Medicare
Intermediary Manual
Part 2 – Audits, Reimbursement, Program Administration

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1834

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2958 - 2959	2-906.1 - 2-906.8 (10 pp.)	2-906.1 - 2-906.8 (10 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: 10/01/2000*
IMPLEMENTATION DATE: May 3, 2002

Section 2958, Beneficiary Services, is revised to reflect Budget Performance Requirements (BPRs) implemented in FY 2001 and FY 2002 for beneficiary telephone customer service.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

2958. BENEFICIARY SERVICES

Every member of your customer service team should be committed to providing the highest level of service to our primary customer, the Medicare beneficiary. This commitment should be reflected in the manner in which you handle each beneficiary inquiry. The following guidelines are designed to help you ensure that this high level of service is provided.

A. Written Inquiries.--

1. Guidelines for Handling Written Inquiries.--Stamp all written inquiries with the date of receipt in the corporate mail room and control them until you send final answers. In addition:

- o Answer inquiries timely;
- o Do not send handwritten responses;
- o Contractors must include a contact's name and telephone number in the response;
- o Consider written appeal requests as valid if all requirements for filing are met. These requests need not be submitted on prescribed forms to be considered valid. If appeal requests are valid, they are not to be considered written inquiries for workload reporting;
- o The CMS Alpha Representation must be on all responses; and
- o Keep responses in a format from which reproduction is possible.

2. Guidelines for High Quality Written Responses to Inquiries.--Contractors must have a correspondence Quality Control Program (containing written policies and procedures) that is designed to improve the quality of written responses. In addition, contractors must perform a continuous quality review of outgoing letters, computer notices, and responses to requests for appeals of initial determinations. This review consists of the following elements:

a. Accuracy.--Content is correct with regard to Medicare policy and your data. Overall, the information broadened the inquirer's understanding of the issues which prompted the inquiry.

b. Responsiveness.--The response addresses the inquirer's major concerns and states an appropriate action to be taken.

c. Clarity.--Letters have good grammatical construction, sentences are of varying length (as a general rule, keep the average length of sentences to no more than 12-15 words), and paragraphs generally contain no more than five sentences. All written inquiries are to be processed using a font size of 12, and a font style of Universal or Times New Roman, or another similar style for ease of reading by the beneficiary.

Contractors must make sure that responses to beneficiary correspondence are clear; language must be below the 8th grade reading level, unless it is clear that the incoming request contains language written at a higher level. Contractors may use a software package to verify that responses to beneficiary inquiries are written at the appropriate reading level. Whenever possible, written replies should contain grammar comparable to the level noted in the incoming inquiry.

d. Timeliness.--Substantive action is taken and an interim or final response is sent within 45 calendar days from receipt of the inquiry. In instances where a final response cannot be sent within 45 calendar days (e.g., inquiry must be referred to a specialized unit for response), send an interim response acknowledging receipt of the inquiry and the reason for the delay.

If you are responsible for handling both Part A and Part B claims, inquiries requiring responses from both of these areas share the same timeframe for response (i.e., the 45-day period starts on the same day for both responses). Ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is most efficient for your conditions. If you respond separately, each response must refer to the fact that the other area of inquiry will be responded to separately. Every contractor will have the flexibility to respond to beneficiary written inquiries by phone within 45 calendar days. A report of contact should be developed for tracking purposes. The report of contact should include the following information:

- Beneficiaries name and address;
- Telephone number;
- Beneficiaries HICN;
- Date of contact;
- Internal inquiry control number;
- Subject;
- Summary of discussion;
- Status;
- Action required (if any); and
- The name of the customer service representative who handled the inquiry.

