchange makes an advance determination of tax credit eligibility for individuals who enroll in QHP coverage through the Exchange and seek financial assistance. Using information available at the time of enrollment, the Exchange determines whether the individual meets the income and other requirements for advance payments and the amount of the advance payments available pay premiums. Under section 1412, advance payments occur periodically to the issuer of the QHP in which the individual enrolls. Section 1402 provides for the reduction of cost sharing for certain individuals enrolled in a QHP through an Exchange, and section 1412 provides for the advance payment of these reductions to issuers. The statute directs issuers to reduce cost sharing for essential health benefits for individuals who have household incomes between 100 and 400 percent of the federal poverty level (FPL), enroll in a silver-level QHP through an individual market Exchange, and qualify for advance payments of the premium tax credit. HHS will use the data collection to make payments or collect charges from issuers under the following programs: advance payments of the premium tax credit, advanced cost-sharing reductions, and Marketplace user fees. HHS will use the template to make payments in January 2014 and for a number of months thereafter. http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-31015.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					SUMMARY OF NIHB ANALYSIS: **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/31/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-31/pdf/2014-02065.pdf	
29.h.	**Verification of Income for Tax Credits and Cost Sharing** **ACTION: Guidance** **NOTICE:** Verification of Household Income and Other Qualifications for the Provision of Affordable Care Act Premium Tax Credits and Cost-Sharing Reductions **AGENCY:** HHS	HHS (no reference number)	Issue Date: 12/31/2013 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This report describes the statutory, regulatory, and policy requirements that both State-based Marketplaces and Federally-facilitated Marketplaces must follow. This report also discusses each verification requirement and describes the operational processes used for each verification. http://www.cms.gov/CCIIO/Resources/Letters/Downloads/verifications-report-12-31-2013.pdf **SUMMARY OF NIHB ANALYSIS:** This document reviews the verification requirements and processes for each of the data elements HHS will gather through the application process. HHS prepared this report in response to the provision in the recent budget agreement requiring the HHS Secretary to certify the occurrence of income verification.	
31.f.	**Employer Shared Responsibility** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Shared Responsibility for Employers Regarding Health Coverage **AGENCY:** IRS	~~REG-138006-12~~ TD 9655	Issue Date: 1/2/2013 Due Date: 3/18/2013 NIHB File Date: Date of Subsequent		**SUMMARY OF AGENCY ACTION:** This document contains proposed regulations providing guidance under section 4980H of the Internal Revenue Code (Code) with respect to the shared responsibility for employers regarding employee health coverage. These proposed regulations would affect only employers that meet the definition of ''applicable large employer'' as described in these proposed regulations. As discussed in section X of this preamble, employers may rely on these proposed regulations for guidance pending the issuance of final regulations or other applicable guidance. This document also provides notice of a public hearing on these proposed regulations. **SUMMARY OF NIHB ANALYSIS:** (Edited summary from IRS.)	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Agency Action, if any: Issued correction 3/15/2013; issued Final Rule 2/12/2014		**BASICS OF THE EMPLOYER SHARED RESPONSIBILITY PROVISIONS** **1. What are the Employer Shared Responsibility provisions?** Starting in 2014, employers employing at least a certain number of employees (generally 50 full-time employees and full-time equivalents, explained more fully below) will be subject to the Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code (added to the Code by the Affordable Care Act). Under these provisions, if these employers do not offer affordable health coverage that provides a minimum level of coverage to their full-time employees, they may be subject to an Employer Shared Responsibility payment if at least one of their full-time employees receives a premium tax credit for purchasing individual coverage on one of the new Affordable Insurance Exchanges. To be subject to these Employer Shared Responsibility provisions, an employer must have at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees (for example, 100 half-time employees equals 50 full-time employees). As defined by the statute, a full-time employee is an individual employed on average at least **30** hours per week (so half-time would be 15 hours per week). **2. When do the Employer Shared Responsibility provisions go into effect?** The Employer Shared Responsibility provisions generally go into effect on January 1, 2014. Employers will use information about the employees they employ during 2013 to determine whether they employ enough employees to be subject to these new provisions in 2014. See question 4 for more information on determining whether an employer is subject to the Employer Shared Responsibility provisions. **WHICH EMPLOYERS ARE SUBJECT TO THE EMPLOYER SHARED RESPONSIBILITY PROVISIONS?** **4. I understand that the employer shared responsibility provisions apply only to employers employing at least a certain number of employees? How does an employer know whether it employs enough employees to be subject to the provisions?** To be subject to the Employer Shared Responsibility provisions, an employer must employ at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50 (for example, 40 full-time employees employed 30 or more hours per week on average plus 20 half-time employees employed 15 hours per week on average are equivalent to 50 full-time employees). Employers will determine each year, based on their current number of employees, whether they will be considered a large employer for the next year. For example, if an employer has at least	

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					50 full-time employees, (including full-time equivalents) for 2013, it will be considered a large employer for 2014. Employers average their number of employees across the months in the year to see whether they meet the large employer threshold. The averaging can take account of fluctuations that many employers may experience in their work force across the year. For those employers that may be close to the 50 full-time employee (or equivalents) threshold and need to know what to do for 2014, special transition relief is available to help them count their employees in 2013. See question 19 below for information about this transition relief. The proposed regulations provide additional information about how to determine the average number of employees for a year, including information about how to take account of salaried employees who may not clock their hours and a special rule for seasonal workers. **5. If two or more companies have a common owner or are otherwise related, are they combined for purposes of determining whether they employ enough employees to be subject to the Employer Shared Responsibility provisions?** Yes, consistent with longstanding standards that apply for other tax and employee benefit purposes, companies that have a common owner or are otherwise related generally are combined together for purposes of determining whether or not they employ at least 50 full-time employees (or an equivalent combination of full-time and part-time employees). If the combined total meets the threshold, then each separate company is subject to the Employer Shared Responsibility provisions, even those companies that individually do not employ enough employees to meet the threshold. (The rules for combining related employers do not apply for purposes of determining whether an employer owes an Employer Shared Responsibility payment or the amount of any payment). The proposed regulations provide information on the rules for determining whether companies are related and how they are applied for purposes of the Employer Shared Responsibility provisions. **6. Do the Employer Shared Responsibility provisions apply only to large employers that are for-profit businesses or to other large employers as well?** All employers that employ at least 50 full-time employees or an equivalent combination of full-time and part-time employees are subject to the Employer Shared Responsibility provisions, including for-profit, non-profit and government entity employers. **7. Which employers are not subject to the Employer Shared Responsibility**	

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					provisions? Employers who employ fewer than 50 full-time employees (or the equivalent combination of full-time and part-time employees) are not subject to the Employer Shared Responsibility provisions. An employer with at least 50 full-time employees (or equivalents) will not be subject to an Employer Shared Responsibility payment if the employer offers affordable health coverage that provides a minimum level of coverage to its full-time employees. **LIABILITY FOR THE EMPLOYER SHARED RESPONSIBILITY PAYMENT** **10. Under what circumstances will an employer owe an Employer Shared Responsibility payment?** In 2014, if an employer meets the 50 full-time employee threshold, the employer generally will be liable for an Employer Shared Responsibility payment only if: (a) The employer does not offer health coverage or offers coverage to less than 95% of its full-time employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on an Exchange; [No requirement to offer coverage to dependents in 2014.], or (b) The employer offers health coverage to at least 95% of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on an Exchange, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable to the employee (see question 11, below) or did not provide minimum value (see question 12, below). After 2014, the rule in paragraph (a) applies to employers that do not offer health coverage or that offer coverage to less than 95% of their full time employees and the dependents of those employees. ["Dependents" do not include spouses.] **11. How does an employer know whether the coverage it offers is affordable?** If an employee's share of the premium for employer-provided coverage would cost the employee more than 9.5% of that employee's annual household income, the coverage is not considered affordable for that employee. If an employer offers multiple healthcare coverage options, the affordability test applies to the lowest-cost option available to the employee that also meets the minimum value requirement (see question 12, below.) Because employers generally will not know their employees' household incomes, employers can take advantage of one of the affordability safe harbors set forth in the	

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					proposed regulations. Under the safe harbors, an employer can avoid a payment if the cost of the coverage to the employee would not exceed 9.5% of the wages the employer pays the employee that year, as reported in Box 1 of Form W-2, or if the coverage satisfies either of two other design-based affordability safe harbors. **12. How does an employer know whether the coverage it offers provides minimum value?** A minimum value calculator will be made available by the IRS and the Department of Health and Human Services (HHS). The minimum value calculator will work in a similar fashion to the actuarial value calculator that HHS is making available. Employers can input certain information about the plan, such as deductibles and co-pays, into the calculator and get a determination as to whether the plan provides minimum value by covering at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan. **13. If an employer wants to be sure it is offering coverage to all of its full-time employees, how does it know which employees are full-time employees? Does the employer need to offer the coverage to all of its employees because it won't know for certain whether an employee is a full-time employee for a given month until after the month is over and the work has been done?** The proposed regulations provide a method to employers for determining in advance whether or not an employee is to be treated as a full-time employee, based on the hours of service credited to the employee during a previous period. Using this look-back method to measure hours of service, the employer will know the employee's status as a full-time employee at the time the employer would offer coverage. The proposed regulations are consistent with IRS notices that have previously been issued and describe approaches that can be used for various circumstances, such as for employees who work variable hour schedules, seasonal employees, and teachers who have time off between school years. **CALCULATION OF THE EMPLOYER SHARED RESPONSIBILITY PAYMENT** **14. If an employer that does not offer coverage or offers coverage to less than 95% of its employees owes an Employer Shared Responsibility payment, how is the amount of the payment calculated?** In 2014, if an employer employs enough employees to be subject to the Employer Shared Responsibility provisions and does not offer coverage during the calendar year to at least 95% of its full-time employees, it owes an Employer Shared Responsibility payment equal to the number of full-time employees the employer employed for the year (minus 30) multiplied by $2,000, as long as at least one full-time employee receives the premium tax credit. (Note that for purposes of this	

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					calculation, a full-time employee does not include a full-time equivalent). For an employer that offers coverage for some months but not others during the calendar year, the payment is computed separately for each month for which coverage was not offered. The amount of the payment for the month equals the number of full-time employees the employer employed for the month (minus up to 30) multiplied by 1/12 of $2,000. If the employer is related to other employers (see question 5 above), then the 30-employee exclusion is allocated among all the related employers. The payment for the calendar year is the sum of the monthly payments computed for each month for which coverage was not offered. After 2014, these rules apply to employers that do not offer coverage or that offer coverage to less than 95% of their full time employees and the dependents of those employees. **15. If an employer offers coverage to at least 95% of its employees, and, nevertheless, owes the Employer Shared Responsibility payment, how is the amount of the payment calculated?** For an employer that offers coverage to at least 95% of its full-time employees in 2014, but has one or more full-time employees who receive a premium tax credit, the payment is computed separately for each month. The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12 of $3,000. The amount of the payment for any calendar month is capped at the number of the employer's full-time employees for the month (minus up to 30) multiplied by 1/12 of $2,000. (The cap ensures that the payment for an employer that offers coverage can never exceed the payment that employer would owe if it did not offer coverage). After 2014, these rules apply to employers that offer coverage to at least 95% of full time employees and the dependents of those employees. **MAKING AN EMPLOYER SHARED RESPONSIBILITY PAYMENT** **16. How will an employer know that it owes an Employer Shared Responsibility payment?** The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after employees' individual tax returns are due for that year claiming premium tax credits and after the due date for employers that meet the 50 full-time employee (plus full-time equivalents) threshold to file the information returns identifying their full-time employees and describing the coverage that was offered (if any). **17. How will an employer make an Employer Shared Responsibility payment?** If it	

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					is determined that an employer is liable for an Employer Shared Responsibility payment after the employer has responded to the initial IRS contact, the IRS will send a notice and demand for payment. That notice will instruct the employer on how to make the payment. Employers will not be required to include the Employer Shared Responsibility payment on any tax return that they file. TRANSITION RELIEF **18. I understand that the Employer Shared Responsibility provisions do not go into effect until 2014. However, the health plan that I offer to my employees runs on a fiscal plan year that starts in 2013 and will run into 2014. Do I need to make sure my plan complies with these new requirements in 2013 when the next fiscal plan year starts?** For an employer that as of December 27, 2012, already offers health coverage through a plan that operates on a fiscal year (a fiscal year plan), transition relief is available. First, for any employees who are eligible to participate in the plan under its terms as of December 27, 2012 (whether or not they take the coverage), the employer will not be subject to a potential payment until the first day of the fiscal plan year starting in 2014. Second, if (a) the fiscal year plan (including any other fiscal year plans that have the same plan year) was offered to at least one third of the employer's employees (full-time and part-time) at the most recent open season or (b) the fiscal year plan covered at least one quarter of the employer's employees, then the employer also will not be subject to the Employer Shared Responsibility payment with respect to any of its full-time employees until the first day of the fiscal plan year starting in 2014, provided that those full-time employees are offered affordable coverage that provides minimum value no later than that first day. So, for example, if during the most recent open season preceding December 27, 2012, an employer offered coverage under a fiscal year plan with a plan year starting on July 1, 2013 to at least one third of its employees (meeting the threshold for the additional relief), the employer could avoid liability for a payment if, by July 1, 2014, it expanded the plan to offer coverage satisfying the Employer Shared Responsibility provisions to the full-time employees who had not been offered coverage. For purposes of determining whether the plan covers at least one quarter of the employer's employees, an employer may look at any day between October 31, 2012 and December 27, 2012. **19. Is transition relief available to help employers that are close to the 50 full-time employee threshold determine their options for 2014?** Yes. Rather than being required to use the full twelve months of 2013 to measure whether it has 50 full-time employees (or an equivalent number of part-time and full-time employees), an employer	

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					may measure using any six-consecutive-month period in 2013. So, for example, an employer could use the period from January 1, 2013, through June 30, 2013, and then have six months to analyze the results, determine whether it needs to offer a plan, and, if so, choose and establish a plan. **ADDITIONAL INFORMATION** **20. When can an employee receive a premium tax credit?** Premium tax credits generally are available to help pay for coverage for employees who • are between 100% and 400% of the federal poverty level and enroll in coverage through an Affordable Insurance Exchange, • are not eligible for coverage through a government-sponsored program like Medicaid or CHIP, and • are not eligible for coverage offered by an employer or are eligible only for employer coverage that is unaffordable or that does not provide minimum value. **21. If an employer does not employ enough employees to be subject to the Employer Shared Responsibility provisions, does that affect the employer's employees' eligibility for a premium tax credit?** No. The rules for how eligibility for employer-sponsored insurance affects eligibility for the premium tax credit are the same, regardless of whether the employer employs enough employees to be subject to the Employer Shared Responsibility provisions. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** IRS on 3/15/2013 issued a correction to these proposed regulations. IRS on 2/12/2014 issued a document that contains final regulations providing guidance to employers subject to the shared responsibility provisions regarding employee health coverage under section 4980H of the Internal Revenue Code (Code), enacted by ACA. These regulations affect employers referred to as applicable large employers (generally meaning, for each year, employers that had 50 or more full-time employees, including full-time equivalent employees, during the prior year). Generally, under section 4980H, if an applicable large employer, for a calendar month, fails to offer to its full-time employees health coverage that is affordable and that provides minimum value, it might face an assessable payment if a full-time employee enrolls for that month in a qualified health plan for which the employee receives a premium tax credit.	

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					http://www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf According to a February 10, 2014, *Washington Post* article, these final regulations give medium-sized employers--those with between 50 and 99 employees--an extra year, until 2016, before they must offer health insurance to their full-time employees or potentially face an assessable payment The *Post* article is available at http://www.washingtonpost.com/national/health-science/white-house-delays-health-insurance-mandate-for-medium-sized-employers-until-2016/2014/02/10/ade6b344-9279-11e3-84e1-27626c5ef5fb_story.html.	
31.t.	**Amendments to Excepted Benefits** **ACTION: Proposed Rule** **NOTICE:** Amendments to Excepted Benefits **AGENCY:** IRS/DoL/CMS	REG-143172-13 DoL RIN 1210-AB60 CMS-9946-P	Issue Date: 12/24/2013 Due Date: 2/24/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This proposed rule would amend the regulations regarding excepted benefits under ERISA, the Internal Revenue Code, and the Public Health Service Act. Excepted benefits generally do not have to meet the health reform requirements added to those laws by HIPAA and ACA. http://www.gpo.gov/fdsys/pkg/FR-2013-12-24/pdf/2013-30553.pdf **SUMMARY OF NIHB ANALYSIS:** No comments recommended.	
31.u.	**Options Available for Consumers with Cancelled Policies** **ACTION: Guidance** **NOTICE:** Options Available	CCIIO (no reference number) **See also 7.dd.**	Issue Date: 12/19/2013 Due Date: None NIHB File		**SUMMARY OF AGENCY ACTION:** ACA provides many new consumer protections. In some instances, health insurance issuers in the individual and small group markets will cancel policies that do not include the new protections for policy or plan years beginning in 2014. Because some consumers have found other coverage options more expensive than their cancelled plans or policies, President Obama has announced a transition period allowing for the renewal of canceled plans and policies between 1/1/2014 and 10/1/2014, under certain circumstances. Some states have adopted the transitional	

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	for Consumers with Cancelled Policies **AGENCY:** CCIIO		Date: Date of Subsequent Agency Action, if any: Issued clarification 1/3/2014		policy, enabling health insurance issuers to renew their existing plans and policies. Some health insurance issuers will not renew canceled plans or policies. To ensure that consumers who will have their policies canceled can keep affordable health insurance coverage, this document reminds consumers in the individual market of the many options already available to them and clarifies another option for consumers in the individual market. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/3/2014 issued guidance that includes questions and answers to clarify 12/19/2013 guidance on options available for consumers with cancelled policies. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-faq-01-03-2014.pdf This guidance restates instructions for individuals who have canceled policies and seek to purchase catastrophic coverage and/or avoid a tax penalty.	
31.v.	**Instructions for the Application for Indian-Specific Exemptions** **ACTION: Guidance** **NOTICE:** Instructions for the Application for Exemption for American Indians and Alaska Natives and Other Individuals who are Eligible to Receive	CMS (no reference number) **See also 31.q.**	Issue Date: 1/10/2014 Due Date: 1/13/2014 TTAG File Date: 1/13/2014 Date of	TTAG response:	**SUMMARY OF AGENCY ACTION:** On 12/20/2013, CMS forwarded two draft documents that it intends to include with the guidance and instructions to the Application for Exemption from the Shared Responsibility Payment for American Indians and Alaska Natives (AI/ANs). These documents pertain to exemptions available to members of Indian Tribes, which includes members of federally recognized Indian tribes and Alaska Native shareholders in a regional or village corporation established under the Alaska Native Claims Settlement Act (ANCSA), as well as to individuals eligible for services from an Indian health care provider, from the shared responsibility payment established under ACA for failure to obtain minimum essential coverage. On 1/10/2014 (following an ACA policy subcommittee discussion on the issue), CMS	See Table C.

