Data Change Request Instructions

[10/2023]

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Introduction

These instructions provide guidance for the Centers for Medicare & Medicaid Services (CMS) users and issuers on properly submitting a data change request (DCR) and the required supporting documentation in the Plan Management (PM) Community.

Overview

Prior to the initial Qualified Health Plan (QHP) Application submission deadline, issuers may make changes to their QHP Application data without state or CMS authorization. After the initial submission deadline, issuers may not add new plans to a QHP Application. Issuers may not change an off-Exchange plan to "on-Exchange" or "Both." Issuers may not change plan type (e.g., HMO, PPO) or market type (e.g., individual, SHOP) values. QHPs, excluding stand-alone dental plans (SADPs), may not change from a child-only plan to a non-child-only plan. For all other changes, issuers may upload revised QHP Application templates and make other necessary changes to their QHP Applications in response to state or CMS feedback until the final submission deadline for data changes.

After the final deadline for issuer changes to QHP Applications, issuers will only make corrections as directed by CMS or by their state. Issuers whose applications are not accurate after the final deadline for issuer submission of changes to the QHP Application may enter a ***limited data correction window*** at CMS' direction and may be subject to compliance action by CMS. Issuer changes made in the limited data correction window that are not approved by CMS and/or the state may result in compliance action by CMS, which could include decertification and suppression of the issuer's plans on HealthCare.gov.

After the QHP certification process concludes, CMS may offer additional data change submission windows on an as-needed basis. CMS will only consider approving changes that do not alter the QHP's certification status or require re-review of data previously approved by the state or CMS. CMS will offer windows for Small Business Health Options Program (SHOP) quarterly rate updates. A request for a data change after the final submission deadline, excluding administrative changes or SHOP quarterly rate updates, may be made to correct inaccuracies in or the incompleteness of a QHP Application, and may result in compliance action. Discrepancies between the issuer's QHP Application and approved state filings may result in a plan not being certified or compliance action if CMS has already certified a plan as a QHP. Issuers that request to make changes that affect consumers may have their plans suppressed from display on HealthCare.gov until the data is corrected and refreshed for consumer display.

Before making QHP Application data changes after the final QHP Application submission deadline, issuers must request to make the change and receive approval from CMS and their state. For QHPs in states that do not enforce market-wide requirements, the CMS Form Filing team, rather than the state, must authorize data changes. Issuers in State-based Exchanges on the Federal Platform (SBE-FPs) should direct DCRs to their state Exchange for approval. CMS will not review requests for changes from issuers in SBE-FPs. SBE-FP issuers should contact their state for their state-specific revision submission deadlines, and SBE-FP states should contact CMS via the Plan Management State Coordination inbox <planmanagementstatecoordination@cms.hhs.gov> before transferring data from SERFF to HIOS.

To request a data change after the final submission deadline, issuers are required to provide a justification for each requested change. Issuers in Federally-facilitated Exchange (FFE) states must submit signed evidence of state or CMS Form Filing approval. Issuers are responsible for ensuring that requested changes comply with federal QHP certification standards set forth in the Patient Protection and Affordable Care Act (PPACA), federal regulations, and all other guidelines discussed in the Letter to Issuers. CMS does not require a DCR for administrative data changes made in HIOS Plan Finder or for URLs (excluding Interoperability and Transparency in Coverage) in the HIOS Marketplace Plan Management System (MPMS) Module. Issuers must make all changes to administrative data, such as customer service numbers, in HIOS Plan Finder, and all changes to URLs in the MPMS Module. Changes to Interoperability and Transparency in Coverage URLs (excluding content within the URLs) do require a DCR.

Requesting a Change by State Exchange Type

Change Request by Exchange Type	Steps
Issuers in FFE states	Issuers must submit requests in the Cases tab of the PM Community as soon as they are aware of a need to make state-approved changes to template data. For issuers requesting changes to SHOP quarterly rates, requests must be submitted by no later than the "Final Date to Submit Data Change Requests" listed on the QHP Certification website. • Requests must include documented approval by the state regulator or, for issuers in states that do not enforce market-wide requirements, CMS Form Filing. • CMS will respond to DCRs via email from CMS Marketplace <CMS_FEPS@ffeat.org>. • Once CMS approves a change, the issuer must resubmit their templates during the window provided by CMS in the email response. Issuers will be able to submit changes between 8:00 a.m. Eastern Time (ET) on the window start date and 6:00 p.m. ET on the window end date.
Issuers in states performing plan management functions	Issuers must submit requests in the Cases tab of the PM Community as soon as they are aware of a need to make state-approved changes to template data. For issuers requesting changes to SHOP quarterly rates, requests must be submitted by no later than the "Final Date to Submit Data Change Requests" listed on the QHP Certification website. • Issuers should concurrently submit requests to their state to begin the state approval process for the requested changes sent to CMS. • CMS will respond to DCRs via email from CMS Marketplace <CMS_FEPS@ffeat.org>. • QHP issuers in states performing plan management should work with their state to secure state approval and to request reopening SERFF binders once changes are approved. Issuers in states performing plan management should contact their state for the revision submission deadline before 3:00 p.m. ET on the transfer deadline provided in the email response from CMS.
Issuers in SBE-FPs	Issuers in SBE-FPs should direct DCRs to their state Exchange for approval. CMS will not review requests for changes from issuers in SBE-FPs. SBE-FP issuers should contact their state for the revision submission deadline, and SBE-FP states should contact CMS via the Plan Management State Coordination inbox <planmanagementstatecoordination@cms.hhs.gov> before transferring data from SERFF to HIOS.

