Instructions for the Data Change Requests Process

Contents

Instructions for the Data Change Requests Process 1
1. Overview 1
2. Purpose 2
3. Data Requirements 2
4. Data Change Request Form 3
4.2 Form/Workbook Instructions 4
4.2.1 QHP Application Data Change Request Form 4
4.2.2 State Authorization QHP Data Change Form 6
4.2.3 Supplement A. Data Change Request Form 7
4.2.4 Supplement B. Data Change Request Workbook 9
4.2.4.1 P&B Benefits Package 9
4.2.4.2 P&B Cost Share Variance 10
4.2.4.3 Business Rules 10
4.2.4.4 Service Area 11
4.3 Service Area Petitions 11
4.4 SHOP Quarterly Rate Changes 11
4.5 Submission 12

1. Overview

After the initial deadline for Qualified Health Plan (QHP) Applications, issuers will need to submit proper documentation and justification for data changes to be made to their QHPs and stand-alone dental plans (SADP) to satisfy the requirements to change data.

During the QHP review and modification period, issuers are required to submit requests for specific types of changes as detailed in the Annual Letter to Issuers. For plan year (PY) 2017, issuers must submit requests to change the service area of their QHPs, including SADPs.

After the final deadline for QHP Application changes, the Centers for Medicare & Medicaid Services (CMS) may offer data correction windows. For PY17, the data change request (DCR) windows are limited to

- Small Business Health Options Program (SHOP) second-, third-, or fourth-quarter rate changes;
- corrections to QHP and SADP data displayed to consumers;
- changes to align QHP data with products and plans approved by the state; or
- requests made by CMS.

These instructions provide guidance for the forms that need to be completed and submitted in order to properly request data changes. All of the instructions in this document apply to both QHP and SADP issuers.

2. Purpose

The purpose of a DCR is to clearly identify changes that an issuer intends to make to its plans, and to submit proper documentation to justify these data changes.

3. Data Requirements

To complete this section, issuers will need the following:

1. A QHP Application Data Change Request Form
    a. Specific information about data fields that require revisions
        i. Issuers requesting Plans & Benefits (P&B), Business Rules, or Service Area template changes must complete Supplement B, Data Change Request Workbook (see below).
        ii. For changes to the Plans & Benefits Template that affect the plan's actuarial value (AV) calculation under 45 CFR 156.135 and 156.140:[1]

            Please check **Yes**.

            If **Yes**, the issuer needs to submit the plan's old and new AV Calculator screenshots, along with a copy of the old and new version of the Plans & Benefits Template.
    b. Details about the revisions needed, including original and revised values.
    c. Must be signed and authorized by a representative of the issuer.

[1] Changes that affect a plan's AV calculation include cost-sharing changes such as changing a plan's deductible or a copay/coinsurance amount for benefits that are used in calculating the actuarial value. The benefits used in calculating the AV and their alignment between the Plans & Benefits Template and the AV Calculator can be found in Table 11-2 of the AVC Instructions.

2. Justification for why the change is required

    a. If the first justification is chosen in the "Reason for Requested QHP or SADP Data Changes" section of the Data Change Request Form, issuers must include copies of the relevant section of their form filing.

    b. If the second justification is chosen, issuers must include screenshots of the data errors.

3. State Authorization of QHP Data Change Request Form

    a. Required only for issuers in Federally-facilitated Marketplaces (FFMs), or approval from CMS form filing if a QHP or dual issuer in a direct enforcement state.

4. Supplement A, Data Change Request Form

    a. Describes the consumer impact of the data change

5. Supplement B, Data Change Request Workbook

    a. Required for P&B, Business Rules, and Service Area Template change.

6. Form filing documentation

    a. Required only if the first justification is selected in the QHP Application Data Change Request Form.

All of the above documents, if applicable, are required to receive approval for changing data in the QHP Application.[2]

The appropriate forms required for DCRs are located here: https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html. CMS will only review data change requests that include all applicable documents listed in Section 3. DCRs that are missing necessary data elements will need to be resubmitted with all required components.

If an issuer in an FFM is unable to have its state complete a State Authorization of QHP Data Change Request Form, it may instead submit other evidence of state approval. This usually is in the form of an e-mail from the state. However, the form is preferred and CMS retains the discretion to require the completed form.

4. Data Change Request Form

Figure 1 shows key items that are important for completing the data correction submission.