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Services from an Indian Health Care Provider **AGENCY:** CMS		Subsequent Agency Action, if any:		sent a request for review of a revised version of these instructions. The revised instructions combined the two previously forwarded documents into one document. **SUMMARY OF TTAG ANALYSIS:** These instructions are "critical to the basic ability of Exchanges to determine eligibility for and issue certificates of exemption and will also assist Exchanges, HHS, and IRS in ensuring program integrity and quality improvement." In addition, because the Indian-specific exemptions reflect the Federal trust responsibility toward AI/ANs, CMS has an obligation to establish an accurate, user-friendly, and easily understood application process that minimizes the burden on the applicant. These instructions require some revisions to improve the completeness and accuracy of the information provided by applicants for the Indian-specific exemptions.	
31.w.	**Q&A on Cost-Sharing Reductions for Contract Health Services** **ACTION: Guidance** **NOTICE:** Question and Answer on Cost-Sharing Reductions for Contract Health Services **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 1/8/2014 Due Date: 1/14/2014 NIHB File Date: 1/14/2013 Date of Subsequent Agency Action, if any: Issued Final Guidance 2/18/2014	TTAG response:	**SUMMARY OF AGENCY ACTION:** On the TTAG conference call on 1/8/2014, CMS asked TTAG to provide comments on draft guidance to QHPs pertaining to cost-sharing protections for members of Indian tribes through Contract Health Services (CHS). The guidance takes the form of a Q&A document. CMS requested that TTAG submit comments by 1/14/2014. **SUMMARY OF NIHB ANALYSIS:** The language included in the guidance is not consistent with the statutory definition of "contract health service," found at 25 U.S.C. § 1603(5), and there is a need for the addition of some language to the last paragraph to clarify that the referral eliminates any cost-sharing, including at the time of initial service. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/18/2014 issued final guidance that answers the question of what documentation standards, under the maintenance of records requirements in 45 CFR 156.480, apply for cost-sharing reductions for an item or service furnished through referral from an Indian health program, including an urban Indian program, under contract health services. According to this guidance, "45 CFR 156.420(b)(2) specifies that issuers must provide cost-sharing reductions to eligible enrollees under 45 CFR 155.350(b) on any 'item or service that is an EHB furnished … through referral under contract health services.' 45 CFR 156.430 provides for payments to issuers for cost-sharing reductions. To document eligibility for reimbursement for cost-sharing reductions provided to an enrollee on an EHB provided through referral under contract health services, as defined in 25 U.S.C.	See Table C.

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					1603(5) and any implementing guidance, and to meet the standards set forth at 45 CFR 156.480, the issuer must retain documentation that includes the following information: • Identification of the patient receiving the item or service (e.g. name and date of birth); • The name and address of the provider delivering the item or service; • A description of the item or service furnished through referral under contract health services, including the date(s) the item or service was provided; and • The name of the Indian health program issuing the referral under contract health services, contact information for the program, and the date of the referral. • A copy of the referral. (We note that many of the required elements above may be contained in the referral itself.)" http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/q-and-a-on-contract-health-services-2-18-14.pdf	
31.x.	**MEC and Other Rules on the Shared Responsibility Payment** **ACTION: Proposed Rule** **NOTICE:** Minimum Essential Coverage and Other Rules Regarding the Shared Responsibility Payment for Individuals **AGENCY:** IRS	REG-141036-13	Issue Date: 1/27/2014 **Due Date: 4/28/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This document contains proposed regulations relating to the requirement to maintain minimum essential coverage enacted by ACA, as amended by the TRICARE Affirmation Act. These proposed regulations affect individual taxpayers who might have liability for the shared responsibility payment for not maintaining minimum essential coverage. This document also provides notice of a public hearing (scheduled for 5/21/2014 at 10 a.m. ET) on these proposed regulations. IRS must receive outlines of topics for discussed at the public hearing by 4/28/2014. http://www.gpo.gov/fdsys/pkg/FR-2014-01-27/pdf/2014-01439.pdf **SUMMARY OF NIHB ANALYSIS:** This proposed rule provides a detailed review of MEC requirements, as well as exemptions from the tax penalty for not maintaining MEC. This proposed rule advances the NIHB recommendation on permitting individuals who qualify for services from Indian health care providers to apply for an exemption on a Federal income tax return. The preamble to this proposed rule states (79 FR 4306-7): "Consistent with guidance released by the Secretary of HHS on October, 28, 2013, the	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					proposed regulations provide that an individual who enrolls in a plan through an Exchange during the open enrollment period for coverage for 2014 may claim a hardship exemption for months in 2014 prior to the effective date of the individual's coverage without obtaining a hardship exemption certification from an Exchange [NOTE: The HHS action only involved the release of a notice (Notice 2014-10), not a formal regulation]. If additional situations are identified where an individual should be allowed to claim a hardship exemption without obtaining a hardship exemption certification from an Exchange, the Secretary of HHS and the Secretary of the Treasury will continue to coordinate guidance. To facilitate issuing guidance in this situation, the proposed regulations provide that a taxpayer may claim a hardship exemption on a return if the Secretary of HHS issues published guidance of general applicability describing the hardship and indicating that the hardship can be claimed on a Federal income tax return pursuant to guidance published by the Secretary of the Treasury, and the Secretary of the Treasury issues published guidance of general applicability allowing an individual to claim such hardship exemption on a Federal income tax return without obtaining a hardship exemption from an Exchange." Clarification is needed on what additional action Treasury will need to take to permit an individual to apply for any additional exemption for which HHS might stipulate individuals can apply through a Federal income tax return. Or specifically, when (hopefully) HHS indicates that individuals eligible for services from an Indian health care provider can apply for the exemption on a Federal income tax return, what additional action will Treasury need to take before the individuals can apply. NIHB and/or TTAG and others should submit comments to support the IRS action to which the above analysis refers.	
32.c.	**Bundled Payments for Care Improvement 2014 Winter Period** **ACTION: Notice** **NOTICE:** Medicare Program; Bundled Payments for Care Improvement	CMS-5504-N4	Issue Date: 2/14/2014 **Due Date: 4/18/2014** NIHB File Date:		**SUMMARY OF AGENCY ACTION:** This notice announces an open period for additional organizations to apply for consideration for participation in Models 2, 3, and 4 of the Bundled Payments for Care Improvement initiative. Interested organizations must submit Models 2, 3, and 4 Open Period intake forms by April 18, 2014, in a searchable word or PDF format via email at BundledPayments@cms.hhs.gov. http://www.gpo.gov/fdsys/pkg/FR-2014-02-14/pdf/2014-03311.pdf **SUMMARY OF NIHB ANALYSIS:** Some I/T/Us may find it beneficial to participate in	

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	Models 2, 3, and 4 2014 Winter Open Period **AGENCY:** CMS		Date of Subsequent Agency Action, if any:		this bundled payment demonstration.	
39.b.	**Basic Health Program** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity **AGENCY:** CMS	CMS-2380-~~P~~F	Issue Date: 9/25/2013 Due Date: 11/25/2013 NIHB File Date: NIHB File Date: 11/22/2013; ANTHC, TSGAC, and TTAG also filed comments 11/22/2013 Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 2/7/2014	NIHB response: ANTHC response: TSGAC response: TTAG response:	**SUMMARY OF AGENCY ACTION:** This proposed rule would establish the Basic Health Program, as required by section 1331 of ACA. The Basic Health Program provides states with the flexibility to establish a health benefits coverage program for low-income individuals who would otherwise qualify to purchase coverage through the Affordable Insurance Exchange (Exchange, or Health Insurance Marketplace). The Basic Health Program would complement and coordinate with enrollment in a QHP through the Exchange, as well as with enrollment in Medicaid and CHIP. This proposed rule sets forth a framework for Basic Health Program eligibility and enrollment, benefits, delivery of health care services, transfer of funds to participating states, and federal oversight. In addition, this proposed rule would amend other rules issued by the HHS Secretary to clarify the applicability of those rules to the Basic Health Program. http://www.gpo.gov/fdsys/pkg/FR-2013-09-25/pdf/2013-23292.pdf A CMS fact sheet on this proposed rule is available at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-09-20.html. **SUMMARY OF NIHB ANALYSIS:** The Basic Health Program applies to individuals between the Medicaid eligibility level in the State (or 138% FPL, whichever is higher) in States that choose to adopt the Basic Health Program option. The proposed rule maintains the protections for AI/ANs provided under an Exchange to AI/ANs who might enroll under a Basic Health Plan option. These protections appear in proposed 45 CFR 600.160, including a) special monthly enrollment periods, b) permitting tribal sponsorship, c) no cost-sharing, and d) I/T/U as payer of last resort. In addition, tribal consultation requirements appear in 45 CFR 600.155. The definition of Indian under the ACA applies under the Basic Health program. Section 1331 of ACA establishing the Basic Health Program provides that, with regard to	See Table C.

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					premiums, "the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay (in the rating area in which the individual resides) if the individual had enrolled in the applicable second lowest cost silver plan." No reference appears to the ability of AI/ANs to enroll in a bronze plan and maintain the cost-sharing protections. As such, AI/ANs might have to pay a premium based on the premium of the second-lowest-cost silver plan in the area, rather than the premium of a lower-cost bronze plan.	
39.c.	**Basic Health Program: Federal Funding Methodology for 2015** **ACTION: ~~Proposed~~ Final Methodology** **NOTICE:** Basic Health Program: ~~Proposed~~ Final Federal Funding Methodology for Program Year 2015 **AGENCY:** CMS	CMS-2380-~~P~~FN	Issue Date: 12/23/2013 Due Date: 1/22/2014 TTAG File Date: 1/22/2014; TSGAC also filed comments 1/22/2014 Date of Subsequent Agency Action, if any: Sent Final Methodology to OMB 2/11/2014	TTAG response: TSGAC response:	**SUMMARY OF AGENCY ACTION:** This document provides the methodology and data sources necessary to determine federal payment amounts made to states that elect to establish a Basic Health Program certified by the HHS Secretary under section 1331 of ACA to offer health benefits coverage to low-income individuals otherwise eligible to purchase coverage through Affordable Insurance Exchanges. http://www.gpo.gov/fdsys/pkg/FR-2013-12-23/pdf/2013-30435.pdf **SUMMARY OF NIHB ANALYSIS:** In discussions with CMS, staff indicated that the ACA does not provide for *mandating* that States that exercise the Basic Health Program option charge AI/AN no more than the equivalent of the cost of a bronze plan (as requested by Tribal representatives). The proposed funding methodology indicated below, though, provides funding adjustments that account for AI/AN choosing bronze plans and the higher cost to the Federal government for the cost-sharing reductions for AI/AN that result. These higher Federal subsidy costs would be factored into the calculation of the payment level from the Federal government to states electing the Basic Health Program option. Although the final rule for CMS-2380-P has not yet been published, the proposed funding methodology outlined below could support a policy whereby the Federal government, if not requiring, encourages States to limit premium contributions for AI/AN to the bronze-plan equivalent. This may be accomplished by CMS making available to states that elect to limit premiums for AI/AN the higher Federal payments. For states that do not elect to limit premiums for AI/AN to the equivalent of the bronze plan premium, CMS could withhold payment of the higher amounts.	See Table C (**see also 39.b.**).

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					The following are excerpts from the published notice-- **77402 Federal Register** / Vol. 78, No. 246 / Monday, December 23, 2013 / Proposed Rules "We further propose a separate calculation that includes different adjustments for American Indian/Alaska Native BHP enrollees, as described in section E." **Federal Register** / Vol. 78, No. 246 / Monday, December 23, 2013 / Proposed Rules **77405** "For American Indian/Alaska Native BHP enrollees, we propose to use the lowest cost bronze plan as the basis for the reference premium as described further in section E." **Federal Register** / Vol. 78, No. 246 / Monday, December 23, 2013 / Proposed Rules **77409** *"E. Adjustments for American Indians and Alaska Natives* There are several exceptions made for American Indians and Alaska Natives enrolled in QHPs through an Exchange to calculate the PTC and CSRs. Thus, we propose adjustments to the payment methodology described above to be consistent with the Exchange rules. We propose the following adjustments: 1. We propose that the adjusted reference premium for use in the CSR portion of the rate would use the lowest cost bronze plan instead of the second lowest cost silver plan, with the same adjustments for the premium trend factor and population health factor. American Indians and Alaska Natives are eligible for CSRs with any metal level plan, and thus we believe that eligible persons would be more likely to select a bronze level plan instead of a silver level plan. (It is important to note that this would not change the PTC, as that is the maximum possible PTC payment, which is always based on the second lowest cost silver plan.) **We invite comments as to whether** other assumptions are warranted about the distribution, among bronze plans charging various premiums, of American Indian and Alaska Native BHP-eligible individuals. 2. We propose that the actuarial value for use in the CSR portion of the rate would be	