Completing a Data Change Request

1. Introduction

All issuers in FFE states and states performing plan management functions, including issuers applying for off-Exchange SADP certification, must submit DCRs for all changes made after the final submission deadline.

2. Data Requirements

To complete the DCR Form, issuers will need the following:

1. HIOS Issuer ID
2. Issuer Legal Name
3. State
4. Plan ID(s) impacted by the change requested
5. Description of the change requested
6. Justification for why the change is required
7. Signature by authorized representative
8. State approval or approval from CMS Form Filing.

3. Quick Reference

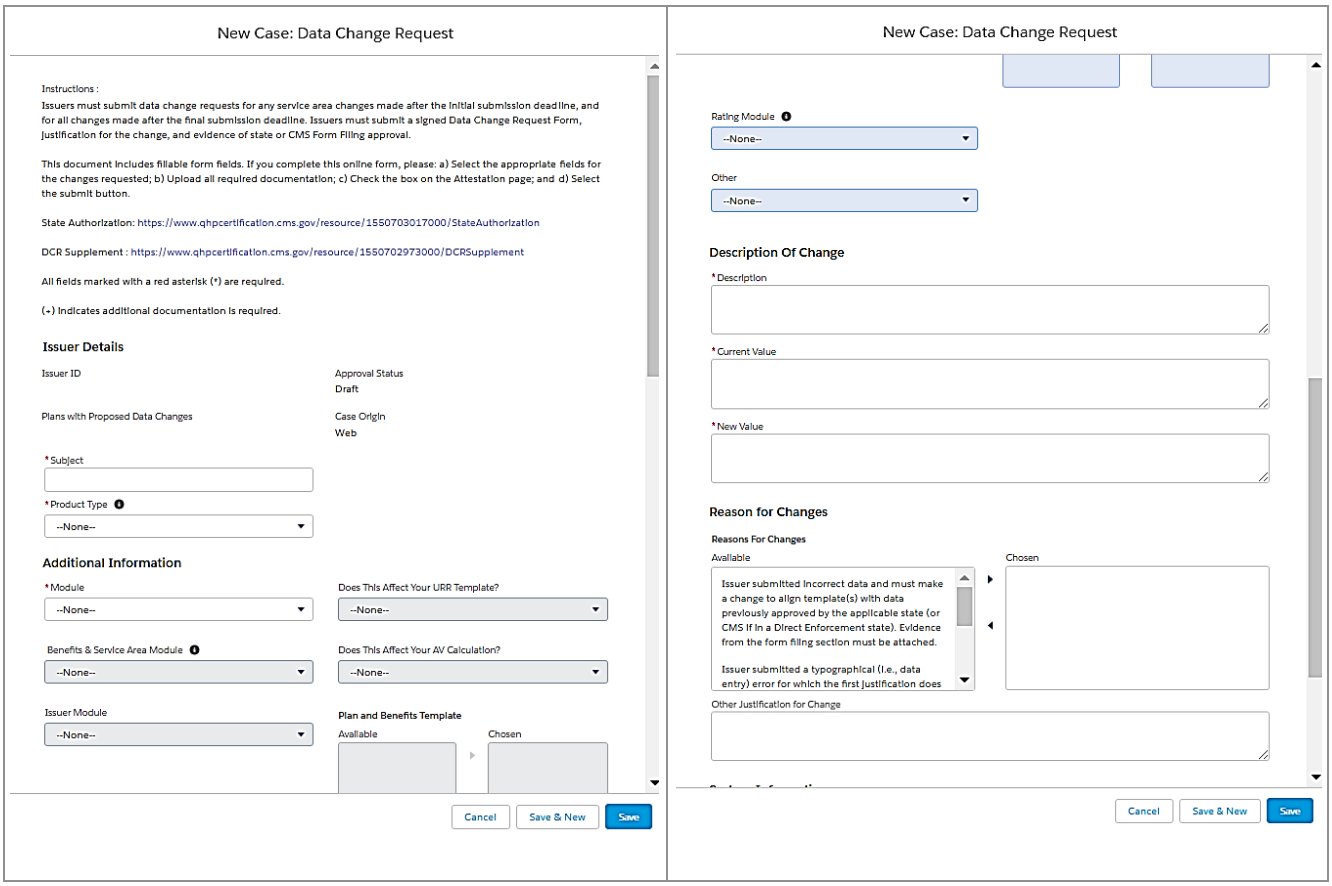
Key Changes for 2024
• No key changes for plan year (PY) 2024.