[2] Please note that some additional documentation may be requested on a case-by-case basis.

Figure 1. Section Highlights

- Issuers must submit all requests for changes to QHP data to the Exchange Operations Support Center help desk at CMS_FEPS@cms.hhs.gov.
- CMS will respond to data change requests via e-mail from Marketplace_HelpDesk @lmi.org.
- Data change request forms can be found at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html.
- Issuers may only submit one change per data change request.
- CMS will deny data change requests that do not include all required elements.

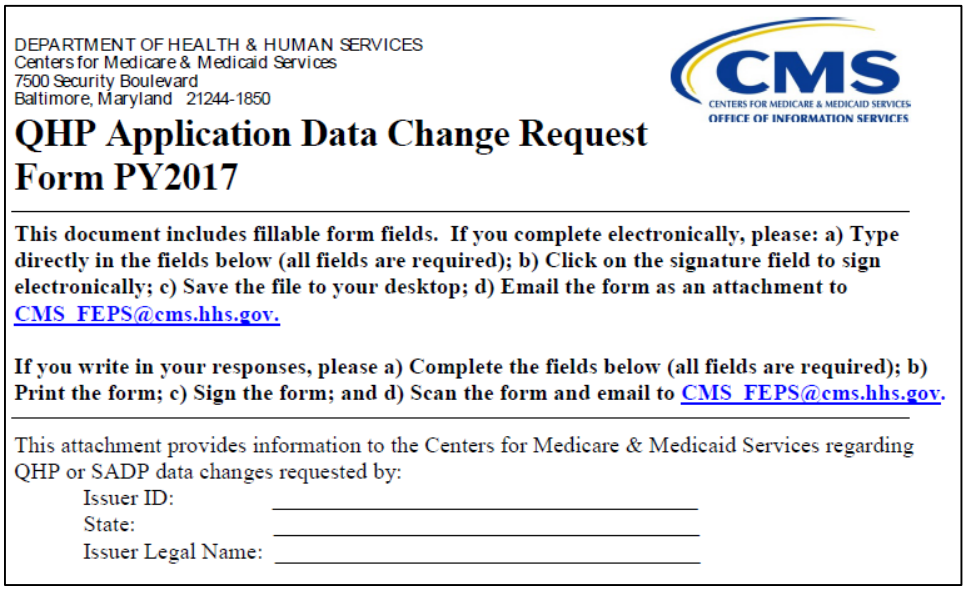
4.2 Form/Workbook Instructions

Complete the following instructions for entering data into the appropriate forms/workbook.

4.2.1 QHP Application Data Change Request Form

Complete the following steps when entering data into the QHP Application Data Change Request Form (Figure 2).

Figure 2. QHP Application Data Change Request Form



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QHP Application Data Change Request Form PY2017

This document includes fillable form fields. If you complete electronically, please: a) Type directly in the fields below (all fields are required); b) Click on the signature field to sign electronically; c) Save the file to your desktop; d) Email the form as an attachment to CMS_FEPS@cms.hhs.gov.

If you write in your responses, please a) Complete the fields below (all fields are required); b) Print the form; c) Sign the form; and d) Scan the form and email to CMS_FEPS@cms.hhs.gov.

This attachment provides information to the Centers for Medicare & Medicaid Services regarding QHP or SADP data changes requested by:

Issuer ID: _____
State: _____
Issuer Legal Name: _____

1. *Issuer ID*. Enter your five-digit Health Insurance Oversight System (HIOS) issuer ID.
2. *State*. Enter the state in which you are currently offering coverage.
3. *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 you use for submission.
4. *Impacted Plan IDs*. Enter the Plan IDs that would be affected by the change being requested. The Plan ID is the 14-character, HIOS-generated plan ID number.

5. *Impacted QHP Templates and Fields*. Use the check boxes to select which QHP Template will be affected by the DCR. Issuers should only select one template, as changes to more than one template should be submitted in additional DCRs. When selecting the template, indicate which data elements or fields will specifically be changed.

6. *Description of requested QHP or SADP data changes*

    a. *Current Value*. Indicate the current information listed in the template.

    b. *Requested New Value*. Indicate the requested information that will appear in the new template.

    If this section does not provide enough room, the issuer must include an attachment that provides this information at a detailed level.