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					0.60 instead of 0.70, which is consistent with the actuarial value of a bronze level plan. 3. We propose that the induced utilization factor for use in the CSR portion of the rate would be 1.15, which is consistent with the proposed HHS Notice of Benefit and Payment Parameters for 2015 induced utilization factor for calculating advance CSR payments for persons enrolled in bronze level plans and eligible for CSRs up to 100 percent of actuarial value. 4. We propose that the change in the actuarial value for use in the CSR portion of the rate would be 0.40. This reflects the increase from 60 percent actuarial value of the bronze plan to 100 percent actuarial value, as American Indians and Alaska Natives are eligible to receive CSRs up to 100 percent of actuarial value."	
39.d.	**Basic Health Program Report for Exchange Premium** **ACTION: Request for Comment** **NOTICE:** Basic Health Program Report for Health Insurance Exchange Premium **AGENCY:** CMS	CMS-10510	Issue Date: 12/23/2013 Due Date: 1/2/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction 12/27/2013		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Basic Health Program Report for Health Insurance Exchange Premium; *Use*: In accordance with section 1331 of ACA, the Basic Health Program (BHP) receives federal funding by determining the amount of payments that the federal government would have made through premium tax credits (PTCs) and cost-sharing reductions (CSRs) for individuals enrolled in BHP had they instead enrolled in an Exchange. To calculate these amounts for each state, CMS needs the reference premiums for the second-lowest-cost silver plans (SLCSPs) in each geographic area in a state, as SLCSPs serve as a basic unit in the calculation of PTCs and CSRs under the Exchanges. In addition, the reference premiums for these SLCSPs serve as critical components in the BHP payment methodology to estimate what PTCs and CSRs would have received in payments. Similarly, **CMS needs to collect reference premiums for the lowest-cost bronze plans to appropriately account for CSR calculations for AI/ANs**. Reference premiums serve as foundational inputs into the BHP payment methodology. CMS has the necessary information to determine these reference premiums for states with Exchanges operated by the Federally Facilitated Exchange (FFE) or in Partnership with FFE. Therefore, this collection pertains to only the 17 states operating State-Based Exchanges.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					http://www.gpo.gov/fdsys/pkg/FR-2013-12-23/pdf/2013-30434.pdf CMS-10510 and a Supporting Statement for this PRA request are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10510.html. **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/27/2013 issued a document that corrects a date in the 12/23/2013 FR notice titled "Basic Health Program Report for Health Insurance Exchange Premium." On page 77469, in the third column, in the third paragraph, the first sentence should read, "We are requesting OMB review and approval of this collection by January 6, 2014, with a 180-day approval period," not "December 23, 2013." http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30989.pdf	
41.d.	**New Safe Harbors** **ACTION: Notice** **NOTICE:** Solicitation of New Safe Harbors and Special Fraud Alerts **AGENCY:** HHS OIG	OIG-122-N	Issue Date: 12/27/2013 Due Date: 2/25/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** In accordance with section 205 of HIPAA, this annual notice solicits proposals and recommendations for developing new and modifying existing safe harbor provisions under the federal anti-kickback statute (section 1128B(b) of the Social Security Act), as well as developing new HHS OIG Special Fraud Alerts. http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30429.pdf **SUMMARY OF NIHB ANALYSIS:**	
44.e.	**Multi-Payer Advanced Primary Care Practice Demonstration**	CMS-10485	Issue Date: 7/12/2013		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Provider Survey; *Use*: On 9/16/2009, HHS announced the establishment	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	ACTION: Request for Comment **NOTICE:** Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Provider Survey **AGENCY:** CMS		Due Date: 9/10/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 1/29/2014 Due Date: 2/28/2014		of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration, under which Medicare joined Medicaid and private insurers as a payer participant in state-sponsored patient-centered medical home (PCMH) initiatives. CMS selected eight states to participate in this demonstration: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. CMS proposes to conduct this provider survey to understand how participating practice structures and functions vary, particularly with respect to their adoption of different components of the PCMH model of care. Researchers evaluating the MAPCP Demonstration plan to combine these survey data with claims data to conduct statistical analyses that identify which particular medical home care processes relate to the largest gains in health care quality and reductions in health care cost trends. http://www.gpo.gov/fdsys/pkg/FR-2013-07-12/pdf/2013-16740.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/29/2014 issued a new version of this PRA request. Subsequent to the publication of the 60-day notice in the 7/12/2013 FR (78 FR 41931), CMS has revised the survey. CMS also has made a slight increase in the annual burden hours.	
46.d.	**Preliminary DSH Allotments for FY 2014** **ACTION: Request for Comment** **NOTICE:** Medicaid Program; Preliminary Disproportionate Share Hospital (DSH) Allotments for Fiscal Year (FY) 2014 and the Preliminary Institutions for Mental Diseases	CMS-2389-N	ssue Date: 2/28/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This notice announces the preliminary federal share disproportionate share hospital (DSH) allotments for FY 2014 and the preliminary federal share FY 2014 limits on aggregate DSH payments that states can make to institutions for mental diseases (IMDs) and other mental health facilities. This notice also includes additional information regarding the calculation of the FY 2014 DSH allotments and FY 2014 IMD DSH limits. http://www.gpo.gov/fdsys/pkg/FR-2014-02-28/pdf/2014-04032.pdf **SUMMARY OF NIHB ANALYSIS:**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Disproportionate Share Hospital Limits for FY 2014 **AGENCY:** CMS					
48.b.	**Medical Loss Ratio Rebate Calculation Report and Notices** **ACTION: Request for Comment** **NOTICE:** Annual MLR and Rebate Calculation Report and MLR Rebate Notices **AGENCY:** CMS	CMS-10418	Issue Date: 12/4/2012 Due Date: 2/4/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 2/22/2013; issued revision 11/22/2013; issued revision 1/31/2014 **Due Date:** 3/25/2013; 1/21/2014; **3/5/2014**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Annual MLR and Rebate Calculation Report and MLR Rebate Notices; *Use*: Under Section 2718 of the Affordable Care Act and implementing regulation at 45 CFR part 158, a health insurance issuer (issuer) offering group or individual health insurance coverage must submit a report to the Secretary concerning the amount the issuer spends each year on claims, quality improvement expenses, non-claims costs, federal and state taxes and licensing and regulatory fees, and the amount of earned premium. An issuer must provide an annual rebate if the amount it spends on certain costs compared to its premium revenue (excluding federal and states taxes and licensing and regulatory fees) does not meet a certain ratio, referred to as the medical loss ratio (MLR). **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/22/2013 issued a revision of this PRA request. The 60-day Federal Register notice published on 12/4/2012 (77 FR 71801), pertained to the 2012 MLR Annual Reporting Form and Instructions, and the comment period closed on 2/4/2013. CMS received a total of 4 public comments on 25 specific issues regarding the notice of the revised MLR PRA package. Most of the comments addressed clarifying the instructions or correcting typographical errors, the removal of calculated cells and the ability of issuers to copy and paste data onto the form, and the inclusion of a credibility indicator for small issuers to eliminate the need for small issuers to fill out the complete MLR reporting form. CMS have taken into consideration all of the proposed suggestions and has made changes to the 2012 MLR Annual Reporting Form and Instructions. http://www.gpo.gov/fdsys/pkg/FR-2013-02-22/pdf/2013-04015.pdf CMS on 11/22/2013 issued a revision of this PRA request. Based upon experience in the MLR data collection and evaluation process, CMS has updated its annual burden hour estimates to reflect the actual numbers of submissions, rebates, and rebate notices. The	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					2013 MLR Reporting Form and instructions also reflect changes for the 2013 reporting year and beyond set forth in the March 2012 update to 45 CFR 158.120(d)(5) regarding aggregation of student health plans on a nationwide basis, similar to expatriate plans. In addition, the instructions address recent applicability guidance issued by the Departments of Labor and Treasury and HHS concerning expatriate plan reporting prior to plan years ending before or on 12/31/2015. In 2014, issuers likely will send fewer notices and rebate checks to policyholders and subscribers, resulting in a reduction in burden. However, the requirement to report data on student health plans will increase burden for some issuers. CMS estimates a net reduction in total information collection burden. http://www.gpo.gov/fdsys/pkg/FR-2013-11-22/pdf/2013-28049.pdf CMS on 1/31/2014 issued a revision of this PRA request. According to CMS, the 60-day notice published in the 11/22/2013 FR (78 FR 70059) pertained to the 2013 MLR Annual Reporting Form and Instructions, with comments closing on 1/21/2014. CMS received a total of 2 public comments on 12 specific issues regarding the notice of the revised MLR PRA package. Most of the comments addressed clarifying of the instructions, updates for recent guidance issuance, treatment of Student Health Plans, treatment of ACA fees, adjusted MLR standard experience aggregation, annual mini-med multipliers for credibility determination, reporting for both QIA and non-claims costs, and reporting requirements for businesses in run-off. CMS has considered all of the proposed suggestions and has revised the 2013 MLR Annual Reporting Form and Instructions. http://www.gpo.gov/fdsys/pkg/FR-2014-01-31/pdf/2014-02061.pdf	
48.e.	**Computation of MLR** **ACTION: Proposed Rule** **NOTICE:** Computation of, and Rules Relating to, Medical Loss Ratio **AGENCY:** IRS	~~REG-126633-12~~ TD 9651	Issue Date: 5/13/2013 Due Date: 8/12/2013 NIHB File Date:		**SUMMARY OF AGENCY ACTION:** This document contains proposed regulations that provide guidance to Blue Cross and Blue Shield organizations, and certain other health care organizations, on computing and applying the medical loss ratio added to the Internal Revenue Code by ACA. This document also contains a request for comments and provides notice of a public hearing on these proposed regulations. http://www.gpo.gov/fdsys/pkg/FR-2013-05-13/pdf/2013-11297.pdf **SUMMARY OF NIHB ANALYSIS:** No comments recommended. This document	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Date of Subsequent Agency Action, if any: Issued Final Rule 1/7/2014		indicates that certain insurers, including Blue Cross/Blue Shield (BC/BS) plans, will lose tax preferences if they fail to meet MLR standards. This document takes a position contrary to the regulation issued by CCIIO (in implementing PHSA § 2718) on costs allowed in the numerator of the MLR calculation. For plans covered under section 833 of the Internal Revenue Code (such as BC/BS plans), the numerator of the MLR calculation cannot include "activities that improve health care quality." **SUMMARY OF SUBSEQUENT AGENCY ACTION:** This document contains final regulations that provide guidance to Blue Cross and Blue Shield organizations, and certain other qualifying health care organizations, on computing and applying the medical loss ratio added to the Internal Revenue Code by ACA. http://www.gpo.gov/fdsys/pkg/FR-2014-01-07/pdf/2014-00092.pdf	
50.e.	**Initial Plan Data Collection to Support QHP Certification** **ACTION: Request for Comment** **NOTICE:** Initial Plan Data Collection to Support Qualified Health Plan Certification and Other Financial Management and Exchange Operations **AGENCY:** CMS	CMS-10433	Issue Date: 11/21/2012 Due Date: 12/21/2012 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 11/1/2013; issued revision 2/10/2014 **Due Date:** 12/31/2013;		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection*: New collection; *Title*: Initial Plan Data Collection to Support Qualified Health Plan (QHP) Certification and Other Financial Management and Exchange Operations; *Use*: To offer insurance through an Exchange, a health insurance issuer must have its health plans certified as Qualified Health Plans (QHPs) by the Exchange. The Exchange must collect data and validate that QHPs meet these minimum requirements and other requirements, and this information collection will facilitate this process. On 7/6/2012, CMS began a 60-day comment period on this information collection, and in response to comments received, the agency has worked to address concerns about duplicate data collection and clarify the data elements in this collection. **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 11/1/2013 issued a revision of this PRA request. According to CMS, in addition to data collection for the certification of QHPs, the reinsurance and risk adjustment programs, outlined by ACA and established by CMS-9975-F, have general information reporting requirements that apply to issuers, group health plans, third party administrators, and plan offerings outside of the Exchanges. Subsequent regulations for these programs, including CMS-9964-F and CMS-9957-F2/CMS-9964-F3, provide further reporting requirements. Based on experience with the first year of data collection, CMS proposes revisions to the data	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			3/12/2014		elements collected and the burden estimates for years two and three. http://www.gpo.gov/fdsys/pkg/FR-2013-11-01/pdf/2013-26083.pdf CMS on 2/10/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-10/pdf/2014-02787.pdf A number of documents related to CMS-10433 (listed below) are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10433.html. • Appendix A.1: Administrative Data v3.22 • **Appendix A.2: Essential Community Providers v3.2** • Appendix A.3.1.: NCQA Template v1.6 • Appendix A.3.1.: URAC Template v1.4 • Appendix A.4: Network Template v1.71 • Appendix B.1: Plans and Benefits Template • Appendix B.2: Prescription Drug Formulary Template • Appendix B.3: Service Area v2.91 • Appendix C.1: Rates Table Template • Appendix C.2: Business Rules Template • Appendix D: Transitional Reinsurance Program, Risk Adjustment Program, and Payment Operations Data Requirements • Supporting Statement Comments warranted on this PRA request, particularly regarding Appendix A.2.	
50.o.	**State Health Insurance Exchange Incident Report** **ACTION: Request for Comment**	CMS-10496	Issue Date: 8/21/2013 Due Date: 9/20/2013		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: State Health Insurance Exchange Incident Report; *Use*: CMS has implemented a Computer Matching Agreement (CMA) with **State-based Administering Entities (AEs)**. This agreement establishes the terms, conditions, safeguards, and procedures under which CMS will disclose certain information to the AEs in accordance	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: State Health Insurance Exchange Incident Report **AGENCY:** CMS		NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/20/2013; issued extension 2/28/2014 **Due Date:** 2/18/2014; **3/31/2014**		with ACA, amendments to the Social Security Act made by ACA, and implementing regulations. AEs, state entities administering Insurance Affordability Programs, will use the data, accessed through the CMS Data Services Hub (Hub), to make eligibility determinations for insurance affordability programs and certificates of exemption. **AEs shall report suspected or confirmed incidents affecting loss or suspected loss of PII within one hour of discovery to their designated CCIIO State Officer**, who will then notify the affected Federal agency data sources, i.e., IRS, Department of Defense, Department of Homeland Security, Social Security Administration, Peace Corps, OPM, and VA. Additionally, AEs shall contact the office of the appropriate Special Agent-in-Charge, Treasury Inspector General for Tax Administration (TIGTA), and the IRS Office of Safeguards within 24 hours of discovery of any potential breach, loss, or misuse of return Information. http://www.gpo.gov/fdsys/pkg/FR-2013-08-21/pdf/2013-20396.pdf **SUMMARY OF NIHB ANALYSIS:** No comments recommended. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/20/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30337.pdf CMS on 2/28/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-28/pdf/2014-04327.pdf	
50.q.	**Third Party Payments of Premiums for QHPs** **ACTION: Guidance** **NOTICE:** FAQ: Third Party Payments of Premiums for Qualified Health Plans in the	CCIIO (no reference number) **See also 50.r.**	Issue Date: 11/4/2013 Due Date: None NIHB File Date:		**SUMMARY OF AGENCY ACTION:** This guidance answers the question of whether third party payors can make premium payments to health insurance issuers for qualified health plans on behalf of enrolled individuals. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf **SUMMARY OF NIHB ANALYSIS:** This guidance might raise questions about premium	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Marketplaces **AGENCY:** CCIIO		Date of Subsequent Agency Action, if any: Issued clarification 2/7/2014		sponsorship programs operated by Tribes and Tribal organizations. Providing a memo to Tribes and HHS highlighting past statements made by, and regulations issued by, the department on premium sponsorship by Tribes might prove useful. HHS appears to have issued this guidance after it clarified that it will not consider QHPs, FFMs, etc. "Federal Health Care Programs" and that, as a result, anti-kickback statutes will not apply to them (see HHS letter to Rep. Jim McDermott below). Having eliminated the concern of providers about anti-kickback statutes, HHS clarified that it does not want providers sponsoring patients when this might cause adverse selection against QHPs. http://mcdermott.house.gov/images/The%20Honorable%20Jim%20McDermott.pdf The following appeared in an explanation of these interacting actions by the law firm McDermott, Will, and Emory: Provider payments of QHP premiums. Although the announcement appeared to remove a major hurdle for providers that may consider payment of premiums to enroll individuals in QHPs, or to keep them enrolled during a grace period, HHS subsequently released a guidance document on Nov. 4, 2013, indicating that the agency "has significant concerns with this practice because it could skew the insurance risk pool and create an unlevel field in the Marketplaces." HHS will monitor this practice and "encourages issuers to reject such third party payments." Other hurdles may continue to apply in addition to HHS's guidance. For example, in order to prevent adverse selection, coverage in the individual market can only be purchased during an annual open enrollment period, or a special enrollment period in a number of limited circumstances. Moreover, coverage purchased during the annual open enrollment periods will not be effective immediately. Finally, state anti-kickback, insurance and other laws will continue to apply." http://www.mwe.com/HHS-Clarifies-that-ACA-Qualified-Health-Plans-are-Not-Subject-to-Federal-Anti-Kickback-Statute-11-05-2013/ **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/7/2014 issued a clarification to address questions that have arisen about whether this guidance applies to payments of premiums and cost sharing made on behalf of QHP enrollees by certain types of third party payors, including **Indian tribes, tribal organizations, and urban Indian organizations (I/T/Us)**.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					According to this clarification: "**The November 4, 2013, FAQ does not apply to payments for premiums and cost sharing made on behalf of QHP enrollees by Indian tribes, tribal organizations, urban Indian organizations** … QHP issuers and Marketplaces are encouraged to accept such payments. As CMS stated in its 2015 Draft Letter to Issuers on Federally-facilitated and State Partnership Exchanges, pursuant to section 1312 of the Affordable Care Act, section 402 of the Indian Health Care Improvement Act, and 45 CFR 155.240(b), a Marketplace may permit Indian tribes, tribal organizations, and urban Indian organizations to pay QHP premiums on behalf of members who are qualified individuals, subject to terms and conditions determined by the Marketplace. Indeed, Federal law specifically provides for this approach." http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf	
50.s.	**State-Based Marketplace Annual Report** **ACTION: Request for Comment** **NOTICE:** State-Based Marketplace Annual Report (SMAR) **AGENCY:** CMS	CMS-10507	Issue Date: 11/15/2013 Due Date: 1/14/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 1/31/2014 **Due Date: 3/5/2014**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: State-Based Marketplace Annual Report (SMAR); *Use*: The annual report serves as the primary vehicle to ensure comprehensive compliance with all reporting requirements contained in ACA. Section 1313(a)(1) of ACA requires a State-based Marketplace (SBM) to keep an accurate accounting of all activities, receipts, and expenditures and to submit a report annually to the HHS Secretary concerning such accounting. CMS will use the information collected from states to assist in determining if a state has maintained a compliant operational Exchange. It also will provide a mechanism to collect innovative approaches to meeting challenges encountered by SBMs during the preceding year. Additionally, it will provide information to CMS regarding potential changes in priorities and approaches for the upcoming year. http://www.gpo.gov/fdsys/pkg/FR-2013-11-15/pdf/2013-27305.pdf CMS-10507 and a Supporting Statement are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10507.html. **SUMMARY OF NIHB ANALYSIS:** No comments recommended.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 1/31/2014 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-31/pdf/2014-02061.pdf	
50.t.	**QHP Quality Rating System Measures and Methodology** **ACTION: Request for Comment** **NOTICE:** Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology **AGENCY:** CMS	CMS-3288-NC	Issue Date: 11/22/2013 Due Date: 1/21/2014 TTAG File Date: 1/21/2014 Date of Subsequent Agency Action, if any:	TTAG response:	**SUMMARY OF AGENCY ACTION:** This notice with comment describes the overall Quality Rating System (QRS) framework for rating Qualified Health Plans (QHPs) offered through an Exchange. This notice seeks comments on the list of proposed QRS quality measures that QHP issuers would have to collect and report, the hierarchical structure of the measure sets and the elements of the QRS rating methodology. In addition, this notice solicits comments on ways to ensure the integrity of QRS ratings, and on priority areas for future QRS measure enhancement and development. http://www.gpo.gov/fdsys/pkg/FR-2013-11-19/pdf/2013-27649.pdf **SUMMARY OF NIHB ANALYSIS:** A review of the QRS framework described in this notice might provide an opportunity to highlight issues of particular concern to AI/ANs and I/T/Us.	See Table C.
50.v.	**Medical Expenditure Panel Survey--Insurance Component** **ACTION: Request for Comment** **NOTICE:** Medical Expenditure Panel Survey--Insurance Component	AHRQ (OMB 0935-0110)	Issue Date: 1/10/2014 **Due Date: 3/11/2014** NIHB File Date: Date of Subsequent		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Medical Expenditure Panel Survey--Insurance Component; *Use*: The Medical Expenditure Panel Survey--Insurance Component (MEPS-IC) measures the extent, cost, and coverage of employer-sponsored health insurance on an annual basis. To ensure that MEPS-IC can capture important changes in the employer-sponsored health insurance market resulting from the implementation of ACA, AHRQ researched and proposed additions to the 2014 survey questionnaires based on the provisions of the law. Many of these proposed additions involve the implementation of the Small Business Health Options Program (SHOP), through which small employers can purchase health insurance beginning in 2014. In addition to new questions recommended for 2014, AHRQ proposes to delete several questions in the	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	AGENCY: AHRQ		Agency Action, if any:		2013 survey to minimize the burden on survey respondents. These questions have less analytic value than others, have poor response rates, or no longer apply due to changes made under ACA. A list of the proposed additions and deletions appears in this notice. All of the supporting documents for the current MEPS-IC are available on the OMB Web site at http://www.reginfo.gov/public/do/PRAViewDocument?ref_nbr=201310-0935-001. http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31480.pdf **SUMMARY OF NIHB ANALYSIS:**	
50.w.	**Retroactive Advance Payments of PTCs and CSRs Due to Exceptional Circumstances** **ACTION: Request for Comment** **NOTICE:** CMS Bulletin to Marketplaces on Availability of Retroactive Advance Payments of the PTC and CSRs in 2014 Due to Exceptional Circumstances **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 2/27/2014 Due Date: None TTAG File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This guidance applies to Marketplaces that, due to technical issues in establishing automated eligibility and enrollment functionality, have had difficulty in providing timely eligibility determinations to applicants and enrolling qualified individuals in Qualified Health Plans (QHPs) through the Marketplace during the initial open enrollment period for the 2014 coverage year. Such a circumstance might qualify as an exceptional circumstance for individuals who could not enroll in a QHP through the Marketplace due to these issues. In this guidance, CMS discusses the availability of advance payments of the premium tax credit (APTC) and advance payments of cost-sharing reductions (CSRs) on a retroactive basis to an issuer once the Marketplace has provided a qualified individual with an appropriate eligibility determination and has determined that the individual qualifies for such assistance and that the individual has enrolled in a QHP through the Marketplace. CMS also clarifies the attendant responsibilities of the QHP issuer in this circumstance. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/retroactive-advance-payments-ptc-csrs-02-27-14.pdf **SUMMARY OF NIHB ANALYSIS:**	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
52.i.	**Home Health PPS Rate Update: Physician Narrative Requirement** **ACTION: Request for Comment** **NOTICE:** Medicare Program--Home Health Prospective Payment System Rate Update for CY 2010: Physician Narrative Requirement and Supporting Regulation **AGENCY:** CMS	CMS-10311	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 12/20/2013 Due Date: 1/21/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Medicare Program--Home Health Prospective Payment System Rate Update for Calendar Year 2010: Physician Narrative Requirement and Supporting Regulation; *Use*: Federal or state surveyors use the conditions of participation and accompanying requirements specified in the regulations as a basis for determining whether a home health agency qualifies for approval or re-approval under Medicare. Contractors and CMS use the physician certification and recertification of the need of the patient for skilled care services and homebound status, clinical justification for skilled nursing management, and evaluation of the care plan specified in the regulations at 42 CFR 424.22 when reviewing the patient medical record as a basis for determining whether the patient qualifies for the Medicare home health benefit and whether the medical record meets the criteria for coverage and Medicare payment. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/20/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-20/pdf/2013-30334.pdf	
52.j.	**Moratoria on Enrollment of Ambulances and HHAs** **ACTION: Notice** **NOTICE:** Medicare, Medicaid, and CHIP: Announcement of New and Extended Temporary Moratoria on Enrollment of Ambulances and Home Health Agencies in	CMS-6046-N	Issue Date: 2/4/2014 Due Date: None NIHB File Date: Date of Subsequent Agency		**SUMMARY OF AGENCY ACTION:** This document announces the imposition of temporary moratoria on the enrollment of new ambulance suppliers and home health agencies in designated geographic locations to prevent and combat fraud, waste, and abuse. http://www.gpo.gov/fdsys/pkg/FR-2014-02-04/pdf/2014-02166.pdf **SUMMARY OF NIHB ANALYSIS:**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Designated Geographic Locations **AGENCY:** CMS		Action, if any:			
54.	**ESI Coverage Verification** **ACTION: Notice** **NOTICE:** Employer-Sponsored Coverage Verification: Preliminary Informational Statement **AGENCY:** CMS	CMS RIN 0938-ZB09	Issue Date: [Approved by OMB 4/26/2012; not yet published] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** To be entered. **SUMMARY OF NIHB ANALYSIS:**	
58.	**Medicare Hospital Conditions of Participation** **ACTION: Final Rule** **NOTICE:** Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation **AGENCY:** CMS	CMS-3244-F	Issue Date: 5/16/2012 Due Date: None NIHB File Date: Date of Subsequent Agency		**SUMMARY OF AGENCY ACTION:** This final rule revises the requirements that hospitals and critical access hospitals (CAHs) must meet to participate in the Medicare and Medicaid programs. These changes serve as an integral part of efforts to reduce procedural burdens on providers. **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/25/2014 issued a document (CMS-3244-F2) that corrects a technical error in this final rule. On page 29075 of this final rule, in the amendatory instructions for 42 CFR 482.42, CMS revised the introductory text of paragraph (a) to include the provisions of paragraph (a)(1)	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Action, if any: Issued correcting amendment 2/25/2014		but inadvertently neglected to omit paragraph (a)(1) from the regulations text. In addition, CMS proposed to remove the burdensome requirement for an infection log at paragraph (a)(2) but inadvertently neglected to omit paragraph (a)(2) from the regulations text. http://www.gpo.gov/fdsys/pkg/FR-2014-02-25/pdf/2014-04024.pdf	
63.c.	**Certification of Compliance for Health Plans** **ACTION: Proposed Rule** **NOTICE:** Administrative Simplification: Certification of Compliance for Health Plans **AGENCY:** CMS	CMS-0037-P	Issue Date: 1/2/2014 **Due Date: 3/3/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This proposed rule would require a controlling health plan (CHP) to submit information and documentation demonstrating its compliance with certain standards and operating rules adopted by the HHS Secretary under HIPAA. This proposed rule also would establish penalty fees for a CHP that fails to comply with the certification of compliance requirements. http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31318.pdf **SUMMARY OF NIHB ANALYSIS:** No comments recommended.	
65.	**Health Care Reform Insurance Web Portal Requirements** **ACTION: Request for Comment** **NOTICE:** Health Care Reform Insurance Web Portal Requirements **AGENCY:** CMS	CMS-10320	Issue Date: 8/15/2012 Due Date: 9/13/2012 TTAG File Date: 9/13/2012; ANTHC also filed comments 9/13/2013	TTAG response:	**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Health Care Reform Insurance Web Portal Requirements 45 CFR Part 159; *Use*: Sections 1103 and 10102 of ACA mandate this information collection. Once collected from insurance issuers of major medical health insurance (issuers) and other affected parties, the data will appear on the Web site http://www.healthcare.gov. Issuers must provide information quarterly, and healthcare.gov will update on a periodic schedule during each quarter. The information provided will help the general public make educated decisions about organizations providing private health insurance. In accordance with ACA, HHS created healthcare.gov to meet the requirements of sections 1103 and 10102 and other provisions of the law, with data collection conducted for six months based upon an emergency information collection request. The interim final rule published on 5/5/2010 served as the emergency Federal Register notice for the prior information collection request.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Date of Subsequent Agency Action, if any: Issued revision 2/3/2014 **Due Date: 4/1/2014**		CMS has begun updating a system (Web portal) where state Departments of Insurance and issuers can log in using a custom user ID and password validation. States might have to provide information on issuers in their state and various Web sites maintained for consumers. Issuers will have to provide information on their major medical insurance products and plans. They ultimately will have the choice to download a basic information template, enter their data into the template, and upload them into the Web portal; to enter their data manually within the Web portal; or to submit .xml files containing their data. Once the states and issuers submit their data, they will receive an email notifying them of any errors and indicating receipt of their submission. CMS requires issuers to verify and update their information on a quarterly basis and asks States to verify their information on an annual basis. In the event that an issuer enhances its existing plans, proposes new plans, or deactivates plans, it would have to update the information in the Web portal. Changes occurring during the three-month quarterly periods can occur by utilizing effective dates for both the plans and rates associated with the plans. **SUMMARY OF TTAG ANALYSIS:** Through ACA subcommittee discussions with CMS/CCIIO, TTAG has sought to have CMS establish a Web portal specifically for tribal governments, particularly for use in supporting tribal sponsorship of premiums. This PRA request offers an opportunity to express this interest formally. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/3/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-03/pdf/2014-02124.pdf Several documents related to CMS-10320 (listed below) are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10320.html. • Appendix A: Supporting Statement • Appendix B: Section 1103 (of ACA) • Appendix C: Insurance Issuer and Product Level Data • Appendix D: Benefits and Pricing • Appendix E: State Requirements	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					• Appendix F: High Risk Pool Market Requirements Plans and issuers must provide the Summary of Benefits and Coverage (SBC) and the uniform glossary of medical and insurance terms. Plans and issuers must provide information about covered services, cost sharing, limitations and exceptions on coverage, coverage examples, and other disclosures in the SBC. These documents outline the timing and formatting required for providing this information.	
70.b.	**Revisions to Medicare Payment Policies Under PFS, et al.** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014 **AGENCY:** CMS	CMS-1600-~~P~~FC	Issue Date: 7/19/2013 Due Date: 9/6/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued Final Rule 12/10/2013 Due Date: 1/27/2014		**SUMMARY OF AGENCY ACTION:** This major proposed rule addresses changes to the physician fee schedule and other Medicare Part B payment policies to ensure that CMS payment systems reflect changes in medical practice and the relative value of services, as well as changes in the statute. http://www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16547.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** This major final rule with comment period addresses changes to the physician fee schedule, clinical laboratory fee schedule, and other Medicare Part B payment policies to ensure that CMS payment systems reflect changes in medical practice and the relative value of services. This final rule with comment period also includes a discussion in the Supplementary Information regarding various programs. http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28696.pdf	
70.c.	**Policy on FOA Disclosure of Payments to Medicare Physicians** **ACTION: Notice**	CMS-0041-N	Issue Date: 1/17/2014 Due Date: None NIHB File Date:		**SUMMARY OF AGENCY ACTION:** This notice sets forth a new policy regarding requests made under the Freedom of Information Act for information on amounts paid to individual physicians under the Medicare program in which CMS will make case-by-case determinations as to whether exemption 6 of the Freedom of Information Act applies to a given request for such information.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Modified Policy on Freedom of Information Act Disclosure of Amounts Paid to Individual Physicians Under the Medicare Program **AGENCY:** CMS		Date of Subsequent Agency Action, if any:		http://www.gpo.gov/fdsys/pkg/FR-2014-01-17/pdf/2014-00808.pdf **SUMMARY OF NIHB ANALYSIS:**	
72.b.	**Medicare PPS and Consolidated Billing for SNFs for FY 2014** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare Program; PPS and Consolidated Billing for Skilled Nursing Facilities for FY 2014 **AGENCY:** CMS	CMS-1446-~~P~~F	Issue Date: 5/6/2013 Due Date: 7/1/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued Final Rule 8/6/2013; issued correction 10/3/2013; issued correction 1/2/2014; issued correction 1/10/2014		**SUMMARY OF AGENCY ACTION:** This proposed rule would update the payment rates used under the prospective payment system (PPS) for skilled nursing facilities (SNFs) for fiscal year (FY) 2014, revise and rebase the SNF market basket, and make certain technical and conforming revisions in the regulations text. This proposed rule also includes a proposed policy for reporting the SNF market basket forecast error correction in certain limited circumstances and a proposed new item for the Minimum Data Set (MDS), Version 3.0. http://www.gpo.gov/fdsys/pkg/FR-2013-05-06/pdf/2013-10558.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBEQUENT AGENCY ACTION:** This final rule updates the payment rates used under the prospective payment system for skilled nursing facilities (SNFs) for FY 2014. In addition, it revises and rebases the SNF market basket, revises and updates the labor related share, and makes certain technical and conforming revisions in the regulations text. This final rule also includes a policy for reporting the SNF market basket forecast error in certain limited circumstances and adds a new item to the Minimum Data Set (MDS), Version 3.0, for reporting the number of distinct therapy days. Finally, this final rule adopts a change to the diagnosis code used to determine which residents will receive the AIDS add-on payment, effective for services provided on or after the 10/1/2014 implementation date for conversion to ICD-10-CM. http://www.gpo.gov/fdsys/pkg/FR-2013-08-06/pdf/2013-18776.pdf CMS on 10/3/2013 issued a document (CMS-1446-CN) that corrects technical errors in the final rule published in the 8/6/2013 FR. http://www.gpo.gov/fdsys/pkg/FR-2013-10-03/pdf/2013-24080.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					CMS on 1/2/2014 issued a document (CMS-1446-CN2) that corrects a technical error that appeared in the final rule published in the 8/6/2013 FR. In the final rule, the Core-Based Statistical Area (CBSA) 44140, Springfield, MA, inadvertently included the wage data of a certain hospital; CMS has removed this data from CBSA 44140 and revised Table A accordingly. http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31435.pdf CMS on 1/10/2014 issued a document (CMS-1446-CN3) that corrects technical errors in the correcting document that appeared in the 1/2/2014 FR. On page 63 of the correcting document, CMS inadvertently omitted the applicability date from the DATES section. http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00277.pdf	
78.c.	**Hospice Request for Certification** **ACTION: Request for Comment** **NOTICE:** Hospice Request for Certification and Supporting Regulations **AGENCY:** CMS	CMS-417	Issue Date: 11/1/2013 Due Date: 12/31/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 1/29/2014 Due Date: 2/28/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Hospice Request for Certification and Supporting Regulations; *Use*: The Hospice Request for Certification serves as the identification and screening form used to initiate the certification process and determine if the provider has sufficient personnel to participate in the Medicare program. http://www.gpo.gov/fdsys/pkg/FR-2013-11-01/pdf/2013-26083.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF AGENCY ACTION:** CMS on 1/29/2014 issued a revision of this PRA request. Subsequent to the publication of the 60-day notice in the 11/1/2013 FR (78 FR 65656), CMS has made minor changes to the form. http://www.gpo.gov/fdsys/pkg/FR-2014-01-29/pdf/2014-01775.pdf No comments recommended.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
78.d.	**Hospice Quality Reporting Program Evaluation** **ACTION: Request for Comment** **NOTICE:** Hospice Quality Reporting Program: Program Evaluation **AGENCY:** CMS	CMS-10504	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Hospice Quality Reporting Program: Program Evaluation; *Use*: Section 3004(c) of ACA mandated that CMS establish a quality reporting program for hospices. Specifically, section 3004(c) added section 1814(i)(5) to the Social Security Act (the Act) to establish a quality reporting program for hospices. This program requires hospices to submit quality data in a time, form and manner specified by the HHS Secretary. CMS seeks to explore how hospices respond to the new quality reporting program (QRP) and its measures. CMS believes in the importance of understanding early trends in outcomes, making adjustments as needed to enhance the effectiveness of QRP, seeking opportunities to minimize provider burden, and ensuring the meaningfulness of the program to providers. The methodology employed in the evaluation uses qualitative interviews (as opposed to quantitative statistical methods). In consultation with research experts, CMS has decided that using a rich, contextual approach to evaluate the process and success of QRP will prove most beneficial at this time. The information collected will help inform CMS about QRP-related experiences, such as program impact related to quality improvement, burden, process-related issues, and education. This information also will inform future measurement development for the hospice QRP, future steps related to data validation, and future monitoring and evaluation. http://www.gpo.gov/fdsys/pkg/FR-2013-11-22/pdf/2013-28049.pdf **SUMMARY OF NIHB ANALYSIS:**	
78.e.	**Hospice Conditions of Participation** **ACTION: Request for Comment** **NOTICE:** Hospice Conditions of Participation	CMS-10277	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Hospice Conditions of Participation and Supporting Regulations; *Use*: Federal or State surveyors use the Conditions of Participation and accompanying requirements as a basis for determining whether a hospice qualifies for approval or re-approval under Medicare. CMS believes that the availability to the hospice of the type of records and general content of records ensures the well-being and safety of patients and professional treatment accountability. This information collection request includes no program changes or new requirements, but CMS plans to adjust the numbers of respondents and responses.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	AGENCY: CMS		Date of Subsequent Agency Action, if any: Issued extension 1/29/2014 Due Date: 2/28/2014		http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28537.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF AGENCY ACTION:** CMS on 1/29/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-29/pdf/2014-01775.pdf	
81.	**Efficiency, Transparency, and Burden Reduction** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Medicare and Medicaid Programs; Part II--Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction **AGENCY:** CMS	CMS-3267-~~P~~F	Issue Date: 2/7/2013 Due Date: 4/8/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 1/9/2014		**SUMMARY OF AGENCY ACTION:** This proposed rule would reform Medicare regulations that CMS has identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers, as well as certain regulations under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). This proposed rule would increase the ability of health care professionals to devote resources to improving patient care by eliminating or reducing requirements that impede quality patient care or that divert resources from providing high quality patient care. http://www.gpo.gov/fdsys/pkg/FR-2013-02-07/pdf/2013-02421.pdf **SUMMARY OF NIHB ANALYSIS:**	
82.e.	**CLIA Program and HIPAA Privacy Rule** **ACTION: Final Rule** **NOTICE:** CLIA Program and	CMS-2319-F	Issue Date: 2/5/2014 Due Date: None		**SUMMARY OF AGENCY ACTION:** This final rule amends Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations to specify that, upon the request of a patient (or his or her personal representative), laboratories subject to CLIA can provide the patient, his or her personal representative, or an individual designated by the patient, as applicable, with copies of completed test reports identifiable as belonging to the patient using the authentication process of the laboratory. Subject to conforming	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	HIPAA Privacy Rule; Patients' Access to Test Reports **AGENCY:** CMS		NIHB File Date: Date of Subsequent Agency Action, if any:		amendments, this final rule retains the existing provisions that require release of test reports only to authorized individuals and, if applicable, to the individuals responsible for using the test reports and to the laboratory initially requesting the test. In addition, this final rule amends the HIPAA Privacy Rule to provide individuals (or their personal representatives) with the right to access test reports directly from laboratories subject to HIPAA (and to direct the transmission of copies of those test reports to individuals or entities designated by them) by removing the exceptions for CLIA-certified laboratories and CLIA-exempt laboratories from the provision that provides individuals with the right of access to their protected health information. These changes to the CLIA regulations and the HIPAA Privacy Rule provide individuals with a greater ability to access their health information, empowering them to take a more active role in managing their health and health care. http://www.gpo.gov/fdsys/pkg/FR-2014-02-06/pdf/2014-02280.pdf **SUMMARY OF NIHB ANALYSIS:**	
82.h.	**HIPAA Eligibility Transaction System Partner Agreement** **ACTION: Request for Comment** **NOTICE:** HIPAA Eligibility Transaction System (HETS) Trading Partner Agreement (TPA) **AGENCY:** CMS	CMS-10157	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued reinstatement 1/31/2014 **Due Date: 3/5/2014**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Reinstatement of a previously approved collection; *Title*: HIPAA Eligibility Transaction System (HETS) Trading Partner Agreement (TPA); *Use*: The HIPAA Eligibility Transaction System (HETS) seeks to allow the release of eligibility data to Medicare providers, suppliers, or their authorized billing agents for the purposes of preparing accurate Medicare claims, determining beneficiary liability, or determining eligibility for specific services. Such information disclosures cannot occur to anyone other than providers, suppliers, or a beneficiary associated with a filed claim. http://www.gpo.gov/fdsys/pkg/FR-2013-11-22/pdf/2013-28049.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/31/2014 issued a reinstatement of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-31/pdf/2014-02061.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
82.i.	**HIPAA Covered Entity and Associate Pre-Audit Survey** **ACTION: Request for Comment** **NOTICE:** HIPAA Covered Entity and Business Associate Pre-Audit Survey **AGENCY:** HHS OCR	HHS OS-21435-60D	Issue Date: 2/24/2014 **Due Date: 4/25/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: HIPAA Covered Entity and Business Associate Pre-Audit Survey; *Use*: This information collection consists of a survey of as many as 1200 HIPAA covered entities (health plans, health care clearinghouses, and certain health care providers) and business associates (entities that provide certain services to a HIPAA covered entity) to determine suitability for the HHS Office for Civil Rights (OCR) HIPAA Audit Program. The survey will gather information about respondents to enable OCR to assess the size, complexity, and fitness of a respondent for an audit. Information collected includes, among other things, recent data about the number of patient visits or insured lives, use of electronic information, revenue, and business locations. http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03830.pdf **SUMMARY OF NIHB ANALYSIS:**	
89.e.	**Notice of Benefit and Payment Parameters for 2015** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015 **AGENCY:** CMS	CMS-9954-~~P~~F	Issue Date: 12/2/2013 Due Date: 12/26/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Sent Final Rule to OMB 2/24/2014		**SUMMARY OF AGENCY ACTION:** This proposed rule sets forth payment parameters and oversight provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost-sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges (FFEs). It also proposes additional standards with respect to composite rating, privacy and security of personally identifiable information, the annual open enrollment period for 2015, the actuarial value calculator, the annual limitation in cost sharing for stand-alone dental plans, the meaningful difference standard for qualified health plans offered through an FFE, patient safety standards for issuers of qualified health plans, and the Small Business Health Options Program. http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf The Proposed 2015 Actuarial Value Calculator is available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/proposed-2015-av-calculator.xls. The Proposed 2015 Actuarial Value Calculator Methodology is available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/proposed-	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					2015-av-calc-methodology.pdf. A Draft User Guide to the Proposed 2015 Actuarial Value Calculator is available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/proposed-2015-av-calc-user-guide.pdf. **SUMMARY OF NIHB ANALYSIS:**	
91.b.	**Waiting Period Limitation and Coverage Requirements** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under ACA **AGENCY:** IRS/DoL/CMS	REG-122706-12 DoL (RIN 1210-AB56) CMS-9952-~~P~~F	Issue Date: 3/21/2013 Due Date: 5/20/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued Final Rule 2/24/2014		**SUMMARY OF AGENCY ACTION:** This proposed rule would implement the 90-day waiting period limitation under section 2708 of the Public Health Service Act, as added by ACA, as amended and incorporated into the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code. This rule also proposes amendments to regulations to conform to ACA provisions currently in effect, as well as those that will become effective beginning in 2014. The proposed conforming amendments would make changes to existing requirements, such as preexisting condition limitations and other portability provisions added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations because they have become moot or need amendment as a result of new market reform protections under ACA. http://www.gpo.gov/fdsys/pkg/FR-2013-03-21/pdf/2013-06454.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** These final regulations implement the 90-day waiting period limitation under section 2708 of the Public Health Service Act, as added by ACA, as amended, and incorporated into ERISA and the Internal Revenue Code. These regulations also finalize amendments to existing regulations to conform to ACA provisions. Specifically, these rules amend regulations implementing existing provisions, such as some of the portability provisions added by HIPAA, because those provisions of the HIPAA regulations have become superseded or require amendment as a result of the market reform protections added by ACA. http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03809.pdf	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
91.c.	**Waiting Period Limitation** **ACTION: Proposed Rule** **NOTICE:** Ninety-Day Waiting Period Limitation **AGENCY:** IRS/DoL/CMS	DoL (RIN 1210-AB60) REG-122706-12 DoL (RIN 1210-AB61) CMS-9952-P2			**SUMMARY OF AGENCY ACTION:** These proposed regulations would clarify the maximum allowed length of any reasonable and bona fide employment-based orientation period, consistent with the 90-day waiting period limitation set forth in section 2708 of the Public Health Service Act, as added by ACA, as amended, and incorporated into ERISA and the Internal Revenue Code. http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03811.pdf **SUMMARY OF NIHB ANALYSIS:** No comments recommended. Roughly, an employer can impose a "bona fide employment-based orientation period" that has the effect of adding an additional month to the waiting period.	
92.h.	**Disclosure and Recordkeeping for Grandfathered Health Plans** **ACTION: Request for Comment** **NOTICE:** Affordable Care Act Grandfathered Health Plan Disclosure, Recordkeeping Requirement, and Change in Carrier Disclosure **AGENCY:** DoL	DoL (OMB 1210-0140)	Issue Date: 5/22/2013 Due Date: 7/22/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 11/29/2013 Due Date: 1/2/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Affordable Care Act Grandfathered Health Plan Disclosure, Recordkeeping Requirement, and Change in Carrier Disclosure; *Use*: Section 1251 of ACA provides that certain plans and health insurance in existence as of 3/23/2010, known as grandfathered health plans, do not have to comply with certain statutory provisions in the law. To maintain its status as a grandfathered health plan, the interim final regulations require the plan to maintain records documenting the terms of the plan in effect on 3/23/2010, and any other documents necessary to verify, explain, or clarify status as a grandfathered health plan. The plan must make such records available for examination upon request by participants, beneficiaries, individual policy subscribers, or a State or Federal agency official. The interim final regulations also require a grandfathered health plan to include a statement in any plan material provided to participants or beneficiaries describing the benefits provided under the plan or health insurance; indicating the plan believes it is a grandfathered health plan within the meaning of section 1251 of ACA; indicating, as a grandfathered health plan, the plan does not include certain consumer protections of ACA; and providing contact information for participants to direct questions regarding which protections apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status and to file complaints. http://www.gpo.gov/fdsys/pkg/FR-2013-05-22/pdf/2013-12191.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					Model language for the disclosure requirement is available at http://www.dol.gov/ebsa/grandfatherregmodelnotice.doc. A Supporting Statement for this PRA request is available at http://www.reginfo.gov/public/do/DownloadDocument?documentID=215530&version=1. This information collection does not include associated forms for the recordkeeping requirement. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 11/29/2013 issued an extension of this PRA request with no changes. http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28557.pdf	
92.i.	**ACA Notice of Rescission** **ACTION: Request for Comment** **NOTICE:** Affordable Care Act Notice of Rescission **AGENCY:** Treasury	TD 9491 (OMB 1545-2180)	Issue Date: 6/27/2013 Due Date: 8/20/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/27/2014 **Due Date: 3/31/2014**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Affordable Care Act Notice of Rescission; *Use*: Section 2712 of the Public Health Service Act (PHS Act), incorporated into section 9815 of the Internal Revenue Code by section 1563(f) of ACA, prohibits group health plans and health insurance issuers from rescinding coverage of an individual unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. The temporary Treasury regulations provide that a group health plan or a health insurance issuer offering group health insurance coverage must provide at least 30 days advance notice to an individual before it can rescind coverage. This notice meets the third-party disclosure requirement under section 2712 of the PHS Act. Individuals about to have their coverage rescinded might need to arrange for other coverage, make decisions about whether they wish to appeal the decision to rescind their coverage, or make arrangements to defer the receipt of medical care that is optional or not needed immediately. Individuals who receive the disclosure can make an informed decision on these matters. http://www.gpo.gov/fdsys/pkg/FR-2013-06-27/pdf/2013-15361.pdf **SUMMARY OF NIHB ANALYSIS:**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					SUMMARY OF SUBSEQUENT AGENCY ACTION: Treasury on 2/27/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-27/pdf/2014-04298.pdf	
92.k.	**ACA Notice of Patient Protection** **ACTION: Request for Comment** **NOTICE:** Affordable Care Act Notice of Patient Protection **AGENCY:** IRS	REG-120399-10 (OMB 1545-2181)	Issue Date: 9/4/2013 Due Date: 11/4/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/27/2014 **Due Date: 3/31/2014**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Affordable Care Act Notice of Patient Protection; *Use*: Section 2719A of the Public Health Service Act (PHS Act), incorporated into Internal Revenue Code section 9815 by section 1563(f) of ACA, directs a group health plan or a health insurance issuer requiring or allowing for the **designation of a primary care provider** to notify participants of the right to designate a primary care provider (including a pediatrician for a child) and of the right to obtain access to obstetrical or gynecological services without referral from a primary care provider. This PRA request includes no changes. http://www.gpo.gov/fdsys/pkg/FR-2013-09-04/pdf/2013-21400.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** IRS on 2/27/2014 issued an extension of this PRA request with no changes. http://www.gpo.gov/fdsys/pkg/FR-2014-02-27/pdf/2014-04298.pdf	
92.n.	**Rules for Group Health Plans Related to Grandfather Status** **ACTION: Request for Comment** **NOTICE:** Interim Final Rules	REG-118412-10 (OMB 1545-2178)	Issue Date: 10/29/2013 Due Date: 12/30/2013 NIHB File Date:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; *Use*: Section 1251 of ACA provides that certain plans and health insurance coverage in existence as of 3/23/2010, known as grandfathered health plans, do not have to comply with certain statutory provisions in the law. Treas. Reg. §54.9815-1215T requires a grandfathered health plan to include a statement in any plan material provided to participants or beneficiaries stating its intent to	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act **AGENCY:** IRS		Date of Subsequent Agency Action, if any: Issued revision 2/27/2014 **Due Date: 3/31/2014**		exist as a grandfathered health plan within the meaning of §1251 of ACA. To maintain status as a grandfathered health plan, the plan or issuer must maintain records documenting the terms of the plan or health insurance coverage in effect on 3/23/2010 and any other documents necessary to verify, explain, or clarify status as a grandfathered health plan. The plan or issuer must make such records available for examination. http://www.gpo.gov/fdsys/pkg/FR-2013-10-29/pdf/2013-25581.pdf A Supporting Statement for this PRA request is available at http://www.reginfo.gov/public/do/DownloadDocument?documentID=212859&version=1. This information collection does not have any associated forms. **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** IRS on 2/27/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-27/pdf/2014-04298.pdf	
92.q.	**ACA Advance Notice of Rescission** **ACTION: Request for Comment** **NOTICE:** Affordable Care Act Advance Notice of Rescission **AGENCY:** DoL	DoL (OMB 1210-0141)	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Affordable Care Act Advance Notice of Rescission; *Use*: Section 2712 of the Public Health Service (PHS) Act, as added by ACA, and DoL interim final regulations provide rules regarding rescissions of health coverage for group health plans and health insurance issuers offering group or individual health insurance coverage. Under the statute and the interim final regulations, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, generally must not rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. This standard applies to all rescissions, whether in the group or individual insurance market or self-insured coverage. The rules also apply regardless of any contestability period of the plan or issuer. PHS Act section 2712 adds a new advance notice requirement when health plans or health insurance issuers rescind coverage where still permissible. Specifically, the	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			extension 2/19/2014 **Due Date: 3/21/2014**		second sentence in section 2712 provides that plans or issuers cannot cancel coverage unless they provide prior notice, and then only as permitted under PHS Act sections 2702(c) and 2742(b). Under the interim final regulations, even if plans or issuers provide prior notice, rescission can occur only in cases of fraud or an intentional misrepresentation of a material fact as permitted under the cited provisions. The interim final regulations require health plans or health insurance issuers to provide at least 30 days advance notice to an individual before they can rescind coverage may be rescinded, regardless of whether the rescission involves group or individual coverage; whether, in the case of group coverage, the rescission involves insured or self-insured coverage; or whether the rescission applies to an entire group or only to an individual within the group. http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28568.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** IRS on 2/19/2014 issued an extension of this PRA request with no changes. http://www.gpo.gov/fdsys/pkg/FR-2014-02-19/pdf/2014-03541.pdf	
92.r.	**ACA Patient Protection Notice** **ACTION: Request for Comment** **NOTICE:** Affordable Care Act Patient Protection Notice **AGENCY:** DoL	DoL (OMB 1210-0142)	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Affordable Care Act Patient Protection Notice; *Use*: Section 2719A of the Public Health Service (PHS) Act, as added by ACA and the DoL interim final regulations, states that, if a group health plan or a health insurance issuer offering group or individual health insurance coverage requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer must permit each participant, beneficiary, or enrollee to designate any participating primary care provider to accept the participant, beneficiary, or enrollee. When applicable, individuals enrolled in a plan or health insurance coverage must know their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires participants or subscribers to designate a primary care physician; or (2) obtain	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Issued extension 2/28/2014 **Due Date: 3/31/2014**		obstetrical or gynecological care without prior authorization. Accordingly, paragraph (a)(4) of the interim final regulations requires such plans and issuers to provide a notice to participants (in the individual market, primary subscribers) of these rights when applicable. The interim final regulations provide model language. Plans and insurers must provide the notice whenever they provide a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage or, in the individual market, provide a primary subscriber with a policy, certificate, or contract of health insurance. http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28568.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** IRS on 2/28/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-28/pdf/2014-04397.pdf	
92.s.	**Rate Increase Disclosure and Review Reporting Requirements** **ACTION: Request for Comment** **NOTICE:** Rate Increase Disclosure and Review Reporting Requirements **AGENCY:** CMS	CMS-10379	Issue Date: 12/27/2013 Due Date: 2/25/2013 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Reinstatement with change of a previously approved information collection; *Title*: Rate Increase Disclosure and Review Reporting Requirements; *Use*: Section 1003 of ACA adds a new section 2794 of the Public Health Service Act (PHS Act) directing the HHS Secretary, in conjunction with states, to establish a process for the annual review of "unreasonable increases in premiums for health insurance coverage." The statute provides that health insurance issuers must submit to the HHS Secretary and the applicable state justifications for unreasonable premium increases prior to the implementation of the increases. Section 2794 also specifies that, beginning with plan years starting in 2014, the HHS Secretary, in conjunction with states, shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange. Section 2794 directs the HHS Secretary to ensure the public disclosure of information and justification relating to unreasonable rate increases. The regulation therefore develops a process to ensure the public disclosure of all such information and	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					justification. Section 2794 requires that health insurance issuers submit justification for an unreasonable rate increase to both CMS and the relevant state prior to its implementation. Additionally, section 2794 requires the HHS Secretary, in conjunction with states, to monitor rate increases effective in 2014 (submitted for review in 2013). To those ends, the regulation establishes various reporting requirements for health insurance issuers, including a Preliminary Justification for a proposed rate increase, a Final Justification for any rate increase determined unreasonable by a state or CMS, and a notification requirement for unreasonable rate increases that the issuer will not implement. On 11/14/ 2013, CMS issued a letter to State Insurance Commissioners outlining transitional policy for non-grandfathered coverage in the small group and individual health insurance markets. If permitted by applicable state authorities, health insurance issuers can continue coverage that would otherwise get terminated or cancelled, and affected individuals and small businesses can re-enroll in such coverage. Under this transitional policy, non-grandfathered health insurance coverage in the individual or small group market renewed for a policy year starting between 1/1/2014 and 10/1/2014 will remain in compliance with certain market reforms if it meets certain specific conditions. These transitional plans remain subject to the requirements of section 2794 but not 2701 (market rating rules), 2702 (guaranteed availability), 2704 (prohibition on health status rating), 2705 (prohibition on health status discrimination), and 2707 (requirements of essential health benefits). In addition, because the single risk pool (1311(e)) depends on all of the aforementioned sections (2701, 2702, 2704, 2705, and 2707), the transitional plans remain exempt from the single risk pool. CMS designed the Unified Rate Review Template and system exclusively for use with the single risk pool plan, and any attempt to include non-single risk pool plans in the Unified Rate Review template or system will create errors, inaccuracies, and limitations that would prevent the effectiveness of reviews of both sets of non-grandfathered plans (single risk pool and transitional). For these many reasons, CMS requires issuers with transitional plans experiencing rate increases subject to review to use the Rate Review Justification system and templates required and utilized prior to 4/1/2013. http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30994.pdf **SUMMARY OF NIHB ANALYSIS:** No comments recommended.	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
92.t.	**ACA Implementation: Market Reform and Mental Health Parity** **ACTION: Guidance** **NOTICE:** Affordable Care Act Implementation FAQs: Market Reform Provisions and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 1/9/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This guidance includes additional Frequently Asked Questions (FAQs) and answers regarding implementation of the market reform provisions of ACA, as well as FAQs regarding implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by ACA. HHS and the Departments of Labor and the Treasury prepared these FAQs. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html **SUMMARY OF NIHB ANALYSIS:**	
92.u.	**Marketplace and Insurance Market Standards for 2015/2016** **ACTION: Proposed Rule** **NOTICE:** Marketplace and Insurance Market Standards for 2015/2016 **AGENCY:** CMS	CMS-9949-P	Issue Date: [Pending at OMB as of 2/11/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any :		**SUMMARY OF AGENCY ACTION:** This proposed rule would update policy based on experience with initial open enrollment. **SUMMARY OF NIHB ANALYSIS:**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
92.v.	**Q&A on Outreach by Medicaid MCOs to Former Enrollees** **ACTION: Guidance** **NOTICE:** Question and Answer on Outreach by Medicaid Managed Care Contractors and Health Insurance Issuers to Former Enrollees **AGENCY:** CCIIO	CCIIO (no reference number)	Issue Date: 2/21/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** Medicaid managed care organizations (MCOs), which provide coverage to beneficiaries on a risk basis, have existed since before the enactment of ACA. Many individuals once enrolled in a Medicaid managed care plan might no longer qualify for Medicaid as determined by States. Many issuers that contract with States as MCOs have become involved in offering Qualified Health Plans (QHPs) on the Federally-Facilitated Marketplace or in State-Based Marketplaces, providing coverage to previously uninsured individuals. This guidance answers the question of whether an issuer with a Medicaid MCO contract can reach out to former enrollees who States disenrolled because of a loss of Medicaid eligibility to assist them in enrolling in health coverage offered by the issuer through the Marketplace. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/medicaid-mco-enrollee-outreach-faq-2-21-14.pdf **SUMMARY OF NIHB ANALYSIS:**	
99.c.	**Evaluation of Wellness and Prevention Programs** **ACTION: Request for Comment** **NOTICE:** Prospective Evaluation of Evidence-Based Community Wellness and Prevention Programs **AGENCY:** CMS	CMS-10509	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Prospective Evaluation of Evidence-Based Community Wellness and Prevention Programs; *Use*: Section 4202(b) of ACA mandated that CMS conduct an evidence review and independent evaluation of wellness programs focusing on the following six intervention areas: chronic disease self-management, increasing physical activity, reducing obesity, improving diet and nutrition, reducing falls, and mental health management. In response, CMS adopted a three-phase approach to evaluate the impact of wellness programs on Medicare beneficiary health, utilization, and costs to determine whether broader participation in wellness programs could lower future growth in program spending. Phase I consisted of a comprehensive literature review and environmental scan to identify a list of wellness programs for further evaluation. Phase II involved a retrospective evaluation of 10 wellness programs in the targeted intervention areas mentioned above. This evaluation sought to use Medicare claims data to assess the impact of 10 wellness programs on beneficiary outcomes, including health service utilization and medical costs. The findings in Phase II indicated that several wellness	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					programs demonstrated the potential to reduce medical costs among participating beneficiaries. In Phase III, CMS will conduct an evaluation to round out its understanding of how wellness programs affect Medicare beneficiaries and what cost saving opportunities exist for the program. This evaluation will (1) describe the overall distribution of readiness to engage with wellness programs in the Medicare population, (2) better adjust for selection biases of individual programs and interventions using beneficiary level survey data, (3) evaluate program impacts on health behaviors, self-reported health outcomes, and claims-based measures of utilization and costs, and (4) better describe program implementation, operations, and cost in relation to the expected benefits. The results of these analyses will inform wellness and prevention activities in the future. To achieve the goals of this project, CMS will conduct a nationally representative survey of Medicare beneficiaries to assess their readiness to participate in community-based wellness programs. CMS will generate national estimates of Medicare beneficiary demand for wellness services and benefits from this survey. In addition, CMS will partner with evidence-based wellness programs for the purposes of enrolling an estimated 2,000 participants per program. CMS will conduct surveys of program participants to assess program impacts on health and behavior. http://www.gpo.gov/fdsys/pkg/FR-2013-11-22/pdf/2013-28049.pdf **SUMMARY OF NIHB ANALYSIS:**	
110.g.	**Procedures for Advisory Opinions on Physician Referrals** **ACTION: Request for Comment** **NOTICE:** Procedures for Advisory Opinions Concerning Physicians'	CMS-R-216	Issue Date: 11/8/2013 Due Date: 1/7/2014 NIHB File Date: Date of		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Procedures for Advisory Opinions Concerning Physicians' Referrals and Supporting Regulations; *Use*: The information collection requirements contained in 42 CFR 411.372 and 411.373 allow CMS to consider requests for advisory opinions and provide accurate and useful opinions. CMS reads and analyzes the information to develop and issue an advisory opinion to the individual or entity that submitted the information. The Center for Medicare, which issues of advisory opinions, serves as the primary office using the information. http://www.gpo.gov/fdsys/pkg/FR-2013-11-08/pdf/2013-26829.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Referrals and Supporting Regulations **AGENCY:** CMS		Subsequent Agency Action, if any: Issued extension 1/17/2014 Due Date: 2/18/2014		**SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/17/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-17/pdf/2014-00915.pdf	
110.h.	**Hospital Disclosures Regarding Physician Ownership** **ACTION: Request for Comment** **NOTICE:** Disclosures Required of Certain Hospitals and Critical Access Hospitals Regarding Physician Ownership **AGENCY:** CMS	CMS-10225	Issue Date: 12/13/2013 Due Date: 2/11/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Disclosures Required of Certain Hospitals and Critical Access Hospitals Regarding Physician Ownership; *Use*: Medicare does not prohibit physician investment in a hospital or critical access hospital (CAH). In addition, Medicare does not require a hospital or CAH to have a physician on-site at all times, although the program does require a hospital or CAH to have the ability to provide basic elements of emergency care to its patients. However, patients might consider an ownership interest by their referring physician, the presence of a physician on-site, or both important factors in their decisions about where to seek hospital care. Accordingly, patients should know about the physician ownership of a hospital, whether a physician remains in the hospital at all times, and hospital plans to address patient emergency medical conditions in the absence of a physician. The disclosures seek to increase the transparency of hospital ownership and operations to patients as they make decisions about receiving hospital care. http://www.gpo.gov/fdsys/pkg/FR-2013-12-13/pdf/2013-29725.pdf **SUMMARY OF NIHB ANALYSIS:**	
110.i.	**Self-Referral Disclosure Protocol** **ACTION: Request for**	CMS-10328	Issue Date: 2/24/2014 **Due Date:**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of currently approved collection; *Title*: Self-Referral Disclosure Protocol; *Use*: The Self-Referral Disclosure Protocol (SRDP), a voluntary self-disclosure instrument, allows providers of services and suppliers to disclose actual or potential violations of section	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Comment **NOTICE:** Self-Referral Disclosure Protocol **AGENCY:** CMS		**4/25/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		1877 of the Social Security Act (the Act). CMS analyzes the disclosed conduct to determine compliance with section 1877 of the Act and the application of the exceptions to the physician self-referral prohibition. In addition, the HHS Secretary, under authority granted by section 6409(b) of ACA and subsequently delegated to CMS, can reduce the amount due and owed for violations. http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03874.pdf **SUMMARY OF NIHB ANALYSIS:**	
112.b.	**IHS Reimbursement Rates for CY 2014** **ACTION: Notice** **NOTICE:** Reimbursement Rates for Calendar Year 2014 **AGENCY:** IHS	IHS RIN 0917-ZA28	Issue Date: [Pending at OMB as of 1/22/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** **SUMMARY OF NIHB ANALYSIS:**	
113.	**Additional Medicare Tax** **ACTION: ~~Proposed~~ Final Rule** **NOTICE:** Rules Relating to Additional Medicare Tax **AGENCY:** IRS	~~REG-130074-11~~ TD 9645	Issue Date: 12/5/2012 Due Date: 3/5/2013 NIHB File Date:		**SUMMARY OF AGENCY ACTION:** This document contains proposed regulations relating to Additional Hospital Insurance Tax on income above threshold amounts ("Additional Medicare Tax"), as added by the Affordable Care Act. Specifically, these proposed regulations provide guidance for employers and individuals relating to the implementation of Additional Medicare Tax. This document also contains proposed regulations relating to the requirement to file a return reporting Additional Medicare Tax, the employer process for making adjustments of underpayments and overpayments of Additional Medicare Tax, and the employer and employee processes for filing a claim for refund for an overpayment of Additional Medicare Tax. This document also provides	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
			Date of Subsequent Agency Action, if any: Issued correction 1/30/2013; issued Final Rule 11/29/2013		notice of a public hearing on these proposed rules. http://www.gpo.gov/fdsys/pkg/FR-2012-12-05/pdf/2012-29237.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSQENT AGENCY ACTION:** This correction makes the following change to the proposed rule that appeared on in the December 5, 2012, FR (77 FR 72268): **§ 31.6205-1 Adjustments of Underpayments. [Corrected]** On page 72276, in the second column, in the middle of the column, immediately below ''6. Adding a new paragraph (c).'', ''The revisions and additions read as follows:'' should appear. http://www.gpo.gov/fdsys/pkg/FR-2013-01-30/pdf/C1-2012-29237.pdf This correction makes the following changes to the proposed rule that appeared on in the December 5, 2012, FR (77 FR 72268): 1. On page 72268, in the preamble, column 2, under the caption DATES, line 6, the language ''Must be received by March 5, 2013.'' is corrected to read ''Must be received by February 28, 2013.''. 2. On page 72272, in the preamble, column 3, under the paragraph heading ''Comments and Public Hearing'', line 16, the language ''www.regulations.gov. or upon request. A'' is corrected to read ''www.regulations.gov or upon request. A''. 3. On page 72273, in the preamble, column 1, under the paragraph heading ''Drafting Information'', line 3, the language ''Gerstein and Ligeia M. Donis of the'' is corrected to read ''Gerstein, formerly of the Office of the Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), Andrew Holubeck and Ligeia M. Donis of the''. http://www.gpo.gov/fdsys/pkg/FR-2013-01-30/pdf/2013-01885.pdf IRS on 11/29/2013 issued a document that contains final regulations relating to Additional Hospital Insurance Tax on income above threshold amounts (''Additional Medicare Tax''), as added by ACA. Specifically, these final regulations provide guidance for employers and individuals relating to the implementation of Additional Medicare Tax, including the requirement to withhold Additional Medicare Tax on certain wages and compensation,	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					the requirement to file a return reporting Additional Medicare Tax, the employer process for adjusting underpayments and overpayments of Additional Medicare Tax, and the employer and individual processes for filing a claim for refund for an overpayment of Additional Medicare Tax. http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28411.pdf IRS on 1/22/2014 issued a document that contains corrections to final regulations (TD 9645) published in the 11/29/2013 FR (78 FR 71468). The final regulations address the Additional Hospital Insurance Tax on income higher than threshold amounts, as added by ACA. http://www.gpo.gov/fdsys/pkg/FR-2014-01-29/pdf/2014-01619.pdf	
121.g.	**Health Insurance Benefit Agreement** **ACTION: Request for Comment** **NOTICE:** Health Insurance Benefit Agreement **AGENCY:** CMS	CMS-1561	Issue Date: 11/1/2013 Due Date: 12/31/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 1/17/2014 Due Date: 2/18/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Health Insurance Benefit Agreement; *Use*: Applicants to the Medicare program must agree to provide services in accordance with Federal requirements. CMS-1561 allows CMS to ensure that applicants comply with the requirements. Applicants must sign the completed form and provide operational information to CMS to assure that they continue to meet the requirements after approval. http://www.gpo.gov/fdsys/pkg/FR-2013-11-01/pdf/2013-26083.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/17/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-17/pdf/2014-00915.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
121.h.	**Medicare Enrollment Application: Part A Institutional Providers** **ACTION: Request for Comment** **NOTICE:** Medicare Enrollment Application: Part A Institutional Providers **AGENCY:** CMS	CMS-855A	Issue Date: 11/15/2013 Due Date: 1/14/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Medicare Enrollment Application: Medicare Part A Institutional Providers; *Use*: CMS has revised the CMS-855 Medicare Enrollment Applications information collection request to remove the CMS-855I, CMS-855B and CMS-855R applications from its collection. CMS has found that the regulations governing the enrollment requirements for health care facilities occur at intervals separate from the other provider and supplier types reimbursed by Medicare. Consequently, CMS might need to revise and submit the CMS-855A enrollment application for OMB approval at intervals separate from the other enrollment applications, which include the CMS-855B, CMS-855I, and CMS-855R enrollment applications. CMS plans to maintain the continuity of the CMS-855 enrollment applications by using the same formats and layout of the current CMS-855 enrollment applications, regardless of the separation of the CMS 855A from the collective enrollment application package. CMS has made editorial and clerical corrections to CMS-855A to simplify and clarify the current data collection and to remove obsolete requirements. CMS also has re-numbered and re-sequenced the sections and sub-sections within the form to create a more logical flow of the data collection. In addition, CMS has added a data collection for an address to mail the periodic request for the revalidation of enrollment information (only if it differs from other addresses currently collected). CMS-855A also will collect more specific information regarding types of Home Health Agency sub-units. Other than the information above, new data collected in this revision package includes information on, if applicable, where the supplier stores its patient records electronically. http://www.gpo.gov/fdsys/pkg/FR-2013-11-15/pdf/2013-27305.pdf **SUMMARY OF NIHB ANALYSIS:**	
126.b.	**Evaluation of the Rural Community Hospital Demo** **ACTION: Request for Comment**	CMS-10508	Issue Date: 11/15/2013 Due Date: 1/14/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Evaluation of the Rural Community Hospital Demonstration (RCHD); *Use*: Section 10313 of ACA extended and expanded the Rural Community Hospital Demonstration (RCHD). Originally authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), RCHD provides enhanced reimbursement for inpatient services to small rural hospitals that do not qualify as critical	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Evaluation of the Rural Community Hospital Demonstration **AGENCY:** CMS		NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 1/23/2014 Due Date: 2/24/2014		access hospitals (CAHs). RCHD seeks to increase the capability of these hospitals to meet the health care needs of rural beneficiaries in their service areas. As a demonstration, RCHD aims to provide information to assess the feasibility and advisability of establishing a new category of rural community hospitals for reimbursement policy. For the original demonstration, MMA required a Report to Congress six months after the end of the demonstration, a requirement unchanged by ACA. An initial evaluation, conducted between 2007 and 2011 in preparation for a Report to Congress, focused on the 17 hospitals that had participated at some point between October 2004 and March 2011. CMS received findings from this evaluation in the Interim Evaluation Report of the Rural Community Hospital Demonstration (an unpublished report). The current five-year evaluation of RCHD will extend and build on the prior evaluation and produce the Report to Congress required by the MMA. It will assess the impact of the RCHD in meeting its goals: to enable hospitals to achieve community benefits, such as improved services for their communities (especially Medicare beneficiaries); meet their individual strategic goals; and improve the financial solvency and viability of the participating hospitals. In addition, the evaluation will determine the feasibility and advisability of creating a new payment category of rural hospitals. To achieve this objective, the evaluation will examine how RCHD hospitals responded to payment options and assess how the costs to Medicare under RCHD compare to existing alternative payment options. The evaluation also will summarize the characteristics of the markets served by RCHD hospitals, including beneficiary proximity to inpatient providers and competition among providers in the area. CMS will use the information to assess the implications of expanding the RCHD payment system to hospitals in various market environments. In addition, the evaluation will examine the potential costs of expanding the RCHD payment methodology, accounting for alternative approaches to targeting rural hospitals. http://www.gpo.gov/fdsys/pkg/FR-2013-11-15/pdf/2013-27305.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/23/2014 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-23/pdf/2014-01208.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					This demonstration provides enhanced reimbursement rates for inpatient services to small rural hospitals that do not qualify as critical access hospitals (CAHs). Tribal health organizations (THOs) participating in the demo (or interested in participating in the demo) might want to review and comment on this PRA request.	
132.e.	**Outpatient/Ambulatory Surgery Experience of Care Survey** **ACTION: Request for Comment** **NOTICE:** Outpatient and Ambulatory Surgery Experience of Care Survey **AGENCY:** CMS	CMS-10500	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 12/27/2013 Due Date: 1/27/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: *Outpatient and Ambulatory Surgery Experience of Care Survey*; *Use*: CMS will use the information collected through the field test to inform the development of a larger national survey effort, including development of the final survey instrument and data collection procedures. CMS will use the data collected in this survey effort to conduct a rigorous psychometric analysis of the survey content. Such an analysis seeks to assess the measurement properties of the proposed instrument and sub-domain composites created from item subsets to assure the definition of information reported from any future administrations of the survey. This field test also will serve to refine data collection procedures. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/27/2013 issued a new version of this PRA request. CMS has revised this PRA request since the publication of the 60-day notice in the 10/4/2013 FR (78 FR 61848). http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-31015.pdf	
134.f.	**Outpatient Rehab Facility/CMHC Cost Report** **ACTION: Request for Comment** **NOTICE:** Outpatient Rehabilitation Facility,	CMS-2088-92	Issue Date: 10/23/2013 Due Date: 12/23/2013 NIHB File Date:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Outpatient Rehabilitation Facility, Community Mental Health Center Cost Report and Supporting Regulations; *Use*: Outpatient rehabilitation facilities and community mental health centers must file the cost report with their Medicare Administrative Contractor (MAC). MACs use the cost report to calculate provider cost-to-charge ratios, which help in computing outlier payments and determining a final cost settlement for providers by comparing interim payments received to the reasonable cost for the fiscal period covered by the cost report.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Community Mental Health Center Cost Report and Supporting Regulations **AGENCY:** CMS		Date of Subsequent Agency Action, if any: Issued extension 1/2/2014 Due Date: 2/3/2014		In addition, CMS uses data collected in the cost report to support program operations and payment refinement activities and to make Medicare Trust Fund projections. CMS and other stakeholders also use this date to analyze a myriad of health care measures on a national level. Stakeholders include OMB, CBO, the Medicare Payment Advisory Commission, Congress, researchers, universities, and other interested parties. http://www.gpo.gov/fdsys/pkg/FR-2013-10-23/pdf/2013-24854.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/2/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31390.pdf	
135.d.	**LTCH Quality Reporting Program Evaluation** **ACTION: Request for Comment** **NOTICE:** Long Term Care Hospital Quality Reporting Program: Program Evaluation **AGENCY:** CMS	CMS-10502	Issue Date: 11/22/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Long Term Care Hospital Quality Reporting Program: Program Evaluation; *Use*: Section 3004(a) of ACA mandated that CMS establish a quality reporting program for Long Term Care Hospitals (LTCHs). Specifically, section 3004(a) added section 1886(m)(5) to the Social Security Act (the Act) to establish a quality reporting program for LTCHs. This program requires LTCHs to submit quality data in a time, form and manner specified by the HHS Secretary. CMS seeks to explore how LTCHs respond to the new quality reporting program (QRP) and its measures. CMS believes in the importance of understanding early trends in outcomes, making adjustments as needed to enhance the effectiveness of QRP, seeking opportunities to minimize provider burden, and ensuring the meaningfulness of the program to providers. The methodology employed in the evaluation uses qualitative interviews (as opposed to quantitative statistical methods). In consultation with research experts, CMS has decided that using a rich, contextual approach to evaluate the process and success of QRP will prove most beneficial at this time. The information collected will help inform CMS about QRP-related experiences, such as program impact related to quality improvement, burden, process-related issues, and education. This information also will inform future measurement development for the	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					LTCH QRP, future steps related to data validation, and future monitoring and evaluation. http://www.gpo.gov/fdsys/pkg/FR-2013-11-22/pdf/2013-28049.pdf **SUMMARY OF NIHB ANALYSIS:**	
145.a.	**Health Insurance Providers Fee** **ACTION:** ~~**Proposed**~~ **Final Rule** **NOTICE:** Health Insurance Providers Fee **AGENCY:** IRS	~~REG-118315-12~~ TD 9643	Issue Date: 3/4/2013 Due Date: 6/3/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued correction 3/22/2013; issued Final Rule 11/29/2013; issued correction 1/22/2014		**SUMMARY OF AGENCY ACTION:** This document contains proposed regulations that provide guidance on the annual fee imposed on covered entities engaged in the business of providing health insurance for U.S. health risks. This fee is imposed by section 9010 of ACA. The regulations affect persons engaged in the business of providing health insurance for U.S. health risks. http://www.gpo.gov/fdsys/pkg/FR-2013-03-04/pdf/2013-04836.pdf **SUMMARY OF NIHB ANALYSIS:** The fee seeks to raise revenues to fund the ACA. In 2014, IRS expects to collect $8 billion, increasing to $14 billion per year. In the proposed regulations, a number of entities providing health insurance are excluded from the fee. Excluded entities include employer self-insured plans and governments. The regulations specifically exclude Indian tribal governments from the fee. No comments recommended. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** This document contains a correction to a notice of proposed rulemaking and notice of public hearing (REG-118315-12) published in the Federal Register on 3/4/2013 (78 FR 14034). This document makes the following correction: **§ 57.1 [Corrected]**: On page 14042, column 1, line 17 of paragraph (b), the language "section 9010 of the ACA, as amended." is corrected to read "section 9010 of the ACA." http://www.gpo.gov/fdsys/pkg/FR-2013-03-22/pdf/2013-06701.pdf IRS on 11/29/2013 issued a document that contains final regulations relating to the annual fee imposed on covered entities engaged in the business of providing health insurance for U.S. health risks by section 9010 of ACA, as amended. These final regulations affect persons engaged in the business of providing health insurance for U.S.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					health risks. http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28412.pdf IRS on 1/22/2014 issued a document to correct an error that appeared in the final regulations published in the 11/29/2013 FR. On page 71481 of the final regulations, in the second column, in the first full paragraph, in the last line, "§ 1.414(c)-(5)" should read "§ 1.414(c)-5)". http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/C1-2013-28412.pdf	
145.b.	**Report of Health Insurance Provider Information** **ACTION: Request for Comment** **NOTICE:** Report of Health Insurance Provider Information **AGENCY:** IRS	Form 8963	Issue Date: 11/21/2013 Due Date: 1/21/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 1/29/2014 Due Date: 2/28/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Report of Health Insurance Provider Information; *Use*: Section 9010 of ACA, as amended, imposes an annual fee on health insurance providers that provide health insurance for U.S. health risks (a covered entity). In REG-118315-12 (**see 145.a.**), IRS described how it will administer this fee. This regulation treats members of a controlled group as a single covered entity. This regulation generally allows members of a controlled group to designate a single entity to report on their behalf. The information collection covered under this request will address the recordkeeping requirements prescribed in §57.2(e)(2) of REG-118315-12, under which each member of a controlled group must maintain records of consent to the selection of the designated entity. This information collection also will address the reporting requirements prescribed in §57.3. IRS will use the collected data for compliance purposes. In a situation where the designated entity reports information for another controlled group member covered entity, IRS might need to verify that the member covered entity gave the designated entity consent to report on its behalf. http://www.gpo.gov/fdsys/pkg/FR-2013-11-21/pdf/2013-27893.pdf A Supporting Statement for this PRA request is available at http://www.reginfo.gov/public/do/DownloadDocument?documentID=401859&version=2. **SUMMARY OF NIHB ANALYSIS:** No comments recommended. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** IRS on 1/29/2014 issued a revision of this PRA request.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					This PRA request clarifies reporting requirements for the members/participants in a "controlled group," including a record of giving consent to the designated (lead) entity. Excluded entities include employer self-insured plans and governments, with the regulations specifically excluding tribal governments. No comments recommended.	
147.c.	**Quarterly CHIP Statement of Expenditures and Budget Report** **ACTION: Request for Comment** **NOTICE:** Quarterly Children's Health Insurance Program (CHIP) Statement of Expenditures for the Title XXI Program (CMS-21) and State Children's Health Insurance Program Budget Report for the Title XXI Program State Plan Expenditures (CMS-21B) **AGENCY:** CMS	CMS-21 and CMS 21B	Issue Date: 2/14/2014 **Due Date: 4/15/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Quarterly Children's Health Insurance Program (CHIP) Statement of Expenditures for the Title XXI Program (CMS-21) and State Children's Health Insurance Program Budget Report for the Title XXI Program State Plan Expenditures (CMS-21B); *Use*: Forms CMS-21 and CMS-21B provide CMS with the information necessary to issue quarterly grant awards, monitor current-year expenditure levels, determine the allowability of state claims for reimbursement, develop CHIP financial management information, provide for state reporting of waiver expenditures, and ensure states do not exceed their federally established allotment. Further, CMS needs these forms for the redistribution and reallocation of unspent funds over the federally mandated timeframes. http://www.gpo.gov/fdsys/pkg/FR-2014-02-14/pdf/2014-03293.pdf **SUMMARY OF NIHB ANALYSIS:**	
151.a.	**Request for Employment Information** **ACTION: Request for Comment**	CMS-R-297	Issue Date: 4/4/2013 Due Date: 6/3/2013		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension without change of a currently approved collection; *Title*: Request for Employment Information; *Use*: The Social Security Administration uses this form to obtain information from employers regarding whether Medicare beneficiary coverage under a group health plan is based on current employment status. http://www.gpo.gov/fdsys/pkg/FR-2013-04-04/pdf/2013-07800.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Request for Employment Information **AGENCY:** CMS		NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 7/26/2013; issued revision 1/2/2014 Due Date: 8/26/2013; 2/3/2014		**SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 7/26/2013 issued an extension of this PRA request with no changes. http://www.gpo.gov/fdsys/pkg/FR-2013-07-26/pdf/2013-18004.pdf No comments recommended as this PRA request pertains to an existing form used solely for Medicare purposes. CMS on 1/2/2014 issued a revision of this PRA request. *Use*: Section 1837(i) of the Social Security Act provides for a special enrollment period for individuals who delay enrolling in Medicare Part B because they receive coverage through a group health plan based on their own current employment status or that of their spouse. Disabled individuals with Medicare also might delay enrollment because they have large group health plan coverage based on their own current employment status or that of a family member. When these individuals apply for Medicare Part B, they must provide proof that the group health plan coverage is (or was) based on current employment status. http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31390.pdf	
153.j.	**CMS/VA Computer Matching Program** **ACTION: Notice** **NOTICE:** Privacy Act of 1974: CMS Computer Matching Program Match No. 2013-01; HHS Computer Matching Program Match No. 1312 **AGENCY:** CMS	CMS (no reference number)	Issue Date: 12/5/2013 Due Date: 30 days (approx. 1/6/2014) NIHB File Date: Date of Subsequent Action, if any:		**SUMMARY OF AGENCY ACTION:** In accordance with the requirements of the Privacy Act of 1974, as amended, this notice announces the renewal of a computer matching program (CMP) that CMS plans to conduct with the Purchased Care at the Health Administration Center (PC@HAC) of VA. CMS has provided background information about the proposed matching program in the "Supplementary Information" section of this notice. Although the Privacy Act requires only that CMS provide an opportunity for interested individuals to comment on the proposed CMP, the agency invites comments on all portions of this notice. http://www.gpo.gov/fdsys/pkg/FR-2013-12-05/pdf/2013-29066.pdf **SUMMARY OF NIHB ANALYSIS:**	