Tips for completing the DCR Form
• **A detailed description of the QHP data change requested should include specific information about data fields that require revisions, including original and revised values.** • **Issuers requesting changes to their Plans & Benefits, Business Rules, or Service Area Templates must complete the DCR Supplement.** • **Fill out the DCR Supplement tab that corresponds to the respective template. All other tabs must be blank.** • **Evidence of state approval, including specific content about the requested data changes if operating in an FFE state OR approval from CMS Form Filing if a QHP or dual issuer in a state that does not enforce market-wide requirements, must be included.** • **CMS Form Filing requires the *State Authorization of QHP Data Change Request Form* to be submitted, along with the other documentation of the requested change, for authorization consideration before the DCR is submitted.** • **If the issuer received notification from CMS about needed data changes, include documentation of the CMS request (i.e., an email or communication).**

4. Detailed Section Instructions

Issuers that need to submit a DCR can do so by logging into the PM Community. In the top navigation bar, click on the Cases tab down arrow to open the drop-down menu and select “New Case” to generate a new DCR. This will allow issuers to enter data into a fillable form. When completing the online form, note that all fields with a red asterisk (*) are required, and fields with a plus sign (+) require additional documentation to be uploaded. **Figure 1** shows the entirety of the form.

Figure 1. DCR Form



There are four parts to submit a DCR:

- Fill out the “New Case: Data Change Request” Form
- Add Issuers and Plan IDs
- Upload Supporting Documents
- Attest and Submit.

The following steps walk an issuer through the four parts to submit a DCR.

“New Case: Data Change Request” Form	Steps
Issuer Details	The two required (*) fields in this section of the DCR form are “Subject” and “Product Type.” The “Subject” is a summary that allows the issuer to distinguish between their multiple DCR submissions. The “Product Type” is a drop-down, single-select field that allows the issuer to identify the product type for the plans included in the DCR. The issuer must select one of the following options: • QHP (Medical-Only) • SADP, or • Dual ○ Dual indicates an issuer offers both medical and dental plans.

"New Case: Data Change Request" Form	Steps
Additional Information	Issuers are required to identify the module and corresponding template or other forms that require revisions. Please note that issuers can only select one module/template per submission. Therefore, changes to additional modules/templates should be submitted in additional DCRs. Issuers should also submit separate DCRs for the individual and SHOP markets. The available modules (and sections/templates) include: • Benefits & Service Area Module ○ Plans & Benefits Template, Network ID Template, Service Area Template, Prescription Drug Template, Supporting Documentation, Transparency in Coverage Template • Issuer Module ○ Program Attestations, Licensure, Good Standing, Accreditation, Essential Community Provider (ECP)/Network Adequacy • Rating Module ○ Business Rules Template, Rates Template • Other. Choosing specific sections/templates may require issuers to answer additional questions and provide supporting documentation. Fields that only apply to specific sections/ templates are greyed out until a selection is made that allows these fields to unlock. *Benefits and Service Area Module* Issuers requesting Plans & Benefits, Business Rules, or Service Area Template changes must complete and upload the DCR Supplement. For changes to the **Plans & Benefits Template** that affect the plan's actuarial value (AV) calculation under 45 *Code of Federal Regulations (*CFR) 156.135 and 156.140, issuers must respond to the following question: • Does This Affect Your AV Calculation? ○ If the issuer chooses YES, they must submit the plan's old and new AV Calculator screenshots, along with a copy of the old and new version of the Plans & Benefit Template, during Step 3: Upload Supporting Documents. *Rating Module* For changes to the **Rates Table Template** of the Rating Module, issuers submitting a DCR with the "QHP (Medical-Only)" product type must answer the following question: • Does This Affect the Unified Rate Review (URR) Template?
Description of Change	This section of the form allows the issuer to identify the changes requested, including any current and revised values. The issuer is required to provide responses for each of the fields described below: • **Description of Change**: Enter a detailed description of the requested data changes. • **Current Value**: Indicate the current value(s) for the field that is proposed to change. • **New Value**: Indicate the proposed updated value(s).
Reason for Changes	Select all reasons that apply regarding the request for the DCR (Note: Issuers can select more than one option). The issuer must select the appropriate option under the "Available" column on the left, then select the arrow icon pointing to the right. For example, if the issuer selects "Other," clicking the arrow will move "Other" from the "Available" column to the "Chosen" column on the right. The available options include: • *Issuer submitted incorrect data and must make a change to align template(s) with data previously approved by the applicable state (or CMS if in a state that does not enforce market-wide requirements). Evidence from the form filing section must be attached.*