7. *Reason(s) for requested QHP or SADP data changes*. Select all that apply for the reason that this request to change data is being made.

    a. The issuer submitted incorrect data on the QHP/SADP Template(s) and must make a change to align template(s) with QHP/SADP data previously approved by the applicable state.

    b. The issuer submitted a typographical (i.e., data entry error) for which the first justification does not apply, resulting in incorrect data display on the Marketplace consumer portal.

    c. The issuer is making routine updates to the administrative information, which includes URL changes.

    If the first option is selected, the issuer must attach relevant section(s) of form filings.

    If the second option is selected, the issuer must provide evidence of the typographical error on its templates.

8. *Additional detail to justify need for changes* (optional). This is not a required field; however, issuers may enter additional information that might be relevant to explain why the data change is being requested. This field should be used in lieu of the justification fields for Service Area and Quarterly Rate Change requests.

9. *State approval documentation*. Select the documentation that is included with this form that corresponds to the authorization required by the issuer's state:

    a. State evidence of approval is included (required for FFM states).

    b. The request is for a medical or dual issuer in a direct enforcement state, and CMS form filing approval is included.

c. The request is for an issuer in a state performing plan management functions.

10. *Signature*. The authorized representative of the issuer who is completing this form must read, sign, and date the last portion of the form. This section indicates that the representative confirms that the information completed on the form is accurate and has been approved by the applicable state. It also confirms that the information on this form is compliant with the federal QHP certification standards as stated in the Affordable Care Act, federal and state regulations, and the 2017 Letter to Issuers in the Federally-facilitated Marketplaces.

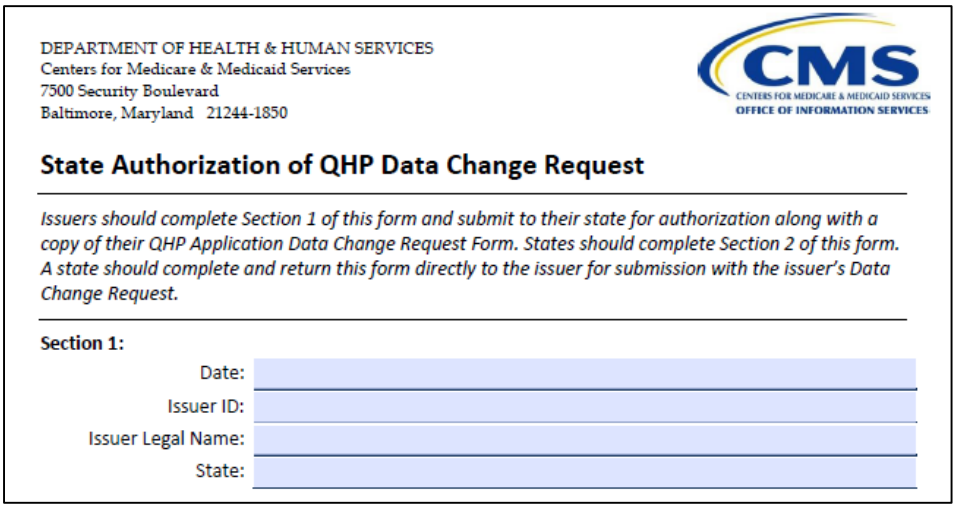
4.2.2 State Authorization QHP Data Change Form

Issuers in FFMs, including direct enforcement states, should complete this form. QHP or dual issuers in direct enforcement states should submit the form to CMS form filing.

Complete the following steps when entering data into the State Authorization QHP Data Change Request (Figure 3).

Issuers should complete Section 1 of this form and submit it to their state (or CMS form filing) for authorization along with their QHP Application Data Change Request Form (Figure 3). States should complete Section 2 of this form and return it directly to the issuer for submission.

Figure 3. State Authorization QHP Data Change Request PY17



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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:

Section 1:

1. *Date*. Enter the date in which the issuer is submitting the form to the state for approval filling out the form.

2. *Issuer ID*. Enter the five-digit HIOS issuer ID.

3. *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 you use for submission.

4. *State*. Enter the state in which the issuer is currently offering coverage.

5. *Description of data change*. Enter the information about what data elements are being changed in the template, as well as, why they are being changed. This description must align with data changes described in the Data Change Request Form.

Section 2:

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

1. ***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.