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
153.k.	**CMS/SSA/IRS Computer Matching Program** **ACTION: Notice** **NOTICE:** Privacy Act of 1974, CMS Computer Match No. 2013-03, HHS Computer Match No. 1314, SSA Computer Match No. 1048, IRS Project No. 241 **AGENCY:** CMS	CMS (no reference number)	Issue Date: 1/28/2014 Due Date: 30 days (approx. 2/27/2014) NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** In accordance with the requirements of the Privacy Act of 1974, as amended, this notice announces the establishment of a computer matching program (CMP) that CMS plans to conduct with the Social Security Administration and IRS. This CMP seeks to establish the conditions under which: (1) IRS agrees to disclose return information relating to taxpayer identity to SSA and (2) SSA agrees to disclose return information relating to beneficiary and employer identity, commingled with information disclosed by the IRS, to CMS. These disclosures will provide CMS with information to determine the extent to which any Medicare beneficiary has coverage under any group health plan. http://www.gpo.gov/fdsys/pkg/FR-2014-01-28/pdf/2014-01566.pdf **SUMMARY OF NIHB ANALYSIS:**	
157.b.	**Medicare Secondary Payer and Certain Civil Money Penalties** **ACTION: Advanced Notice of Proposed Rule Making** **NOTICE:** Medicare Program; Medicare Secondary Payer and Certain Civil Money Penalties **AGENCY:** CMS	CMS-6061-ANPRM	Issue Date: 12/11/2013 Due Date: 2/10/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This advance notice of proposed rulemaking (ANPRM) solicits public comment on specific practices for which CMS might impose civil money penalties (CMPs) for failure to comply with Medicare Secondary Payer reporting requirements for certain group health plan and non-group health plan arrangements. http://www.gpo.gov/fdsys/pkg/FR-2013-12-11/pdf/2013-29473.pdf **SUMMARY OF NIHB ANALYSIS:**	
164.b.	**Medicare Secondary Payer and "Future Medicals"** **ACTION: Proposed Rule**	CMS-6047	Issue Date: [Pending at OMB as of 8/1/2013		**SUMMARY OF AGENCY ACTION:** This proposed rule would announce the intention of CMS regarding means beneficiaries or their representatives can use to protect the interest of Medicare with respect to Medicare Secondary Payer (MSP) claims involving automobile and liability insurance (including self-insurance), no-fault insurance, and	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	NOTICE: Medicare Secondary Payer and "Future Medicals" **AGENCY:** CMS		Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		workers' compensation where future medical care is claimed or the settlement, judgment, award, or other payment releases (or has the effect of releasing) claims for future medical care. **SUMMARY OF NIHB ANALYSIS:**	
165.c.	**Application for Medicare Part B Enrollment** **ACTION: Request for Comment** **NOTICE:** Application for Enrollment in Medicare the Medical Insurance Program **AGENCY:** CMS	CMS-40B	Issue Date: 10/23/2013 Due Date: 12/23/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 1/2/2014 Due Date: 2/3/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Application for Enrollment in Medicare the Medical Insurance Program; *Use*: Form CMS-40B establishes entitlement to and enrollment in supplementary medical insurance for beneficiaries who have Part A but not Part B. This form solicits information used to determine enrollment for individuals who meet the requirements in section 1836 of the Social Security Act, as well as the entitlement of the applicant or a spouse regarding a benefit or annuity paid by the Social Security Administration (SSA) or OPM for premium deduction purposes. SSA will use the collected information to establish Part B enrollment. http://www.gpo.gov/fdsys/pkg/FR-2013-10-23/pdf/2013-24854.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/2/2014 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-02/pdf/2013-31390.pdf	
165.d.	**Application for Hospital Insurance** **ACTION: Request for**	CMS-18F5	Issue Date: 12/6/2013 Due Date:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Application for Hospital Insurance and Supporting Regulations; *Use*: Regulations at 42 CFR 406.6 specify the individuals who must file an application for Medicare Hospital Insurance (Part A) and those who need not file an	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Comment **NOTICE:** Application for Hospital Insurance and Supporting Regulations **AGENCY:** CMS		2/4/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued extension 2/14/2014 **Due Date: 3/17/2014**		application for Part A. Section 406.7 lists CMS-18F5 as the application form. This form elicits information that the Social Security Administration and CMS need to determine entitlement to Part A and Supplementary Medical Insurance (Part B). http://www.gpo.gov/fdsys/pkg/FR-2013-12-06/pdf/2013-29144.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/14/2014 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-14/pdf/2014-03290.pdf	
171.	**Medicaid Emergency Psychiatric Demonstration Evaluation** **ACTION: Request for Comment** **NOTICE:** Medicaid Emergency Psychiatric Demonstration (MEPD) Evaluation **AGENCY:** CMS	CMS-10487	Issue Date: 7/26/2013 Due Date: 9/24/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 12/6/2013 Due Date: 1/6/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Medicaid Emergency Psychiatric Demonstration (MEPD) Evaluation; *Use*: Since the inception of Medicaid, inpatient care provided to adults ages 21 to 64 in institutions for mental disease (IMDs) has not drawn federal matching funds. The Emergency Medical Treatment and Active Labor Act (EMTALA), however, requires IMDs that participate in Medicare to provide treatment for psychiatric emergency medical conditions (EMCs), even for Medicaid patients. Section 2707 of ACA directs the HHS Secretary to conduct and evaluate a demonstration project to determine the impact of providing payment under Medicaid for inpatient services delivered by private IMDs to individuals with emergency psychiatric conditions between the ages of 21 and 64. CMS will use the data to evaluate the Medicaid Emergency Psychiatric Demonstration (MEPD) in accordance with the ACA mandates. Congress will use this evaluation to determine whether to continue or expand the demonstration. If the demonstration expands, the data collected will help inform both CMS and its stakeholders about possible effects of contextual factors and important procedural issues to consider in the expansion, as well as the likelihood of various outcomes. http://www.gpo.gov/fdsys/pkg/FR-2013-07-26/pdf/2013-17985.pdf **SUMMARY OF NIHB ANALYSIS:**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					SUMMARY OF SUBSEQUENT AGENCY ACTION: CMS on 12/6/2013 issued a new version of this PRA request. Subsequent to publication of the 60-day notice in the 7/26/2013 FR (78 FR 45205), CMS has increased the burden estimate to reflect an increase in time assessed for reviewing medical records and the need to obtain additional informed consents for beneficiary interviews. CMS also has made changes to the "Key Informant Interview Questions" for clarification purposes. http://www.gpo.gov/fdsys/pkg/FR-2013-12-06/pdf/2013-29143.pdf	
175.b.	**Medicaid Drug Use Review Program** **ACTION: Request for Comment** **NOTICE:** Medicaid Drug Use Review Program **AGENCY:** CMS	CMS-R-153	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Medicaid Drug Use Review Program; *Use*: This information collection serves to: establish patient profiles in pharmacies, identify problems in prescribing, dispensing, or both prescribing and dispensing; determine the ability of each program to meet minimum standards required for federal financial participation; and ensure quality pharmaceutical care for Medicaid patients. State Medicaid agencies that have prescription drug programs must perform prospective and retrospective drug use review to identify aberrations in prescribing, dispensing, and patient behavior. http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28537.pdf **SUMMARY OF NIHB ANALYSIS:**	
175.c.	**Submitting Drug Identifying Information to Medicaid Programs** **ACTION: Request for Comment** **NOTICE:** Medicaid Payment for Prescription Drugs--Physicians and Hospital Outpatient Departments	CMS-10215	Issue Date: 12/27/2013 Due Date: 2/25/2014 NIHB File Date: Date of Subsequent		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Medicaid Payment for Prescription Drugs--Physicians and Hospital Outpatient Departments Collecting and Submitting Drug Identifying Information to State Medicaid Programs; *Use*: In accordance with the Deficit Reduction Act of 2005, states must provide for the collection and submission of utilization data for certain physician-administered drugs to receive federal financial participation for these drugs. Physicians, serving as respondents to states, submit National Drug Code numbers and utilization information for "J" code physician-administered drugs to provide states with sufficient information to collect drug rebate dollars. http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-31016.pdf	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Collecting and Submitting Drug Identifying Information to State Medicaid Programs **AGENCY:** CMS		Agency Action, if any:		**SUMMARY OF NIHB ANALYSIS:**	
176.	**EPSDT Participation Report** **ACTION: Request for Comment** **NOTICE:** Annual Early and Periodic Screening, Diagnostic, and Treatment Participation Report **AGENCY:** CMS	CMS-416	Issue Date: 8/9/2013 Due Date: 10/8/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 12/6/2013 Due Date: 1/6/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report; *Use*: CMS uses the baseline data collected 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, who receive initial and periodic child health screening services, obtain referral for corrective treatment, and receiving dental, hearing, and vision services. CMS couples this assessment with state results in attaining the set participation goals. 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. http://www.gpo.gov/fdsys/pkg/FR-2013-08-09/pdf/2013-19321.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/6/2013 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-06/pdf/2013-29143.pdf	
180.	**Flu Vaccination Standard for Certain Providers and Suppliers** **ACTION: Request for Comment** **NOTICE:** Influenza Vaccination Standard for	CMS-3213-F	Issue Date: [Pending at OMB as of 9/27/2013] Due Date: NIHB File Date:		**SUMMARY OF AGENCY ACTION:** This final rule requires certain Medicare and Medicaid providers and suppliers to offer all patients an annual influenza vaccination, unless medically contraindicated or unless the patient or his or her representative or surrogate declined vaccination. This final rule seeks to increase the number of patients receiving annual vaccination against seasonal influenza and decrease the morbidity and mortality rate from influenza. This final rule also requires certain providers and suppliers to develop policies and procedures that will allow them to offer vaccinations for pandemic influenza in case of a future pandemic influenza event.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Certain Participating Providers and Suppliers **AGENCY:** CMS		Date of Subsequent Agency Action, if any:		**SUMMARY OF NIHB ANALYSIS:**	
184.a.	**Clinical Laboratory Improvement Amendments Regulations** **ACTION: Request for Comment** **NOTICE:** Clinical Laboratory Improvement Amendments (CLIA) Regulations **AGENCY:** CMS	CMS-R-26	Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 12/6/2013 Due Date: 1/6/2014 ANTHC File Date: 1/6/2014	ANTHC response:	**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension of a currently approved collection; *Title*: Clinical Laboratory Improvement Amendments (CLIA) Regulations; *Use*: The information serves to determine entity compliance with the congressionally mandated program with respect to the regulation of laboratory testing. In addition, laboratories participating in the Medicare program must comply with CLIA requirements as mandated by section 6141 of OBRA 89. Medicaid, under the authority of section 1902(a)(9)(C) of the Social Security Act, pays for services furnished only by laboratories that meet Medicare (CLIA) requirements. http://www.gpo.gov/fdsys/pkg/FR-2013-10-04/pdf/2013-24250.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 12/6/2013 issued an extension of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2013-12-06/pdf/2013-29143.pdf The unique financial and geographical challenges of IHS facilities and tribal health programs greatly impact their ability to satisfy CLIA-related disclosure requirements pertaining to specimen integrity, communication, and personnel competency assessment. These special circumstances necessitate an increase in the estimated burden for fulfilling these requirements. In addition, the need exists for a rulemaking process that would allow CMS to make more substantive amendments to the CLIA reporting process.	See Table C.