Upon request, send the beneficiary a copy of the report of contact that results from the telephone response. The report of contact should be retained in the same manner and time frame as the current process for written responses. Use your discretion when identifying which written inquiries (i.e., beneficiary correspondence that represent simple questions) can be responded to by phone. Use the correspondence which includes the requestor's telephone number, or use a requestor's telephone number from internal records if more appropriate for telephone responses. If you cannot reach the requestor by phone, do not leave a message for the beneficiary to return the call. A written response should be developed within 45 calendar days from the incoming inquiry.

e. Tone.--Tone is the touch that brings communication to a personal level and removes the appearance that a machine-produced response was used. Appraise all responses, including computer-generated letters and form letters, for tone to make them user-friendly and comprehensible by the reader.

f. E-mail Inquiries.--Any e-mail inquiry received can be responded to by e-mail, **with the exception shown below.** Since e-mail represents official correspondence with the public, it is paramount that contractors use sound e-mail practices and proper etiquette when communicating electronically. However, ensure that e-mail responses utilize the same guidelines that pertain to written inquiries (i.e., timeliness, accuracy, clarity, tone, comprehension, etc.). **Exception:** Responses that are personal in nature (contain financial information, HICN, etc.) cannot be answered by e-mail.

B. Telephone Inquiries.--The guidelines established below apply to all calls to telephone numbers established as beneficiary inquiry numbers. To ensure all inquiries are handled as expeditiously as possible, inbound beneficiary inquiry numbers (and the lines) must be separate from provider inquiry numbers. Providers cannot use numbers established for inquiries from beneficiaries.

1. Availability of Telephone Service.--Make live telephone service available to callers continuously during normal business hours including break and lunch periods. On Federal Holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work, e.g., provide CSR training. Contractors shall notify CMS via the Beneficiary Network Services (BNS) contractor no later than 60 days prior to any planned call center closures. The BNS can be reached by calling 1-866-804-0685. In any situation where CSRs are not available to service callers, CMS reserves the right to re-route call traffic within the network to ensure that callers receive the best possible service. Call center staffing should be based on the pattern of incoming calls per hour and day of the week ensuring that adequate coverage of incoming calls throughout the workday is maintained in accordance with call center standards.

Although the beneficiary should have the ability to transfer to a CSR during operating hours, automated "self-help" tools, such as interactive voice response (IVR) units, may also be used to assist with inquiries. CMS is currently testing Medicare beneficiary IVR scripts with the intent of implementing them at either selected or all call centers depending on the findings of the test. In the interim, contractors are encouraged to increase the use of existing IVRs based upon lessons learned and "best practices" throughout CMS and its partners. IVRs should be updated to address areas of beneficiary confusion as determined by the contractor's inquiry analysis staff and CMS best practices. Contractors updating IVR scripts may request a copy of the Medicare Beneficiary IVR script being tested to use as guidance with script modifications.

Part A intermediaries utilizing IVR technology to assist beneficiaries in obtaining answers to various Medicare questions, may offer the following information:

- Contractor hours of operations for live service provided after hours or during peak times when a caller is waiting on hold;
- General Medicare program information; (These requests as well as those for Medicare publications should be referred to 1-800 Medicare.)
- Specific information regarding claims in process and claims completed;
- A statement if additional evidence is needed to have a claim processed; and
- General information about appeal rights and actions required of a beneficiary to exercise these rights.

It is recommended the IVR be available to beneficiaries from 6 a.m. to 10 p.m. in their local prevailing time, Monday through Friday; and from 6 a.m. to 6 p.m. on weekends and holidays (if these holidays are part of your normal business non-operating hours).

Allowances for claims processing system and mainframe availability, as well as for normal IVR and system maintenance shall be made. Contractors should identify what services can be provided to beneficiaries during times when the processing system is not available. Print and distribute a readily understood IVR operating guide to Medicare beneficiaries upon request.

Intermediaries utilizing IVR technology should report the IVR handle rate which is the number of calls delivered to the IVR in which the beneficiary receive the information they require from the system.

2. Toll-Free Telephone Service.--CMS will be expanding toll-free service for beneficiaries to all Part A intermediaries. This will be accomplished through a new government-wide telephone contract negotiated by the General Services Administration. This telephone service is known as Federal Telephone Service (FTS) 2001. CMS will coordinate the transition from local and non-FTS long distance carriers and the installation of any new telephone service lines to the FTS-2001 contract carrier, MCI/WorldCom.. All inbound beneficiary telephone service shall be handled over the toll-free FTS network. The costs associated with the installation and monthly fees for this toll-free service will be paid centrally by CMS. However, Medicare contractors will still be responsible for all other internal wiring and equipment (ACDs, PBX, etc.) and any local telephone services and line charges.

