Category	Comment Summary	Resolution
3rd party access	Add data use agreement	Out of scope for this document
3rd party access	Provide information on how CMS intends to use the information it collects under this PRA	Out of scope for this document
3rd party access	Create a contact registry for all third-party users	Out of scope for this document
Burden	Increase burden estimates	We have modified the burden estimates for the data collection.
Compliance	Treat as a trial or "soft rollout" year.	HHS Notice of Benefit and Payment Parameters for 2016 establishes that 45 CFR 156.122(d)(1)(2) and 156.230(c) are effective on January 1, 2016.
Compliance	CMS should have a requirement that all plans prominently list on their directories an email address or phone number for members of the public to directly notify the plan when provider directory information is inaccurate, and a requirement that plans be accountable for investigating these reports and modifying directories accordingly in response	Out of scope for this document
Compliance	CMS should have a requirement that plans internally audit their directories and modify directories accordingly based on audit findings	Out of scope for this document
Compliance	CMS should have a requirement that plans contact providers listed as in network who have not submitted claims within the past six months to determine whether the provider still intends to be in network.	Out of scope for this document
Compliance	CMS should have a requirement that plans honor provider directory information	Out of scope for this document
Data collected	Remove network tier from plans.json	We propose collecting the network tier field in order for issuers to distinguish between types of providers

Data collected	Remove Drug Tier and Cost Sharing	We believe collecting drug tier and cost sharing information is important for consumers and propose collecting drug tier and cost sharing data
Data collected	Remove plan contact	We propose collecting an email address in order to contact issuer with questions about the data.
Data collected	Clarify that issuers need not include the names of hospital-based providers in the JSON files	We propose clarifying language that hospital-based providers need not be included in the JSON files
Data collected	clarify NPI use; make middle name optional	We propose clarifying language regarding NPIs. CMS changed collection of middle name to an optional field.
Data collected	allow multiple addresses for providers	The JSON format allows for multiple addresses for providers.
Data collected	delete specialty field	We believe collecting provider specialty information is important for consumers and propose collecting specialty field.
Data collected	delete "accepting patients" field	We believe providing information about whether or not a provider is accepting new patients is important for consumers and will collect that data.
Data collected	delete facility type	We propose collecting facility type in order to aid consumers.
Data collected	Remove drug-name	We propose collecting drug names in order to aid consumers.
Data collected	Remove quantity limits	We propose collecting information about whether or not a formulary drug is subject to quantity limits in order to aid consumers.
Data collected	Remove drug tiers	We propose collecting drug tier information in order to aid consumers..

Data collected	Remove cost-sharing sub-type	We propose collecting cost-sharing sub-type in order to aid consumers.
Data collected	Include formulary URL	We added an optional field to collect the formulary URL displayed to consumers and currently provided in the QHP certification templates.
Data collected	Include formulary ID	We propose collecting an optional field to collect the formulary ID.
Data collected	Remove "not less than monthly"	The requirement to collect provider data not less than monthly is a regulatory requirement and beyond the scope of this document. As proposed in the Supporting Statement, issuers would update formularies for machine-readable purposes at least monthly. As a point of clarification, the standard for issuers' own websites is that formularies must be up-to-date pursuant to 45CFR156.122(d)(1).
Data collected	Add date of last update to provider json	We propose adding a required field to collect the date of last update.
Data collected	Add cost-sharing associated with the specific network or formulary sub-type and network tiers	We propose collecting cost-sharing and network tier information.
Data collected	Add physical accessibility of providers' office	We will consider this comment for future enhancements.
Data collected	Recommend RxCUI source be the same for prescription drug template and updated regularly	Out of scope for this document
Data collected	Recommend issuers only show providers for the state where they are offering coverage, plus bordering states where consumers could cross borders for services	Out of scope for this document
Data collected	Recommend no pharmacies or laboratories be included	We believe providing information about pharmacies and laboratories is helpful for consumers and propose including this

		information in the data collection.
Data collected	Recommend only 2016 plans display, not 2015 plans which might be available through SEP	HHS Notice of Benefit and Payment Parameters for 2016 establishes that 45 CFR 156.122(d)(1)(2) and 156.230(c) are effective on January 1, 2016.
Data collected	Include specific descriptions of any available telemedicine services	We agree and have added an optional field to capture whether telemedicine services are available.
Data collected	Work with issuers to find out if claims payment systems or databases could be used to obtain accurate and timely information about which providers are in network	Out of scope for this document
Data collected	Allow future effective date providers	We will consider this comment for future enhancements and guidance.
Data collected	Include primary care status indicator	We believe this indicator could cause confusion due to the number of providers who can be both primary and specialty providers. We do not propose including a primary care provider indicator.
Dental	Reporting on dental providers in this framework should be required of both SADPs and major medical plans with "embedded" dental benefits	SADPs must meet all QHP requirements (except formulary requirements) unless otherwise specified. This includes off-Marketplace SADPs, as they are required to be the same as on-Marketplace SADPs in order to be certified. We expect SADP issuers to adhere to machine-readable requirements for off-Marketplace SADPs.