TABLE B: SUMMARY OF NOTICES & REGULATIONS UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
184.b.	**Clinical Laboratory Improvement Amendments Application Form** **ACTION: Request for Comment** **NOTICE:** Clinical Laboratory Improvement Amendments (CLIA) Application Form and Supporting Regulations **AGENCY:** CMS	CMS-116	Issue Date: 12/13/2013 Due Date: 2/11/2014 NIHB File Date: Date of Subsequent Agency Action, if any: Issued revision 2/24/2014 **Due Date: 3/26/2014**		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Revision of a currently approved collection; *Title*: Entities performing laboratory testing specimens for diagnostic or treatment purposes must complete the application. This information serves as a vital part of the certification process. http://www.gpo.gov/fdsys/pkg/FR-2013-12-13/pdf/2013-29725.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/24/2014 issued a revision of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-02-24/pdf/2014-03877.pdf	
184.c.	**CLIA Budget Workload Reports** **ACTION: Request for Comment** **NOTICE:** Clinical Laboratory Improvement Amendments of 1988 (CLIA) Budget Workload Reports and Supporting Regulations **AGENCY:** CMS	CMS-102 and CMS-105	Issue Date: 1/10/2014 **Due Date: 3/11/2014** NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: Extension without change of a currently approved collection; *Title*: Clinical Laboratory Improvement Amendments of 1988 (CLIA) Budget Workload Reports and Supporting Regulations; *Use*: CMS will use the collected information to determine the amount of Federal reimbursement for surveys conducted. Use of the information includes program evaluation, audit, budget formulation, and budget approval. Form CMS-102, a multi-purpose form, captures and records all budget and expenditure data. Form CMS-105 captures the annual projected CLIA workload that the State survey agency will accomplish. CMS regional offices also use the information to approve the annual projected CLIA workload. The section 1864 agreement with the State requires the information. http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00195.pdf **SUMMARY OF NIHB ANALYSIS:**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
185.a.	**Healthcare Fraud Prevention Partnership: Data Sharing** **ACTION: Request for Comment** **NOTICE:** Healthcare Fraud Prevention Partnership (HFPP): Data Sharing and Information Exchange **AGENCY:** CMS	CMS-10501	Issue Date: 10/23/2013 Due Date: 12/23/2013 NIHB File Date: Date of Subsequent Agency Action, if any: Issued new request 1/10/2014 Due Date: 2/10/2014		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Healthcare Fraud Prevention Partnership (HFPP): Data Sharing and Information Exchange; Use: Section 1128C(a)(2) of the Social Security Act (Act) authorizes the HHS Secretary and the Attorney General to consult with, and arrange for the sharing of data with, representatives of health plans to establish a Fraud and Abuse Control Program as specified in Section 1128(C)(a)(1) of the Act. The Healthcare Fraud Prevention Partnership (HFPP), officially established by a Charter in fall 2012 by HHS and the Department of Justice, seeks to detect and prevent the prevalence of health care fraud through data and information sharing and applying analytic capabilities by the public and private sectors. HFPP seeks to identify the optimal way to coordinate nationwide sharing of health care claims information, including aggregating claims and payment information from large public health care programs and private insurance payers. In addition to sharing data and information, HFPP focuses on advancing analytics, training, outreach, and education to support anti-fraud efforts and achieving its objectives, primarily through goal-oriented, well-designed fraud studies. http://www.gpo.gov/fdsys/pkg/FR-2013-10-23/pdf/2013-24854.pdf **SUMMARY OF NIHB ANALYSIS:** **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 1/10/2014 issued a new version of this PRA request. http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2014-00188.pdf	
185.b.	**Revisions to HHS OIG Civil Monetary Penalty Rules** **ACTION: Request for Comment** **NOTICE:** Medicare and	HHS OIG RIN 0936-AA04	Issue Date: [Pending at OMB as of 2/5/2014] Due Date: NIHB File		**SUMMARY OF AGENCY ACTION:** This proposed rule makes changes to the Civil Monetary Penalties Law (CMPL) regulations at 42 CFR 1003 to implement authorities under ACA and other statutes. ACA provides for CMPs, assessments, and exclusion for: • Failure to grant access timely access to OIG; • Ordering or prescribing while excluded; • Making false statements, omissions, or misrepresentations in an enrollment application;	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	State Health Care Programs: Fraud and Abuse; Revisions to the Office of the Inspector General's Civil Monetary Penalty Rules **AGENCY:** HHS OIG		Date: Date of Subsequent Agency Action, if any:		• Failure to return an overpayment; and • Making or using a false record or statement that is material to a false or fraudulent claim. The proposed rule reflects these statutory changes. HHS OIG also proposes a reorganization of 42 CFR 1003 to make the regulations more accessible to the public and to add clarity to the regulatory scheme. OIG proposes an alternate methodology for calculating penalties and assessments for employing excluded individuals in positions in which the individuals do not directly bill the Federal health care programs for furnishing items or services. In addition, OIG clarifies the liability guidelines under its authorities, including the CMPL, the Emergency Medical Treatment and Labor Act; section 1140 of the Social Security Act (the Act) for conduct involving electronic mail, Internet, and telemarketing solicitations; and section 1927 of the Act for late or incomplete reporting of drug-pricing information. **SUMMARY OF NIHB ANALYSIS:**	
185.c.	**Revisions to HHS OIG Exclusion Authorities** **ACTION: Request for Comment** **NOTICE:** Revisions to the Office of Inspector General's Exclusion Authorities **AGENCY:** HHS OIG	HHS OIG RIN 0936-AA05	Issue Date: [Pending at OMB as of 2/5/2014] Due Date: NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** ACA significantly expanded HHS OIG authority to protect Federal health care programs from fraud and abuse. OIG proposes to update its regulations to codify the changes made by ACA in the regulations. At the same time, OIG proposes updates pursuant to the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) and other statutory authorities, as well as technical changes to clarify and update the regulations. **SUMMARY OF NIHB ANALYSIS:**	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
186.	**DSW Resource Center Core Competencies Survey** **ACTION: Request for Comment** **NOTICE:** Direct Service Workforce (DSW) Resource Center (RC) Core Competencies (CC) Survey Instrument **AGENCY:** CMS	CMS-10512	Issue Date: 11/29/2013 Due Date: 1/28/2014 NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** *Type of Information Collection Request*: New collection; *Title*: Direct Service Workforce (DSW) Resource Center (RC) Core Competencies (CC) Survey Instrument; *Use*: This survey comprises part of Phase IIIB of the Direct Service Workforce Resource Center Road Map of Core Competencies for the Direct Service Workforce, a multi-phased research project implemented to identify a common set of core competencies across community-based long-term services and supports (LTSS) population sectors: aging, behavioral health (including mental health and substance use), intellectual and developmental disabilities, and physical disabilities. Phase IIIB includes (1) field testing and a national study to validate the core competency set among the workforce; (2) establishing the core competency set in the public domain; and (3) providing technical assistance to promote the development of specializations within each sector. The survey serves as item 1 of Phase IIIB. The DSW RC, states, direct service agencies, and other partners interested in implementing the core competencies will use the data collected in the survey. The target populations for the surveys include DSW professionals, front line supervisors and managers, agency administrators and directors, participants and families/guardians, and self-advocates. This survey seeks to confirm and validate the relevance and applicability of the DSW RC set of core competencies to actual direct service workers, their employers, and their participants. Information gained from the survey will lend credibility to the set of core competencies. http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28537.pdf **SUMMARY OF NIHB ANALYSIS:**	
188.	**Emergency Preparedness Requirements** **ACTION: Proposed Rule** **NOTICE:** Medicare and	CMS-3178-P	Issue Date: 12/27/2013 **Due Date:** ~~**2/25/2014**~~ **3/31/2014**		**SUMMARY OF AGENCY ACTION:** This proposed rule would establish national emergency preparedness requirements for Medicare- and Medicaid-participating providers and suppliers to ensure that they adequately plan for both natural and man-made disasters and coordinate with federal, state, tribal, regional, and local emergency preparedness systems. It also would ensure that these providers and suppliers adequately prepare to meet the needs of patients, residents, clients, and participants during disasters and emergency situations.	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers **AGENCY:** CMS		NIHB File Date: Date of Subsequent Agency Action, if any: Issued due date extension 2/21/2014		CMS proposes emergency preparedness requirements that 17 provider and supplier types must meet to participate in the Medicare and Medicaid programs. Since existing Medicare and Medicaid requirements vary across the types of providers and suppliers, CMS also proposes variations in these requirements. CMS has based these variations on existing statutory and regulatory policies and differing needs of each provider or supplier type and the individuals to whom they provide health care services. Despite these variations, this proposed rule would provide generally consistent emergency preparedness requirements, enhance patient safety during emergencies for persons served by Medicare- and Medicaid-participating facilities, and establish a more coordinated and defined response to natural and man-made disasters. http://www.gpo.gov/fdsys/pkg/FR-2013-12-27/pdf/2013-30724.pdf **SUMMARY OF NIHB ANALYSIS:** This proposed rule, which seeks to ensure the availability of health care during emergencies, would impose substantial new emergency and disaster preparedness requirements on various Medicare and Medicaid providers and suppliers in an effort to safeguard human resources, ensure business continuity, and protect physical resources. Of note, this proposed rule directs providers to "comply with all applicable Federal and State emergency preparedness requirements" and requires a communications plan that complies with federal and state law, provisions potentially imposing additional emergency preparedness requirements that Tribes currently do not consider applicable. This proposed rule does not include any references to compliance with tribal law. A Health Policy Alternatives summary report on this proposed rule is available at http://www.chausa.org/docs/default-source/advocacy/010814-cha-summary-of-emergency-preparedness-rule.pdf. **SUMMARY OF SUBSEQUENT AGENCY ACTION:** CMS on 2/21/2014 issued document (CMS-3178-N) that extends the comment period for this proposed rule from 2/25/2014 to 3/31/2014. CMS have received inquiries from industry organizations regarding the short time to canvass their membership for input on this proposed rule. One organization stated that it needed additional time to respond because of current regional emergencies requiring the attention of emergency management personnel who likely would have an interest in	