After the installation of the beneficiary FTS 2001 lines is completed, any **Level 2** beneficiary telephone network problems, **as defined below,** associated with these lines are to be reported to [a] **the** central **Beneficiary Network Services (BNS)** toll-free number, **1-866-804-0685.** In addition, all change requests regarding the FTS 2001 lines, (e.g., adding or removing T-1 circuits, changing the routing of incoming calls, etc.), **must** be processed through the **BNS** toll-free number.

Level 2 problems are defined to exclude the following items which are the responsibility of the individual call center management to address prior to contacting the **BNS:**

- The call center is still responsible for first level problem management. This includes fault isolation of call center equipment located on the premises that is used for access onto the FTS 2001 network and handling user trouble calls;

- Call center PBX, ACD, IVR, and CTI equipment problems including headsets, phones, computer hardware, and desktop applications will continue to be resolved by your internal call center technical support organization; and

- The call center is responsible for reporting, monitoring, and maintenance of their customer based premise equipment and CSAM's self reported data.

Any toll-free Medicare beneficiary customer service number provided and paid for by CMS must be printed on all beneficiary notices (MSN, EOMB, etc.) immediately upon activation. Display this toll-free number prominently so the reader will know whom to contact regarding the notice.

3. Inquiry Staff Qualifications.--Fully train CSRs to respond to beneficiary questions, whether of a substantive nature, a procedural nature, or both. CSRs who answer the telephone calls must be qualified to answer general questions about initial claims determinations, the operation of the Medicare program, and appeal rights and procedures. To ensure that these services are provided, CSRs should have the following qualifications:

- Good telephone communications skills;

- Sensitivity for special concerns of the Medicare beneficiaries;

- Ability to handle different situations that may arise; and

- Experience in Medicare claims processing and review procedures.

Prior experience in positions where the above skills are utilized, e.g., claims representative or telephone operator, is desired.

Provide a training program which includes technical instructions on Medicare eligibility, coverage, benefits, claims processing, Medicare systems and administration, use of the Medicare Intermediary Manual (MIM), telephone techniques, and the use of a computer terminal. The training program should also sensitize customer service personnel to the special needs of the elderly, e.g., difficulty in hearing.

4. Guidelines for High Quality Telephone Service.--Handle all beneficiary telephone inquiries in accordance with the guidelines shown below. All tasks related to this activity are mandatory and shall be reported to CMS' web-based Customer Service Assessment and Management System (CSAMS) each month. Standard definitions and detailed calculations for each of the required telephone customer service data elements are posted on the Telephone Customer Service website at https://www.hcfa.gov/medicare/callcenter.

a. Report total calls offered to the beneficiary call center for the month, defined as the number of calls that reach the call center's telephone system, which can be split up according to trunk lines in instances where a call center is taking calls for Part A, Part B and other non-CMS calls.

b. Program all systems related to inbound beneficiary calls to the center to acknowledge each call within 20 seconds (4 rings) before a CSR, IVR or automated call distributor (ACD) prompt is reached. This measure may not be required to be reported, but must be substantiated when requested.

c. Capture and report the number of callers attempting to access as well as those callers unable to access the call center via the toll-free lines in order for CMS to arrive at a monthly Access Rate. Any callers not being given access to a CSR due to any software, gate, vector, application, etc. should ensure that the call is captured as an "incomplete" call on the MCI WorldCom Interact.

d. Each month, answer no less than 85 percent of all callers who chose to speak with a CSR within the first 60 seconds.

e. Provide a recorded message advising callers waiting in queue to speak with a CSR of any temporary delay before a CSR is available. Use the message to also request that the beneficiary have certain information readily available (Medicare card) before speaking with the CSR. During peak volume periods, indicate in the message a preferred time to call.

f. Track and report call abandonment rate, which is the percentage of beneficiary calls that abandon from the CSR queue. This should be reported as two separate measures:

1) Calls abandoned up to and including 60 seconds; and
2) Calls abandoned after 60 seconds.