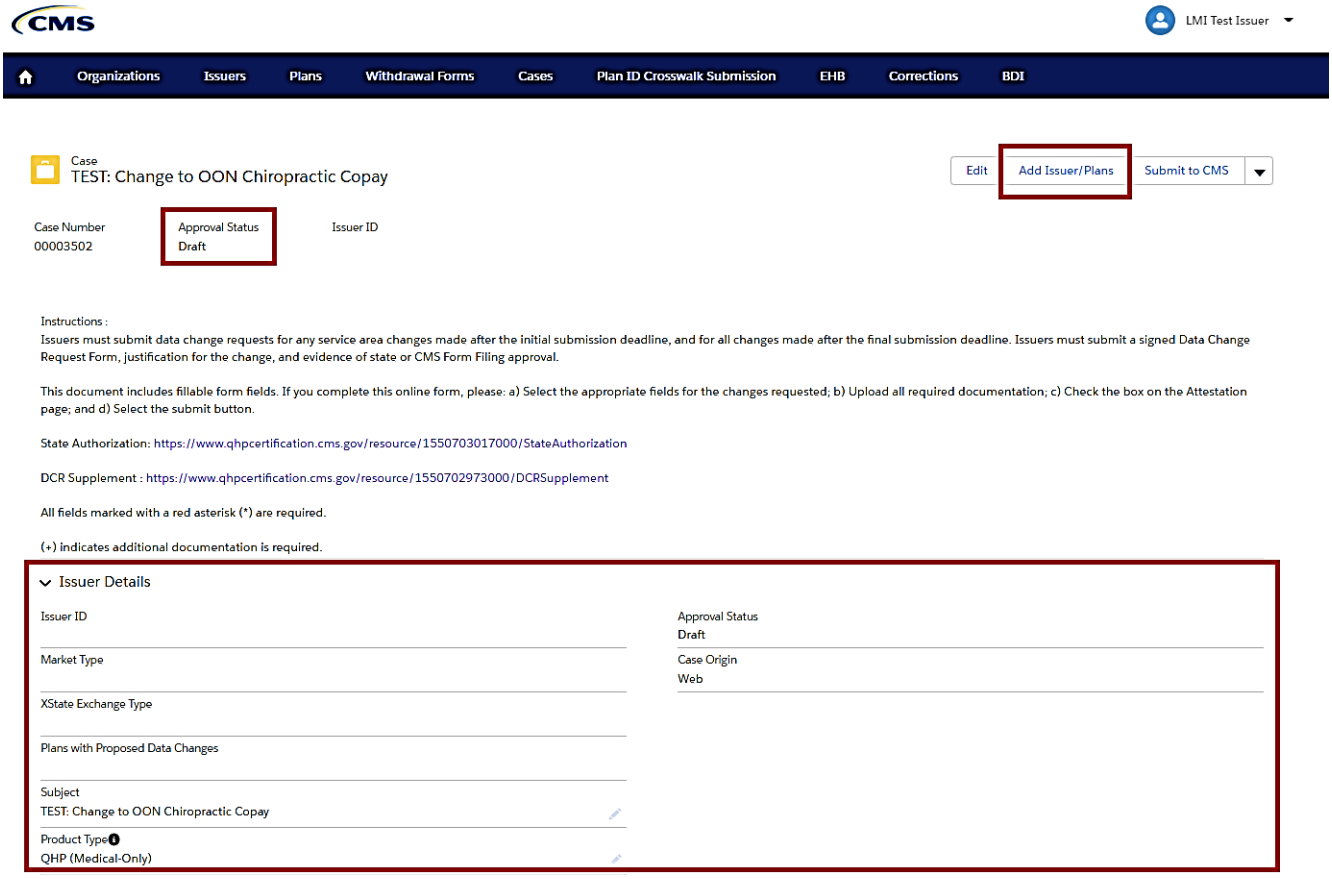
"New Case: Data Change Request" Form	Steps
	If this option is selected, the issuer must attach the relevant section(s) of form filings during Step 3: Upload Supporting Documents. • *Issuer submitted a typographical (i.e., data entry) error for which the first justification does not apply, resulting in incorrect data display on the Exchange consumer portal. Evidence must be attached.* If this option is selected, the issuer must provide evidence of the typographical error on its templates during Step 3: Upload Supporting Documents. • *Issuer is making routine updates to the administrative information, such as plan marketing name changes.* • *Other.* If choosing "Other," please describe the reason in the "Other Justification for Change" field.