Dental	Recommend that CMS consider the unique characteristics of dental providers when finalizing these fields. For example, "facility type" for a dental provider may be different than for other types of major medical providers. Specialty type is also unique for dental providers	We will consider this comment for future enhancements.
Dental	Stand-alone dental plans offering exchange certified off-exchange policies should be exempt from the machine-readable requirements	SADPs must meet all QHP requirements (except formulary requirements) unless otherwise specified. This includes off-Marketplace SADPs, as they are required to be the same as on-Marketplace SADPs in order to be certified. We expect SADP issuers to adhere to machine-readable requirements for off-Marketplace SADPs.
Dental	If stand-alone dental plans are not exempt from this requirement then CMS should phase in the machine-readable requirements for "Exchange certified" dental networks starting in 2017	HHS Notice of Benefit and Payment Parameters for 2016 establishes that 45 CFR 156.122(d)(1)(2) and 156.230(c) are effective on January 1, 2016.
Guidance	CMS should provide guidance around what to do if there is no RxCUI yet and provide a default value so that drug appears for consumer	Out of scope for this document
Integration	We urge CMS to look into creating integrated provider directory and formulary capabilities for heatlthcare.gov as soon as possible	Out of scope for this document
JSON	Urges CMS to go further; reference a set of consumer protection principles for provider directories, which may be helpful in terms of implementing §156.230(b) and §156.122(d).3; http://consumersunion.org/wp-content/uploads/2014/12/Provider_Directories_principles_1214.pdf	We agree that the ability to find providers proficient in languages other than English and provider sex is important. We propose adding optional fields for language other than English and provider sex to the JSON file. CMS will consider remaining suggested fields for future enhancements.
JSON	Change format to "XML or CSV format"	After investigation, we determined that the JSON file format is appropriate for this data collection.

JSON	Standards will lead to consumer confusion due to (1) the enormous challenges to maintaining and improving the accuracy and timeliness of data; (2) the lack of standardized data definitions; (3) the interplay between provider and formulary data and the benefit designs and coverage rules of the associated QHPs; (4) the highly compressed compliance and testing timelines leading up to open enrollment for 2016; and (5) the potential for even greater inaccuracies when third party software developers are given carte blanche with issuers' information	We propose including disclaimer language at access points to the data.
JSON	Questions about plan schema references	We propose clarifying language.
JSON	Recommend specifying that the level of data files be at the issuer level.	We believe that in order to provide adequate information to consumers, data must be collected at the plan level.
JSON	CMS should provide a data dictionary	We agree with the importance of understandable terms. We propose clarifying language and examples in the JSON file.
JSON	Include control totals in each file	Out of scope for this document
JSON	Qualifier values for copay and coinsurance fields are listed as non-required fields. These should be required fields	We agree with the commenter and propose these qualifiers be required fields
JSON	The "machine readable" requirement should be more explicitly defined as it pertains to the proposed schema. It should be stated that to meet this requirement, a file should pass an agreed upon schema validator. There's already one configured for the propose QHP schema: https://github.com/adhocteam/qhpvalidator	Out of scope for this document
JSON	For future maintainability, add a field that identifies the exact version of the schema. Perhaps using describedBy field and conformsTo fields, as is done for data.gov's Common Core Schema.	We propose a required field to collect the date of last update.

JSON	For the sake of consistency and minimizing confusion and redundancy, consider using fields (and naming convention) already in use from "adjacent" domains	We will consider this comment for future enhancements.
JSON	Fields specified by Medicare for a Model Provider Directory , consider adding these: i. plan.json 1. Description of plan's service area 2. Customer service phone number 3. Customer service hours of operation 4. Network services: healthcare/vision/dental ii. provider.json 1. Provider type is defined more specifically: PCPs, Specialists, Hospitals, Skilled Nursing Facilities, Outpatient Mental Health Providers, Pharmacies (rather than Individual, Facility) 2. Neighborhood for larger cities (optional) 3. Provider website & email address (optional) 4. Provider supports eprescribing	We will consider this comment for future enhancements.
JSON	Propose implementing a proof of concept on the proposed schema with Medicare Advantage plans, as a way to more adequately assess the burden and schema effectiveness, as well as serving as a concrete example for QHPs to follow.	CMS does not contemplate using Medicare Advantage plans for proof of concept.