g. Report the monthly average speed of answer. This is the amount of time that all calls waited before being connected to a CSR. It includes ringing, delay recorder(s) and music.

h. CSRs must identify themselves when answering a call, however the use of *both* first and last names in the greeting will be optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR should provide both first and last name. Where the personal safety of the CSR is an issue, call center management should permit the CSR to use an alias. This alias must be known for remote monitoring purposes. CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

i. Track and report monthly average talk time (which includes any time the caller is placed on hold by the CSR), targeting call duration between 3 and 7 minutes (180-420 seconds).

j. Handle no less than 80 percent of calls to completion during the initial call minimizing transfers, referrals and callbacks.

k. Track and report call center handling productivity, calculated by the total calls handled divided by the total CSR FTEs in the center, setting a minimum performance objective of 1100 calls per FTE per month for Non-Medicare Customer Service Center (MCSC) call centers and 1000 calls per month for MCSC call centers. This should be accomplished by all call centers without sacrificing the quality of calls and with minimal referrals. MCSC call centers should take advantage of handling multiple issue calls (Part A, Part B, DME, etc.) without referral to ensure maximum utilization of the MCSC desktop.

l. Track and report occupancy rate, the percent of time that CSRs spend in active call handling (i.e., on incoming calls, after call work or outbound calls).

m. Track and report monthly average after call work time (wrap-time), which includes all the time that the CSR needs to complete all administrative work associated with call activity after the customer disconnects.

n. Report monthly the status of those calls not resolved at first contact. Those calls should be reported as follows:

1) Callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.

` ` 2) Callbacks closed within 5 workdays. This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month.

o. As needed, develop a corrective action plan to resolve deficient performance in the call center, and maintain results on file for regional office (RO) review.

p. Develop a proficiency test to be used for new CSRs and as needed for existing personnel. This test should include questions regarding basic aspects of the Medicare program such as benefits and claims processing; review procedures; questions to indicate familiarity with the system and ability to locate and interpret output; how to read information in the computer system and interpret beneficiary file material; new legislation or changes to policy and procedures; and include problems to solve which indicate ability to handle different situations that may arise such as seeking additional information,referring to specialized staff or involving Benefit Integrity Unit.

q. Maintain and operate a telephone device for the deaf such as TDD/TTY.

r. Maintain the ability to respond directly to telephone inquiries in both English and Spanish.

5. Customer Service Assessment and Management System (CSAMS).--CSAMS is a web-based vehicle for contractors to electronically report their call center's performance metrics. Each call center site must enter all required telephone customer service data elements between the 1st and the 10th of each month for the prior month. After the 10th of the month, users must call the CMS central office to change data.

6. Usage of Beneficiary Question & Answer on www.cms.hhs.gov.--CMS has established a website (www.cms.hhs.gov) that will contain Medicare information to be used in responding to beneficiary inquiries. Each time CMS posts information on this website at *http://www.cms.hhs.gov/faqs/partners/*, call center managers and regional offices will receive an e-mail from CMS central office alerting them to check the site for the new information. Upon receipt of e-mail notifications, call center managers must access this site to obtain the initial posted Medicare information.

CMS intends to provide updated information (primarily in a Q & A format) on frequently asked Medicare-related beneficiary questions. Call center managers are to provide the Q & As to all CSRs when responding to either telephone or written inquiries from beneficiaries for use as a desk reference. These Q & As will be useful in all forms of communication with beneficiaries. Whenever possible, in order to provide consistent and accurate responses from all Medicare contractors, CSRs are to use the CMS-provided responses for beneficiary inquiries.

As CMS develops additional beneficiary Q & As, they will continue to be posted on this site and all call center managers will be notified directly through e-mail. If the call center manager would like to designate another individual to receive their e-mail notifications, they may unsubscribe and provide another name and e-mail address.

7. Quality Call Monitoring Process.--Monitor, measure, and report the quality of service continuously by utilizing the CMS-developed quality call monitoring (QCM) process. Monitor an average of 3 calls per CSR per month. Monitor the calls in any combination of the following ways: Live remote, live side-by-side (shadow), or taped. Record all monitored calls on the standard scorecard, using the QCM chart as a guideline. Complete the scorecard in its entirety and give written feedback to the CSR in a timely fashion (for live calls, within 2 working days; for taped calls, within 7 working days), coaching and assisting the CSR to improve in areas detected during monitoring. If a CSR answers both beneficiary and provider calls, only 3 calls total per CSR per month need to be monitored.