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
					commenting on this proposed rule. Because of its scope, and because CMS specifically seeks comments to benefit from the vast experiences of emergency management and provider/supplier communities, the agency wants to allow ample time for all sections of the public to comment on this proposed rule. http://www.gpo.gov/fdsys/pkg/FR-2014-02-21/pdf/2014-03710.pdf	
189.	**Annual Update of the HHS Poverty Guidelines** **ACTION: Notice** **NOTICE:** Annual Update of the HHS Poverty Guidelines **AGENCY:** HHS	HHS (no reference number)	Issue Date: 1/22/2014 Due Date: None NIHB File Date: Date of Subsequent Agency Action, if any:		**SUMMARY OF AGENCY ACTION:** This notice provides an update of the HHS poverty guidelines to account for the increase in prices in the last calendar year as measured by the Consumer Price Index. http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/2014-01303.pdf **SUMMARY OF NIHB ANALYSIS:** Beginning January 22, 2014, the 2014 Federal Poverty Guidelines (referred to as "Federal Poverty Level" or "FPL") are to be used when determining Medicaid program eligibility. For the Marketplace, the 2013 FPL will continue to be used for all of the 2014 coverage year. Tribal Self-Governance Advisory Committee handout:  TSGAC FPL Handout - Medicaid and Marke	
190.	**Frontier Community Health Integration Project Demo** **ACTION: Proposed Rule** **NOTICE:** Medicare and Medicaid Programs; Solicitation for Proposals for the Frontier Community Health Integration Project	CMS-5511-N	Issue Date: 2/4/2014 **Due Date: 5/5/2014** NIHB File Date: Date of Subsequent		**SUMMARY OF AGENCY ACTION:** This notice provides eligible entities with the information necessary to apply for participation in the Frontier Community Health Integration Project (FCHIP) demonstration. The demonstration seeks to better integrate the delivery of acute care, extended care, and other health care services, as well as improve access to care for Medicare and Medicaid beneficiaries residing in very sparsely populated areas. CMS will use a competitive application process to select eligible entities for participation in this demonstration, which will last as long as 3 years. Interested and eligible parties can obtain complete solicitation and supporting information on the CMS Web site at http://innovation.cms.gov/initiatives/index.html.	