Legality	This requirement seems to have no basis under Public Law 111-148 (cited in the Notice of Proposed Collection) as passed by Congress and enacted in March 2010. A requirement IS created therein for GAO Comptroller General to "conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges" to assess the ability of networks to support enrollees in Federal Government health programs. However, this mandate upon GAO doesn't appear to be assumed by CMS on GAO's behalf. CMS CCIIO appears to be overreaching it's authority in requiring this specific public disclosure by Issuers.	Out of scope for this document
Legality	The requirement for disclosure of Network and Formulary content would appear to be discriminatory. The requirement is placed upon Issuers of QHP coverage, with the presumed intent to protect and serve those persons therein covered. HOWEVER, the requirement ignores persons covered by Plans or Benefits NOT designated as a Qualified Health Plans, but which are still subject to rules and regulations promulgated by CMS. In this manner, it would appear that CMS 1) ignores a large segment of the U.S. population who may benefit from any analysis or enforcement resulting from the disclosure requirement; 2) chooses to subject a minority of the U.S. healthcare Issuer community and Plans to the requirement. CMS should broaden it's perspective of what's important in investigating and addressing presumed issues in the Insurance and Healthcare reimbursement community to include ALL PLANS subject to CMS regulation.	We considered broadening requirements for formularies but believe we should see how successful this implementation is, first. States certainly have the option to create such requirements for market wide plans. We do not impose network adequacy requirements on market-wide plans, which is why we did not propose provider directory requirements on them.

Legality	CMS again ventures far beyond the bounds of it's regulatory authority in pushing forward with this requirement. While 45 CFR 156.230 (b) requires network content to be made available via the Internet and written form, it makes no representation as to how publicly available data files will meet the basic litmus of the title of 156.230 (c) Increasing consumer transparency. CMS seems wanton to attempt for QHP Consumer Advocates what it cannot accomplish for Medicare or Medicaid participants or their advocates, centralize a database of allowable/contracted/network/reimbursable providers. For that standpoint, it appears Medicaid and Medicare participants are given short shrift, to the detriment of these more needy populations.	CMS provided notice and comment opportunities regarding this policy about this provision in the Payment Notice. Medicare Part D uses a similar tool in which enrollees can enter their prescription drugs. We believe this will be a useful tool for Marketplace consumers.
Partnership	Asks that CMS work with SBMs to implement a national standard	Out of scope for this document; the Payment Notice final9ized requirements for FFMs only
RxNorm update	RxNorm should be updated on a monthly basis	Out of scope for this document
Terminology	Clarify intended users "third-parties" or "software developers" or "developers" or "marketplace consumers" or "enrollees"	The Payment Notice states that the purpose of establishing machine-readable files with this data would be to provide the opportunity for third parties to create resources that aggregate information on different plans, and that a machine-readable file or format will increase transparency by allowing software developers to access this information and create innovative and informative tools to help enrollees better understand plan's formulary drug lists and provider directories.

Terminology	Recommend that CMS clarify that consumers do not have access to these files on the issuer's websites. Consumers will not understand the information presented in this format (whether JSON or another format).	The Payment Notice states that the purpose of establishing machine-readable files with this data would be to provide the opportunity for third parties to create resources that aggregate information on different plans, and that a machine-readable file or format will increase transparency by allowing software developers to access this information and create innovative and informative tools to help enrollees better understand plan's formulary drug lists and provider directories.
Terminology	We also are not clear on the terminology of exactly what information is being collected. In some places, the information to be collected is with respect to formularies but other places refer to formulary data, prescription formulary, formulary information or formulary drug list. The final CMS rule at §156.120(d)(i) requires plans to publish "a complete list of all covered drugs on its formulary drug list."	We propose some modified language to clarify the requirements.
Terminology	We also strongly urge that CMS confirm that plans do not have to include all formulations of drugs on the formulary.	We propose collecting drug information based upon unique RxCUI, which includes all drug formulations.
Terminology	Clarify whether Summary of Benefits and coverage is required (says "Yes" instead of "Always."	We agree and have and propose the requirement "Always."
Timing	CMS should complete analysis, design, development, and external testing of JSON files and the interfaces with the new search field in the healthcare.gov learning window by no later than the end of August	Out of scope for this document
Timing	Finalize the PRA requirements as soon as possible	We agree with the importance of finalizing the PRA and intend to finalize as soon as possible within PRA process timeframes.

Timing	Recommend plans be given the opportunity to review how their JSON data will appear on HealthCare.gov prior to November 1st	We agree with the importance of issuers viewing and testing their data and propose allowing issuers the ability to view their data within the commenters timeframe.
Timing	We seek a delay in effective date until 2017.	HHS Notice of Benefit and Payment Parameters for 2016 establishes that 45 CFR 156.122(d)(1)(2) and 156.230(c) are effective on January 1, 2016.
Timing	CMS could pilot this initiative and see how it works in a few states for formulary drugs lists.	HHS Notice of Benefit and Payment Parameters for 2016 establishes that 45 CFR 156.122(d)(1)(2) and 156.230(c) are effective on January 1, 2016.
Timing of data updates	We urge CMS to affirm that, as a general standard, consumer-facing formulary drug lists need not be updated more frequently than monthly and that implementation of formulary changes need not be delayed while awaiting updates to consumer-facing lists...in indicating that the machine-readable formulary information need be updated no more frequently than once a month, CMS acknowledges that it is not necessary for all publicly available formulary information to be completely up-to-date at all times	As proposed in the Supporting Statement, issuers would update formularies for machine-readable purposes at least monthly. As a point of clarification, the standard for issuers' own websites is that formularies must be up-to-date pursuant to 45CFR156.122(d)(1).