2. *Reason for change*. Select all that apply for the reason the change is being made:

   a. 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.

   b. 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 Marketplace consumer portal.

   c. The issuer is making routine updates to administrative information, which includes URL changes.

   d. Other:

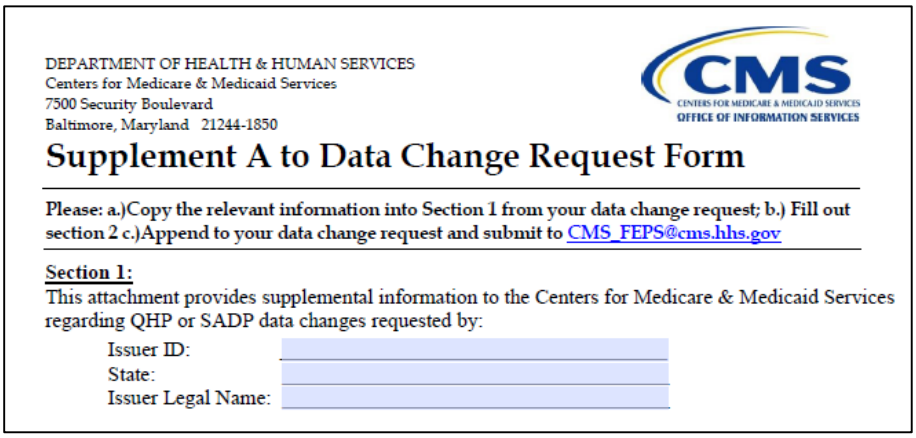
      Fill in this section if none of the above options apply.

3. *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 e-mail address.

4.2.3 Supplement A. Data Change Request Form

Complete the following steps when entering data into Supplement A (Figure 4).

Figure 4. Supplement A, Data Change Request Form PY17



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Supplement A to Data Change Request Form

Please: a.)Copy the relevant information into Section 1 from your data change request; b.) Fill out section 2 c.)Append to your data change request and submit to CMS_FEPS@cms.hhs.gov

Section 1:
This attachment provides supplemental information to the Centers for Medicare & Medicaid Services regarding QHP or SADP data changes requested by:

Issuer ID:
State:
Issuer Legal Name:

Section 1:

1. *Issuer ID.* Enter your five-digit HIOS issuer ID.

2. *State*. Enter the state in which you are currently offering coverage.

3. *Issuer Legal Name*. Enter the issuer's legal name. Verify that *Issuer Legal Name* on the form matches the issuer legal name in the system you use for submission.

4. *Changes affecting Plan IDs, templates, and data elements*. Enter the Plan IDs that would be affected by the change being requested. The Plan IDs are the 14-character, HIOS-generated plan ID numbers. Also include which QHP Templates will be affected by the change of the data, as well as, which data elements or fields will specifically be changed. You must enter all plan IDs, templates, and data elements that are affected, or you will not be approved to make these changes. If this section does not provide enough room, you must include an attachment with this form that identifies what is being changed at a detailed level.

Section 2:

1. *What is the consumer/enrollee impact of the requested changes?*

2. *How many enrollees are currently enrolled in the affected Plan IDs?*

3. *What steps will you take to inform or remediate with enrollees?*

4. *Have you discussed next steps with the appropriate state agency?*

    a. **Yes**. Enter the agency name and the result of the discussion. Include the state contact for any potential follow-up questions.

    b. **No**. Provide detailed description of what you plan on doing moving forward.

4.2.4 Supplement B. Data Change Request Workbook

Issuers making changes to the Plans & Benefits Template, Business Rules Template, or Service Area Template are required to complete Supplement B (Figure 5). This workbook accompanies all other forms and justifications with your DCR, as required by CMS.

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_01-01-2016.

Figure 5. Supplement B, Data Change Request Workbook PY17

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 Plan and Benefits template.	
Field	**Definition**
HIOS Plan ID	HIOS Plan ID (Standard Component ID) with the proposed data change.
Field Name	Specific 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.

4.2.4.1 P&B Benefits Package

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

1. *HIOS Plan ID (Standard Component ID).* Enter the Plan IDs that would be affected by the change being requested. The Plan IDs are the 14-character, HIOS-generated plan ID number.

2. *Field Name*. Enter the specific field/data element that is changing.

3. *Benefit Name*. Enter the benefit name associated with the change.

4. *Original Field Value*. Enter the current value of the field/data element in the template (prior to any changes being made).

5. *Revised Field Value*. Enter the new value for the specific field/data element.

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

If data are being deleted with 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.