Copies of the scorecard and chart may be obtained at the telephone customer service website at *https://www.hcfa.gov/medicare/callcenter*. Use only the official version of the scorecard posted at the website. The QCM reporting tools and format, also posted on the website, must be used to collect monitoring results which will be reported monthly in CSAMS. Train every CSR and auditor on the scorecard and chart and ensure that each person has a copy of the chart available for reference.

Where possible, rotate auditors regularly among the CSRs. Analyze individual CSR data regularly, identify areas needing improvement, implement and document corrective action plans. Analyze QCM data routinely to determine where training is indicated, whether at the individual, team, or call center level.

Monitor CSRs throughout the quarter, using a sampling routine. The sampling routine must ensure that CSRs are monitored at the beginning, middle and end of each month (ensuring that assessments are distributed throughout the week) and during morning and afternoon hours.

Participate in national and regional QCM calibration sessions organized by CMS. Conduct regular calibration sessions (monthly is a suggested minimum).

8. Calls Regarding Claims.--When a telephone representative receives an inquiry from a beneficiary about a claim, first verify that it is the beneficiary by gathering the following information: health insurance claim number, date of birth, full name, and one additional piece of information such as SSN, address, phone number, effective date(s), whether they have Part A and/or Part B coverage. Any information regarding the claim, including why the claim was reduced or denied, may then be discussed with the beneficiary.

If a relative of the beneficiary, an advocacy group, legal representative or friend calls regarding claims information, and the beneficiary has given verbal authorization, you may discuss any claims-related information with the beneficiary and the third party. The verbal authorization is good for 14 days. The CSR should suggest that the beneficiary send in a written authorization if he/she wants the caller to access his/her information for longer than 14 days.

When there is written authorization from the beneficiary authorizing an individual to act on their behalf regarding their Medicare claims, any claims-related information may be discussed with that individual. The written authorization must specify: A period of time, the authorized individual, what information may be disclosed/discussed with that individual, and must be signed and dated by the beneficiary.

When a relative of the beneficiary, an advocacy group, legal representative or friend, acting on behalf of the beneficiary, calls without written authorization, but has identifying information on the beneficiary (i.e., health insurance claims number, date of birth, and full name) and the claim itself (i.e., dates of service and, if applicable, an Explanation of Medicare Benefits (EOMB) claim control number), only the following information can be released:

- Claim has or has not been received;
- Claim has or has not been processed; and
- Beneficiary can expect an EOMB or MSN by a certain date.

If, as a result of a beneficiary inquiry, you discover an obvious error in a previous claims determination, take the necessary action to correct the record. Promptly process any payments due. If the beneficiary gives you information not shown on the record, and that information changes the payment amount, notify the beneficiary that he/she should request a review and indicate what information the beneficiary should provide with the request. Be as specific as possible. Inform the beneficiary he/she should submit the following, if it is available: letters explaining the necessity of the treatment, whether the service provided was more complicated than usual, or other evidence pertinent to the reason for denial or reduction. Remind beneficiaries that they can find information regarding their appeal rights in CMS publications, e.g., The Medicare Handbook, and on the back of their EOMB or MSN notices.

Do not tell the beneficiary that the reviewer will change the determination, but explain that he/she will examine the claim and any new information once a proper request is made. Advise the beneficiary that the review department will explain what constitutes a proper request and what information is needed.

For situations not specifically addressed here, the customer service representative (CSR) should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. The CSR should contact his/her supervisor or the organization's privacy official for determinations if he/she is unsure whether or not to disclose beneficiary-specific information.

Where appropriate, make a record of the telephone contact and of any action taken based upon such contact. Make the oral statements of the beneficiary a part of the file if it appears further action is necessary. This record may assist in establishing good cause in cases where the telephone contact occurs shortly before the deadline for requesting a review. This record will also document subsequent actions you take in the case.