Once the "Reason for Changes" section is completed, note any required documentation that will need to be uploaded during *Step 3: Upload Supporting Documents*. Do not change the fields in the "System Information" or "Internal Use Only" sections.

To finish this part of the form, click the **Save** button.

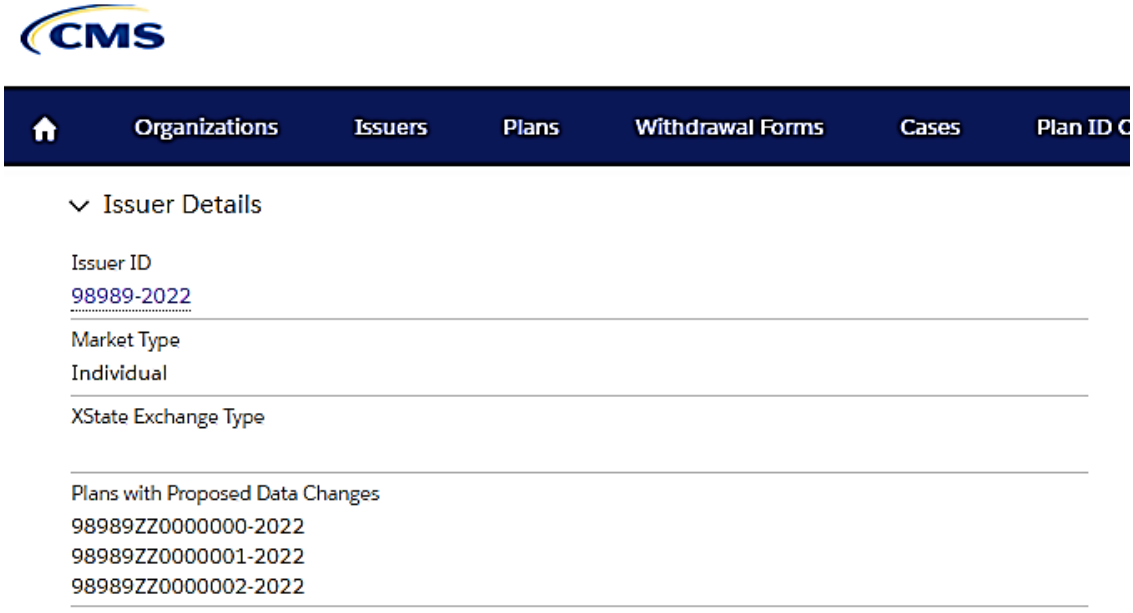
The next segment to complete the DCR is to Add Issuers and Plans. **Figure 2** highlights the page.

Figure 2. Add Issuers and Plans



Add Issuers and Plans	Steps
	Once the form is saved, the issuer is taken to the current Case page. The form will show the data that the issuer entered to this point. Data missing from the following fields—Issuer ID, Market Type, State Exchange Type, and Plans with Proposed Data Changes—are auto-populated after the next step is completed. Also, note that the "Approval Status," indicated just below the **Summary** and to the right of the **Case Number**, is set to "Draft." This status is updated once the Case is submitted to CMS.
	Now, the issuer must select the plans with proposed data changes. To do this, select the **Add Issuers/Plans** button on the upper right side of the page. Selecting this button will open a dialog box. From the search field, the issuer can select from a drop-down of Issuer IDs or type in an Issuer ID. Select the appropriate Issuer ID associated with the plans with proposed data changes.
	Once the appropriate Issuer ID is selected, the issuer will see the list of valid plans to choose from. The issuer may select one, more than one, or all plans, but **should only select those plans affected by this specific DCR**. If the issuer wishes to select all plans, select the box to the left of **PLAN ID**. After selecting the plans with proposed data changes, be sure to select the **Save** button.
	Once the plans with proposed data changes are selected, the form will pre-populate the previously locked fields for Issuer ID, State Exchange Type, and Plans with Proposed Data Changes as shown in **Figure 3**.

Figure 3. Issuer Details—Updated

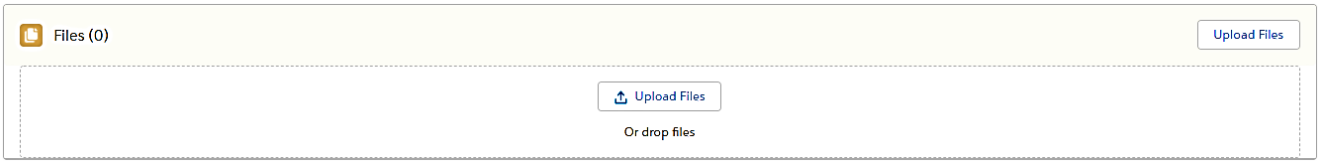


The third segment to complete is to Upload Supporting Documents.