National Indian Health Board

TABLE B: SUMMARY OF NOTICES & REGULATIONS
UPDATED THROUGH 2/28/2014

Ref. #	Short Title/Current Status of Regulation/Title/ Agency	File Code	Issue Date; Due Date & File Date	NIHB Response	Brief Summary of Proposed Agency Action and Summary of NIHB Analysis	NIHB Recs.
	Demonstration **AGENCY:** CMS		Agency Action, if any:		http://www.gpo.gov/fdsys/pkg/FR-2014-02-04/pdf/2014-02062.pdf **SUMMARY OF NIHB ANALYSIS:**	

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

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7.ee.	**2015 Letter to Issuers in FFMs** **ACTION: Guidance** **NOTICE:** Draft 2015 Letter to Issuers in the Federally-Facilitated Marketplaces **AGENCY:** CCIIO	CCIIO (no reference number) Issue Date: 2/4/2014 Due Date: 2/25/2014 TTAG File Date: 2/25/2014; NIHB and TSGAC also filed comments 2/15/2014 Date of Subsequent Agency Action, if any:	TTAG recommendations-- 1. **Chapter 2--QHP and Stand-Alone Dental Plan Certification Standards, Section 2--Service Area**: • a. **State Flexibility**: The opening sentence of Chapter 2, Section 2 (p. 17) reads, "States performing plan management functions in an FFM may use a similar approach [to that CMS will use]"; CMS should require close Federal oversight of all requirements associated expressly with Indian Health Providers (IHPs) to ensure full compliance by states performing plan management functions. • b. **Counties in Service Areas**: The requirement that QHPs serve areas generally no smaller than counties, or a group of counties defined by the Marketplace, should help prevent issuers from avoiding areas with large concentrations of AI/ANs, who tend to have poorer health than other individuals; CMS also should take steps to have Marketplaces encourage QHP applicants to serve areas large enough to encompass an entire reservation when a reservation spans more than one county and consider this factor when assessing whether applicants can choose to serve only part of a county. 2. **Chapter 2, Section 4--Essential Community Providers (ECPs), Subsection i--Evaluation of Network Adequacy with respect to ECP**:	No subsequent Agency action taken (as of 2/28/2014).