9. Calls Regarding Fraud and Abuse.--If a caller indicates an item or service was not received, or that the provider is involved in some potential fraudulent activity, the

complaint should be screened for billing errors or abuse before being sent to the Benefit Integrity Unit. After screening has been performed, if abuse is suspected, the complaint would be handled by the Medical Review Unit. If fraud is suspected, the complaint should be forwarded to the Benefit Integrity Unit and the caller should be told the Benefit Integrity Unit will contact him/her about the complaint. Ask the caller to provide the Benefit Integrity Unit with any documentation he/she may have that substantiates the allegation. Give assurance that the matter will be investigated

10. Equipment Requirements.--To ensure that inquiries receive accurate and timely handling, provide the following equipment:

o On-line access to a computer terminal for each telephone representative responsible for claims-related inquiries to retrieve information on specific claims. Locate the computer terminal so that representatives can research data without leaving their seats;

o An outgoing line for call-backs; and

o A supervisor's console for monitoring telephone representatives' accuracy, responsiveness, clarity, and tone.

11. Telephone Directory Listings.--Effective with the publication of these instructions, intermediaries will not be responsible for the publication of their beneficiary inbound 800 service in any telephone directory. CMS will publish beneficiary inbound 800 numbers in the appropriate directories. No other listings are to be published by the intermediary.

12. Telephone Inbound Service Costs.--Effective with the transition to FTS-2001 service, CMS will pay for the rental of T-1/PRI lines and all connect time charges. These costs will be paid centrally by CMS and only for these telephone service costs. All other costs involved in providing telephone service to Medicare beneficiaries will be born by the contractor. Since these costs are not specifically identified in any cost reports, contractors must maintain records of all costs associated with providing telephone service to beneficiaries (e.g.costs for headsets) and provide this information upon request by RO or CO.

C. Walk-In Inquiries.--

1. General.-- Contractors should not actively publicize the walk-in function. However, give individuals making personal visits to you the same high level of service you would give through phone contact. The interviewer must have the same records available as a telephone service representative to answer any questions regarding general program policy or specific claims-related issues.

If a beneficiary inquires about a denied or reduced claim, give him/her the same careful attention given during a "hearing," i.e., the opportunity to understand the decision made and an explanation of any additional information which may be submitted when a review is sought.

Make the same careful recording of the facts as for a telephone response, if it appears further contact or a review will be required.

2. Guidelines for High Quality Walk-In Service.--

o After contact with a receptionist, the inquirer may meet with a service representative;

o Waiting room accommodations must provide seating;

o Inquiries must be completed during the initial interview to the extent possible; and

o Current Medicare publications must be available to the beneficiary.

D. Surveys.--CMS requires annual surveys of customer service operations to be completed by each contractor within the time frames and areas indicated on the specific notice. Examples include annual call center technology surveys, staffing profiles, training needs, etc..

2959. PROVIDER SERVICES

Every member of your customer service team should be committed to providing the highest level of service to our primary partner, the Medicare provider. This commitment should be reflected in the manner in which you handle each provider inquiry. The following guidelines are designed to help you ensure that this high level of service is provided.

A. Written Inquiries.--

1. Guidelines for Handling Written Inquiries.--Stamp all written inquiries with the date of receipt in the corporate mail room, and control them until you send final answers. In addition:

o Answer inquiries timely;

o Responses on speed memo forms may be hand-written. In all other cases, do not send hand-written responses;

o Consider written appeal requests as valid if all requirements for filing are met. These requests need not be submitted in the prescribed forms in order to be considered valid. If appeal requests are valid, they are not to be considered written inquiries for workload reporting; and

o Keep responses in a format from which reproduction is possible.

2. Guidelines for High Quality Written Responses to Inquiries.--Perform a continuous quality appraisal of outgoing letters, computer notices, and responses to requests for appeal of an initial determination. This appraisal consists of the following elements:

a. Accuracy.--Content is correct with regard to Medicare policy and your data. Overall, the information broadened the inquirer's understanding of the issues which prompted the inquiry.

b. Responsiveness.--The response addresses itself to the inquirer's major concerns and states an appropriate action to be taken.