Upload Supporting Documents	Steps
	After selecting the plans with proposed data changes, the issuer should upload all required or additional supporting documentation. Supporting documentation includes: • State Authorization Form (see Appendix for details) • DCR Supplement (see Appendix for details) ○ Issuers requesting Plans & Benefits, Business Rules, or Service Area Template changes must submit the relevant parts of the DCR Supplement.

Upload Supporting Documents	Steps
	To upload supporting documents, the issuer can either select **Upload Files** or drop a file into the Files dialog box (**Figure 4**).
	If the issuer selects **Upload Files,** the system automatically opens a file explorer window and allows the issuer to search for files. Select the required supporting documentation files and then select **Open** from the computer's file explorer window.
	Once the files are selected, the "Upload Files" dialog box opens. Be sure to wait until the system has completed uploading the files, indicated by the green check marks appearing on the right, before selecting "Done."
	If the issuer determines that the incorrect file was uploaded, follow these steps to delete and replace: • Select **View All** in the lower right corner of the **Files** dialog box. • In the **Files** window, select the down arrow drop-down button in the lower, far right corner. • Select **Delete**. • Select **Upload Files** and upload the correct/revised documentation. • Select the **Case Number** to navigate back to the Case DCR Form page.

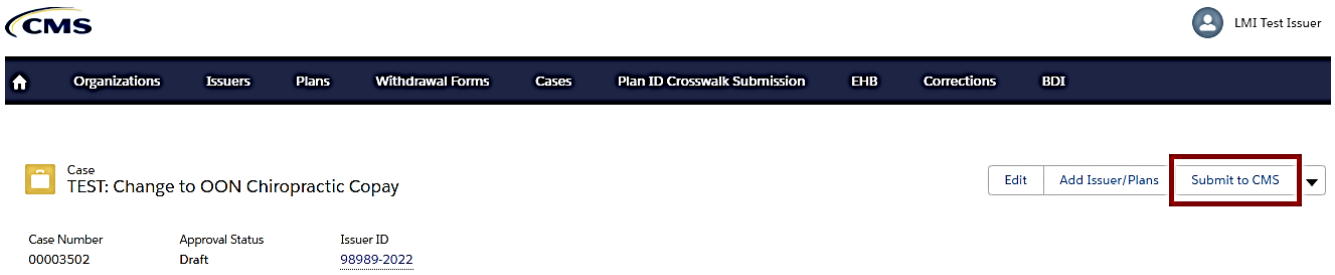
Figure 4. Upload Files Dialog Box



The final segment to complete the new DCR is to Attest and Submit.

Attest and Submit	Steps
	Once the required documentation is uploaded, the issuer should select the **Submit to CMS** button in the far-right corner of the Case page (**Figure 5**).
	Selecting the **Submit to CMS** button will navigate the issuer to the "Attestation" page. If the issuer fails to upload any materials, then an error box will appear, forcing the issuer to click **Cancel** and return to the Case page.
	The issuer should read the attestation and must check the box next to "I Attest" before selecting **Continue**. To return to the previous screen before clicking **Continue**, select the **Cancel** button to close the Attestation page.
	Once the issuer checks the "I Attest" checkbox and selects **Continue**, the DCR is officially submitted for review by CMS.

Figure 5. DCR Form Completed and Ready to Submit to CMS



Disposition of a DCR

The DCR is now with CMS for review. Once CMS has reviewed the DCR, a response is submitted to the issuer via email from CMS Marketplace <CMS_FEPS@ffeat.org>. In addition, the PM Community Cases homepage will update the status to reflect the appropriate disposition:

- Approved
- Approved w/SEP
- Denied
- Incomplete
- Invalid.

Appendix: Resources—Supporting Documents

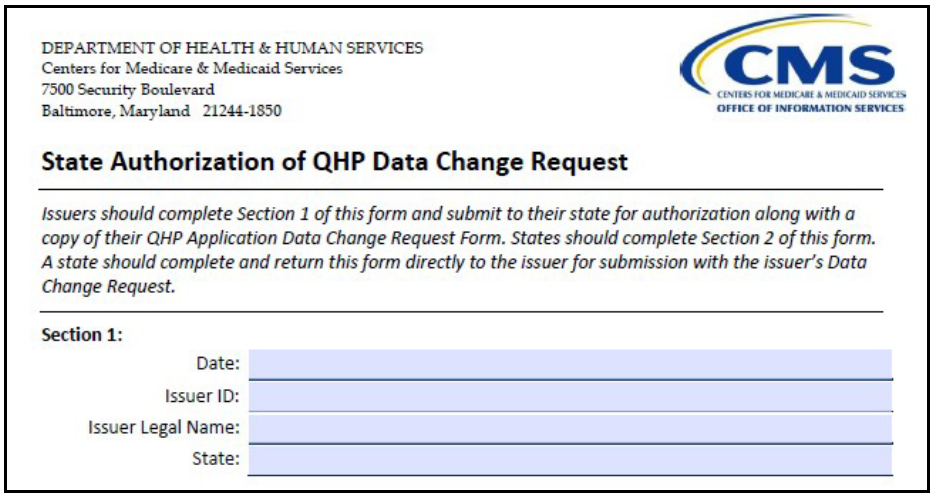
The following section provides additional detail on the State Authorization Form and the DCR Supplement.