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

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			• a. **Proposed Rule**: In Chapter 2, Section 4 (p. 20-21), CMS announces plans to propose a rule that would 1) require QHP applications to "list the offers that [issuers have] extended to all available Indian health providers … in each county in the service area," 2) include an expectation that "issuers … be able to provide verification of such offers if CMS chooses to verify the offers," and 3) consider offers "in good faith" if they include "terms that a willing, similarly-situated, non-ECP provider would accept or has accepted"; regarding this section of the letter and the proposed rule, CMS should: o i. Revise the definition of IHPs to reference the full range of providers operating under the health programs of I/T/Us; o ii. In the letter and the proposed rule, expressly state that any issuer relying on narrative justification to obtain approval for a QHP not meeting the 30 percent ECP standard for 2015 must comply with the requirement to offer to contract with all IHPs in the service area; o iii. Clarify that a contract offered "in good faith" to an IHP must include payment rates at least equal to the generally applicable rates of the issuer for network providers; and o iv. Expressly state its intention to review each QHP application for compliance with the provision of Section 4 regarding contract offers to IHPs and to validate all offers to IHPs listed on applications.	

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

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			• **Alternate ECP Standard of 45 CFR § 156.235(a)(2) and (b)**: In Chapter 2, Section 4, CMS interprets the requirements to satisfy the alternate ECP standard, and this interpretation does not explicitly include the requirement to make good faith contract offers to all IHPs in the service area or in the areas located in, or contiguous to, Health Professional Shortage Areas (HPSA) and areas in which more than 30 percent of the population falls below 200 percent of the federal poverty level; CMS should expressly state that this requirement applies. 3. **Chapter 2, Section 4--Essential Community Providers (ECPs), Subsection ii--Requirement for Payment of Federally Qualified Health Centers (FQHCs)**: In Chapter 2, Section 4, CMS should include a subsection iii that states the requirements in Section 206 of the Indian Health Care Improvement Act regarding payments to IHPs. 4. **Chapter 3--Qualified Health Plan and SADP Design, Section 7--Coverage of Primary Care: 2015 Approach**: CMS should require issuers (through a rule) to make available plans allowing three primary care office visits before the patient must meet any deductible. 5. **Chapter 6--Consumer Support and Related Issues, Section 1--Provider Directory**: Regarding provider directories, CMS encourages issuers to identify the language spoken by providers and whether providers are IHPs; CMS should require issuers to identify whether providers are IHPs. 6. **Chapter 6, Section 2--Complaints Tracking and**	

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

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			Resolution and Section 3--Coverage Appeals: In each of these sections, CMS should require issuers to track complaints and appeals filed by individuals identified as AI/ANs, as well as the subject of these complaints and their resolutions. 7. **Chapter 7--Tribal Relations and Support, Section 1--Model Contract Addendum for Issuers Working with Indian Health Providers**: Chapter 7, Section 1 (p. 51) states that "CMS is continuing to recommend the use of the Model QHP Addendum (Addendum) as described in the 2014 Letter to Issuers"; CMS should revise this section to correspond with Chapter 2, Section 4, which indicates that it plans to propose a rule *requiring* the inclusion of the Addendum in all contracts offered to IHPs. 8. **Chapter 7, Section 2--Tribal Sponsorship of Premiums**: CMS should require issuers to facilitate and accept aggregation premiums paid by tribal sponsors.	
31.v.	**Instructions for the Application for Indian-Specific Exemptions** **ACTION: Guidance** **NOTICE:** Instructions for the Application for Exemption for American Indians and	CMS (no reference number) **See also 31.q.** Issue Date: 1/10/2014 Due Date: 1/13/2014	TTAG recommendations (see attachment below for specific line edits)-- 1. **Page 1, first bullet and Step 2, Item 7**: CMS should add language to the instructions for these items to clarify that "member of an Indian tribe" includes Alaska Native village members and Alaska Native Claims Settlement Act (ANCSA) shareholders. 2. **Step 2, Item 8**: To address concerns that non-pregnant AI/AN women eligible for a Regulatory Hardship Exemption will not understand they should complete more of the	No subsequent Agency action taken (as of 2/28/2014).

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

RRIAR Ref. #	Short Title/Current Status of Regulation/ Title/Agency	File Code & Dates	Summary of NIHB and/or TTAG Recommendations	Evaluation of Subsequent Rule Issued/ Action Taken by Agency
	Alaska Natives and Other Individuals who are Eligible to Receive Services from an Indian Health Care Provider **AGENCY:** CMS	TTAG File Date: 1/13/2014 Date of Subsequent Agency Action, if any:	application, CMS should emphasize the word "only" in the instructions for this item. 3. **Step 2, Items 10 and 11**: CMS should change the language in the instructions for these items and add examples to clarify how to complete these questions on the application; alternatively, the Agency could add an introduction that reads, "If you are an AI/AN and eligible for services from an Indian Health Care Provider even if you are not pregnant and without regard to your marital status, age, or place of residence, you do not need to respond to Items 10 or 11." 4. **Step 2, Items 7, 8, 9, and 10 and Introduction to the Tables, Second Paragraph**: For clarification purposes, CMS should change all instances of "you're" to "you are" in the instructions for these items. 5. **Introduction to Tables, Second Paragraph**: CMS should add the word "only" to the second sentence in this paragraph to emphasize that applicants who can supply the documents listed in Table 1 do not have to supply the documents listed in Table 2; in addition, in the introduction to Table 1, CMS should avoid emphasis on the "Federally recognized tribe" language to prevent confusion about which exemption applies to ANCSA shareholders. 6. **Table 1, Rows 1 and 2**: CMS should add a reference in these rows to the Certificate of Degree of Indian Blood (CDIB), which the Bureau of Indian Affairs (BIA) or a Tribe can issue and which often serves as the only form of proof of tribal membership to which AI/ANs have access. 7. **Table 1, Row 3**: CMS should revise this row to describe fully the categories of Indians entitled to health care services provided by IHS under the Indian Health Care Improvement Act.	

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

RRIAR Ref. #	Short Title/Current Status of Regulation/ Title/Agency	File Code & Dates	Summary of NIHB and/or TTAG Recommendations	Evaluation of Subsequent Rule Issued/ Action Taken by Agency
			 Instructions for AIAN Exemption App-Tribal	
31.w.	**Q&A on Cost-Sharing Reductions for Contract Health Services** **ACTION: Guidance** **NOTICE:** Question and Answer on Cost-Sharing Reductions for Contract Health Services **AGENCY:** CCIIO	CCIIO (no reference number) Issue Date: 1/8/2014 Due Date: 1/14/2014 TTAG File Date: 1/14/2014 Date of Subsequent Agency Action, if any: Issued Final Guidance 2/18/2014	TTAG recommendations (see attachment below for specific line edits)-- 1. **"Contract Health Service" Language**: CMS should make the language of this guidance consistent with the statutory definition of "contract health service" found at 25 USC § 1603(5); this definition includes both services for which an Indian health program might pay and those for which it might not pay. 2. **Cost-Sharing Language**: CMS should add language to the last paragraph of this guidance to clarify that the Indian health program referral eliminates any cost sharing, including at the time of initial service.  TTAG Response to CMS on CMS guidance	In the 2/18/2014 Final Guidance-- 1. **"Contract Health Service" Language**: Accepted. In reference to the term "contract health service," CMS added the phrase "as defined in 25 U.S.C. 1603(5) and any implementing guidance." 2. **Cost-Sharing Language**: Not accepted. CMS did not add this language and deleted the last paragraph entirely. The attachment below compares the last draft and the Final Guidance. The addition of the following bullet marked the most significant change: • A copy of the referral. (We note that many of the required elements above may be contained in the referral itself.) The last draft included the statement, "To document eligibility for reimbursement … the issuer must retain documentation that

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

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				includes the following information," and listed four elements, but it did not explicitly state that the issuer must retain a copy of the referral (as did the Final Guidance). Comparison- CCIIO CHS cost sharing guid
39.c.	**Basic Health Program: Federal Funding Methodology for 2015** **ACTION: ~~Proposed~~ Final Methodology** **NOTICE:** Basic Health Program: ~~Proposed~~ Final Federal Funding Methodology for Program Year 2015 **AGENCY:** CMS	CMS-2380-~~P~~FN Issue Date: 12/23/2013 Due Date: 1/22/2014 TTAG File Date: 1/22/2014; TSGAC also filed comments 1/22/2014 Date of Subsequent Agency Action, if any: Sent Final	TTAG recommendations-- 1. **CSSR Calculation:** With one exception discussed below under "Reference Premium", we support the proposed payment methodology to account for the CSRs in the PTC calculation in the ACA that are particular to American Indians and Alaska Natives as it appears that this methodology will result in an equivalent (or 95 percent) amount of resources available to a state for this purpose. 2. **Reference Premium:** CMS should modify the proposed methodology for determining federal payments to states for the Basic Health Program (BHP) to account for the likelihood that AI/ANs will elect to enroll in a bronze-level qualified health plan (QHP) that consumes the entire premium tax credit (PTC) available to them or their family. Doing so will result in the premium tax credit amount being properly calculated, which will also ensure the full value of the CSR amounts are calculated, and provided to states. 3. **Premium Tax Credit Adjustment**: For any AI/AN-specific adjustment in the formula for PTC payments to states, CMS should ensure it accounts for the likelihood that AI/ANs who	No subsequent Agency action taken (as of 2/28/2014).

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

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		Methodology to OMB 2/11/2014	enroll in a QHP through an Exchange will expend the full value of the PTC available to them. 4. **Application of AI/AN-Specific Protections Under BHP**: CMS should condition the receipt by a state of the payment adjustment for AI/AN-specific benefits and protections on its agreement to ensure that, in its implementation of BHP, AI/ANs will receive protections equivalent to those they would have received by enrolling in a QHP through an Exchange.	
50.t.	**QHP Quality Rating System Measures and Methodology** **ACTION: Request for Comment** **NOTICE:** Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology	CMS-3288-NC Issue Date: 11/22/2013 Due Date: 1/21/2014 TTAG File Date: 1/21/2014 Date of Subsequent Agency Action, if any:	TTAG recommendations-- 1. **Information on Access to I/T/U Providers**: To address the need for timely and accurate information on the inclusion of I/T/U providers in qualified health plan (QHP) networks, CMS should add the following individual QRS measures: • Number of I/T/U providers in the geographic area served by the QHP; • Number of I/T/U providers in the geographic area served by the QHP considered in-network providers; and • Percentage of I/T/U providers in the geographic area served by the QHP considered in-network providers. 2. **Information on AI/AN Member Experience**: To ensure that QHPs help AI/ANs understand and obtain the many AI/AN-specific protections provided by ACA, TTAG, in comments filed on 12/2/2013, recommended that CMS add to the QHP	No subsequent Agency action taken (as of 2/28/2014).

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

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	AGENCY: CMS		Enrollee Survey an AI/AN-specific section with a number of topics, and by adopting these recommendations, CMS will have the information necessary to add the following individual QRS measures: • Percentage of AI/AN members who are aware of the availability of I/T/Us as in-network providers in the QHP; • Percentage of claims denied by the QHP, in full or in part, for services provided at an I/T/U; • Percentage of AI/AN members who have ever had cost sharing in any circumstances in which ACA exempts them; • Percentage of AI/AN members who have entered disputes with the QHP over cost sharing, as well as the percentage of resolved disputes; and • Percentage of AI/AN members who positively rate their experience with QHP personnel. 3. **AI/AN-Specific CAHPS Measures**: QRS, as proposed, includes 13 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures, but these measures might not reflect the special circumstances and needs of AI/ANs; the American Indian Survey--which CAHPS developed in 2004-2005 to help establish benchmarks for AI/AN patient experiences, whether at I/T/U or non-I/T/U facilities--produces a number of AI/AN-specific measures, and CMS should add these measures as individual QRS measures.	

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

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65.	**Health Care Reform Insurance Web Portal Requirements** **ACTION: Request for Comments** **NOTICE:** Health Care Reform Insurance Web Portal Requirements **AGENCY:** CMS	CMS-10320 Issue Date: 8/15/2012 Due Date: 9/13/2012 TTAG File Date: 9/13/2012; ANTHC also filed comments 9/13/2013 Date of Subsequent Agency Action, if any: Issued revision 2/3/2014 **Due Date: 4/1/2014**	TTAG recommendations-- The collection and dissemination of information on health plans will provide information that is necessary for individuals to make educated decisions about plan options, but two areas exist where additional information specific to AI/ANs would improve the quality and utility of the information collected, resulting in a decrease in the information collection burden AI/ANs experience when securing health insurance and accessing health care services: 1. **Use of the Health Care Reform Insurance Web Portal to Facilitate Tribal Sponsorship**: One critical element to consider when selecting a plan is the net premium and cost-sharing amounts an applicant will be responsible for paying, after any available premium assistance. For AI/ANs, premium assistance might include "Tribal Sponsorship." Tribal Sponsorship models envision interested tribes and tribal organizations paying all or part of an AI/AN applicant's share of the premium for a health insurance plan secured through a Health Insurance Exchange (Exchange). Although not currently designed to do so, the Health Care Reform Insurance Web Portal could provide an opportunity to collect, and then disseminate, information on potential Tribal Sponsorship options for AI/AN applicants. CMS should consider establishing such a mechanism to gather and disseminate information on Tribal Sponsorship options. HHS could establish a Web portal to facilitate Tribal Sponsorship that mirrors the functionality of that described in	In the 2/3/2014 revision-- Unable to determine whether CMS responded to these recommendations

RRIAR Ref. #	Short Title/Current Status of Regulation/ Title/Agency	File Code & Dates	Summary of NIHB and/or TTAG Recommendations	Evaluation of Subsequent Rule Issued/ Action Taken by Agency
			this Request for Comment. The Web portal would provide tribes and tribal organizations with a password protected mechanism to submit and update information on Tribal Sponsorship to HHS, including providing contact information for specific tribes offering Tribal Sponsorship and/or contact information for a tribal organization that may coordinate Tribal Sponsorship for multiple tribes. The information would be made available to Exchange enrollment staff, applicant assisters (such as Navigators and in-person assisters), as well as through healthcare.gov to help AI/ANs make educated decisions about their insurance options, including the availability of assistance with premiums that may be available through Tribal Sponsorship. At a minimum, HHS should develop a tribal Web portal capacity that enables some static information to be made available by tribes to the Exchange/call center staff so that the information could then be made available to AI/AN applicants during the Exchange application process. 2. **Inclusion of Indian Health Care Providers in Posted Information on Plan Provider Networks**: Many AI/ANs receive a majority of their health services through I/T/Us. As AI/ANs use the Web site to select a plan, it is critical that they know whether or not their usual Indian Health Care Provider is in the plan's network of providers. Rather than look for the name of a specific doctor, AI/ANs might look for the name of the I/T/U facility where they are most likely to seek care. Health plans should supply this information to HHS, and the department (and Exchanges) should post this information. Although Federal law allows I/T/U providers to bill health	

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			plans for services provided to the plan's enrollees whether or not the I/T/U provider is in the plan's network, it is preferable that the I/T/U be part of a plan's network to facilitate coordination of care, minimize duplication of services, and provide greater certainty to the I/T/U providers in the timeliness and amount of payments.	
184.a.	**Clinical Laboratory Improvement Amendments Regulations** **ACTION: Request for Comment** **NOTICE:** Clinical Laboratory Improvement Amendments (CLIA) Regulations **AGENCY:** CMS	CMS-R-26 Issue Date: 10/4/2013 Due Date: 12/3/2013 NIHB File Date: None Date of Subsequent Agency Action, if any: Issued extension 12/6/2013 Due Date: 1/6/2014 ANTHC File	ANTHC recommendations-- 1. **Burden Estimates**--CMS should: • a. Increase the burden estimates assigned to enrollment and successful participation in proficiency testing (PT) to reflect practical experience and to recognize special circumstances (e.g. limited federal funding, remote lab sites, and transient employees) affecting IHS and tribal health programs; and • b. Clarify the burden estimate for each step in the PT process (i.e. receipt and handling, testing, reporting, and director review/analysis) to facilitate the accuracy of information collection pertaining to PT, as without these changes, the Agency will continue to underestimate the difficulty and time required for laboratories (particularly IHS and tribal facilities) to comply with reporting requirements. 2. **CLIA Reporting Process**--CMS should initiate a formal rulemaking procedure with an associated Notice and Comment period to substantively amend and streamline the	No subsequent Agency action taken (as of 2/28/2014).

National Indian Health Board

TABLE C: NIHB RECOMMENDATIONS AND EVALUATION OF AGENCY'S SUBSEQUENT ACTIONS UPDATED THROUGH 2/28/2014

RRIAR Ref. #	Short Title/Current Status of Regulation/ Title/Agency	File Code & Dates	Summary of NIHB and/or TTAG Recommendations	Evaluation of Subsequent Rule Issued/ Action Taken by Agency
		Date: 1/6/2014	CLIA reporting process; through this procedure, to lessen the burden of IHS and tribal facilities in meeting competency assessment requirements and increase the relevance of these requirements to evaluate competency of all testing personnel, the Agency should: • a. Develop an alternate option for competency assessment, similar to the recent alternate quality control option allowed by 42 CFR § 493.1250; and • Include exceptions for actions falling under § 493.1840(b) or its amendments to allow lesser penalties that will not impact the CLIA certificate(s) of the laboratory director.	