4.2.4.2 P&B Cost Share Variance

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

1. *HIOS Plan ID (Standard Component ID + Variant).* Enter the Plan IDs 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.

2. *Section or Field Name*. Enter the specific field/data element that is changing.

3. *Benefit Name*. Enter the benefit name associated with the change.

4. *Plan Cost Sharing Attribute*. Enter the copay/coinsurance for the benefit changes or individual/family for maximum out-of-pocket or deductible changes.

5. *Network Type*. Enter the network or tier level associated with the data change.

6. *Original Field Value*. Enter the current value of the field/data element in the template (prior to any changes being made).

7. *Revised Field Value*. Enter the new value for the specific field/data element.

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

4.2.4.3 Business Rules

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

1. *Product ID*. Enter the Product IDs that would be affected by the change being requested. The Product IDs are the 10-character, HIOS-generated product ID number.

2. *Plan ID.* Enter the Plan IDs that would be affected by the change being requested. The Plan IDs are the 14-character, HIOS-generated plan ID number.

3. *Field Name*. Enter the specific field/data element that is changing.

4. *Original Field Value*. Enter the current value of the field/data element in the template (prior to any changes being made).

5. *Revised Field Value*. Enter the new value for the specific field/data element.

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

If data are being deleted with 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.

4.2.4.4 Service Area

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

1. *Service Area ID*. Enter the Service Area IDs 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.

2. *Service Area Name.* Enter the name of the service area.

3. *Field Name*. Enter the specific field/data element that is changing.

4. *Original Field Value*. Enter the current value of the field/data element in the template (prior to any changes being made).

5. *Revised Field Value*. Enter the new value for the specific field/data element.

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

If data are being deleted with 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.

4.3 Service Area Petitions

CMS will use a modified DCR process to review issuers' requests to change their service area. Known as service area (SA) petitions, for PY17 these petitions will occur between May 11, 2016—the initial QHP Application deadline—and August 9, 2016—the deadline for SA petitions.

Issuers will submit an SA DCR in the same manner as a normal DCR to the CMS FEPS help desk and include (1) a description of the service area change and (2) evidence of state department of insurance approval. Issuers should complete the "Additional detail to justify need for changes" justification section on the Data Change Request Form rather than choosing one of the prewritten options. Supplement A to the Data Change Request Form is not required.

4.4 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-, or fourth-quarter rates only in advance of the start of the quarter whose rates are 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 would apply for the next quarter and/or any subsequent quarter in the remaining PY. Issuers are prohibited from changing or removing SHOP first-quarter rates and any current-quarter rates or worksheets. If an issuer changes or deletes SHOP first-quarter or any current-quarter rates or worksheets, CMS will suppress these plans.

All QHP rates must match what is in the issuer's Unified Rate Review Template. The rates that the issuer submits to CMS must be the final review and/or approved rates endorsed by the issuer's rate reviewer.

Starting at row 14 of the Rates Table Template, issuers must complete the following steps for each SHOP plan that the rate reviewer approved for a rate change:

- *Column E: Individual Rate* (required). Enter the new individual rate that applies to the given plan, rating area, and age.

- *Column F: Individual Tobacco Rate* (required if the tobacco use of a subscriber is used to determine a rate). Enter the new individual tobacco rate that applies to the given plan, rating area, and age.

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

Issuers will submit a Quarterly Rate Change DCR in the same manner as a normal DCR to the CMS FEPS help desk. Issuers should complete the "Additional detail to justify need for changes" justification section on the Data Change Request Form with the statement "Quarterly Rate Change" rather than choosing one of the prewritten options. Supplement A to the Data Change Request Form is not required.

4.5 Submission

After completing all necessary documentation and compiling the required attachments, issuers should follow these steps to submit a data change request. Issuers must do the following in their request:

1. Compose an e-mail to CMS_FEPS@cms.hhs.gov.

2. Make the e-mail subject line "Request for Changes to QHP Data."

3. Attach all change request documents.

4. CC their Account Manager. CC their state if applicable.

5. Have evidence of state approval including specific content about the requested data changes if operating in an FFM state, *or* approval from CMS form filing if a QHP or dual issuer in a direct enforcement state.

6. If you have heard from CMS directly about needed data changes, include documentation of the CMS request (i.e., an e-mail or communication) in your data change request.

7. Include preferred contact information (desk, mobile, e-mail) in case the help desk or CMS needs to follow up on your ticket.