State Authorization Form

Issuers in FFEs, including states that do not enforce market-wide requirements, should complete this form. QHP or dual issuers in states that do not enforce market-wide requirements should submit the form to CMS Form Filing.

Complete the following steps when completing the State Authorization of QHP Data Change Request Form (**Figure 6**).

Figure 6. State Authorization Form



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF INFORMATION SERVICES

State Authorization of QHP Data Change Request

Issuers should complete Section 1 of this form and submit to their state for authorization along with a copy of their QHP Application Data Change Request Form. States should complete Section 2 of this form. A state should complete and return this form directly to the issuer for submission with the issuer's Data Change Request.

Section 1:

Date:
Issuer ID:
Issuer Legal Name:
State:

Issuers should complete Section 1 of this form and submit it to their state (or CMS Form Filing) for authorization.

States should complete Section 2 of this form and return it directly to the issuer for submission.

Section 1

- *Date*. Enter the date the issuer is submitting the form to the state for approval.
- *Issuer ID*. Enter the five-digit HIOS Issuer ID.
- *Issuer Legal Name*. Enter the issuer's legal name. Verify that the issuer legal name on the form matches the issuer legal name in the system (HIOS or SERFF) used for submission.
- *State*. Enter the state in which the issuer is currently offering coverage.
- *Description of data change*. Enter information about what data elements are being changed in the template, as well as why they are being changed. This description must align with the data changes described in the DCR.

Section 2

Select the appropriate box that identifies the issuer's situation.

- Yes—Select Yes if the issuer is authorized to submit the data change to CMS.
- No—Select No if the issuer is not authorized to submit the data change to CMS.

Reason for change. Select all that apply for the reason of the proposed data change:

- The issuer submitted incorrect data on the QHP/SADP Template(s) and must make a change to align the template(s) with QHP/SADP data previously approved by the state.
- The issuer submitted a typographical error (i.e., data entry error) for which the first justification does not apply, resulting in incorrect data display on the Exchange consumer portal.
- The issuer is making routine updates to administrative information, which includes URL changes.
- Other: Fill in this section if none of the above options apply.

Signature. The state representative must sign and date the last portion of this form, print his or her name, and include a title, phone number, and email address.

DCR Supplement

Issuers making changes to the Plans & Benefits Template, Business Rules Template, or Service Area Template are required to complete the DCR Supplement. This workbook accompanies all other forms and justifications with the DCR, as required by CMS (**Figure 7**).

Only include information in the worksheet that applies to the specific DCR. The other worksheets should be left blank.

Once all proposed data changes have been entered, save the workbook file using the following name structure: DCR_[IssuerID]_[Date(mm-dd-yyyy)]. For example: DCR_12345_01-01-2023.

Figure 7. DCR Supplement

Data Change Request Workbook **Complete the tab(s) for the specific template(s) with the proposed data changes. All other tabs should be left blank.**	
P&B Benefits Package Tab	
This tab references fields from the Benefits Package tab of the Plans and Benefits template.	
Field	**Definition**
HIOS Plan ID or Benefit Package ID	HIOS Plan ID (Standard Component ID) or Benefit Package ID with the proposed data change.
Plan-Level Field Name	Specific plan-level field (data element) that is changing.
Benefit Package-Level Field Name	Specific benefit package-level field (data element) that is changing.
Benefit Name	Benefit with the proposed data change.
Original Field Value	Value of the field in the current template.
Revised Field Value	Proposed data change.

Plans & Benefit Benefits Package—Standard Component ID

Based on the changes being requested, complete the following steps when entering data into the Plans & Benefit Benefits Package worksheet:

- *HIOS Plan ID (Standard Component ID).* Enter each Plan ID that would be affected by the change being requested. The Plan IDs are the 14-character, HIOS-generated Plan ID number.
- *Plan-Level Field Name*. Enter the specific data field/data element that is changing if the change is at the plan level (if applicable).
- *Benefit Package-Level Field Name*. Enter the specific data field/data element that is changing if the change is at the benefit package level (if applicable).
- *Benefit Name*. Enter the benefit name associated with the change.
- *Original Field Value*. Enter the current value of the field/data element in the template (before making any changes).
- *Revised Field Value*. Enter the new value for the specific field/data element.

If new data is being added, that is, if a current value does not exist for the field/data element, then *Original Field Value* should be left blank, and *Revised Field Value* should contain the new value.

If data being deleted has no proposed revised value, then *Original Field Value* should contain the current value in the field/section, and *Revised Field Value* should be left blank.

Plans & Benefit Cost Share Variance—Standard Component ID + Variant

Based on the changes being requested, complete the following steps when entering data into the Plans & Benefit Cost Share Variance worksheet:

- *HIOS Plan ID (Standard Component ID + Variant*). Enter each Plan ID that would be affected by the change being requested. The Plan IDs are the 14-character, HIOS-generated Plan ID number. Also include the specific variant, a two-digit code that is associated with the specific Plan ID.
- *Section or Field Name*. Enter the specific field/data element that is changing.
- *Benefit Name*. Enter the benefit name associated with the change.
- *Plan Cost Sharing Attribute*. Enter the copay/coinsurance for the benefit changes, enter individual/family for maximum out-of-pocket or deductible changes, or enter deductible/copay/coinsurance/limit for Summary of Benefits & Coverage (SBC) Scenario changes.
- *Network Type (INN, OON) or SBC Scenario Type*. Enter the network type (In Network [INN] or Out of Network [OON]) and tier level (if applicable) associated with any benefit data change. Enter the SBC Scenario if making a change to the SBC Scenario.
- *Original Field Value*. Enter the current value of the field/data element in the template (before making any changes).
- *Revised Field Value*. Enter the new value for the specific field/data element.

If new data is being added, that is, if a current value does not exist for the field/data element, then *Original Field Value* should be left blank, and *Revised Field Value* should contain the new value.

If data being deleted has no proposed revised value, then *Original Field Value* should contain the current value in the field/section, and *Revised Field Value* should be left blank.

Business Rules

Based on the changes being requested, complete the following steps when entering data into the Business Rules worksheet:

- *Product ID*. Enter each Product ID that would be affected by the change being requested. The Product IDs are the 10-character, HIOS-generated Product ID number.
- *Plan ID*. Enter each Plan ID that would be affected by the change being requested. The Plan IDs are the 14-character, HIOS-generated Plan ID number.
- *Field Name*. Enter the specific field/data element that is changing.
- *Original Field Value*. Enter the current value of the field/data element in the template (before making any changes).
- *Revised Field Value*. Enter the new value for the specific field/data element.

If new data is being added, that is, if a current value does not exist for the field/data element, then *Original Field Value* should be left blank and *Revised Field Value* should contain the new value.

If data being deleted has no proposed revised value, then *Original Field Value* should contain the current value in the field/section and *Revised Field Value* should be left blank.

Service Area

Based on the changes being requested, complete the following steps when entering data into the Service Area worksheet:

- *Service Area ID*. Enter each Service Area ID that would be affected by the change being requested. The Service Area ID is a six-character code that consists of the state abbreviation plus an "S" and then a sequenced number for the service area.
- *FIPS County Code*. Enter each FIPS County Code that would be affected by the change being requested. The FIPS County Code is a five-digit code.
- *Field Name*. Enter the specific field/data element that is changing.
- *Original Field Value*. Enter the current value of the field/data element in the template (before making any changes).
- *Revised Field Value*. Enter the new value for the specific field/data element.

If new data is being added, that is, if a current value does not exist for the field/data element, then *Original Field Value* should be left blank and *Revised Field Value* should contain the new value.

If data being deleted has no proposed revised value, then *Original Field Value* should contain the current value in the field/section and *Revised Field Value* should be left blank.

SHOP Quarterly Rate Changes

An issuer submitting a SHOP quarterly rate change must submit the entire Rates Table Template with updated worksheets for the effective date range(s) of the quarterly rate change during the applicable data change submission window. Issuers may make changes to SHOP second-, third-, and fourth-quarter rates only before the start of the quarter that has its rates being changed. Issuers may make changes to worksheets with rate effective dates of April 1, July 1, or October 1.

An issuer may submit rate changes that apply for the next quarter or any subsequent quarter in the same plan year. Issuers are prohibited from changing or removing SHOP first-quarter rates and any current or previous quarter rates or worksheets.

All QHP rates must be consistent with the rates filed in the issuer's URR Template. The rates that the issuer submits to CMS must be the final approved rates endorsed by the issuer's rate reviewer.

The Rates Table Template that the issuer submits for the quarterly rate change must be identical to the template submitted in the QHP Application, except for the applicable quarterly rate changes that the rate reviewer approved.

Issuers will submit a Quarterly Rate Change DCR in the same manner as a regular DCR. Issuers should complete the "Additional detail to justify need for changes" justification section in the DCR Form with the statement "SHOP Quarterly Rate Change" rather than choosing one of the prewritten options.