Basic Health Program Enrollment Data Requirements for Federal Payments

Centers for Medicare & Medicaid Services

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Introduction

Section 1331 of the Affordable Care Act provides for the establishment of the Basic Health Program (BHP), which is available to states to operate at their option. BHP provides affordable health benefits coverage for individuals who are citizens or lawfully present non-citizens under age 65 with household incomes between 133 percent and 200 percent of the Federal poverty level (FPL), who are not otherwise eligible for Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer sponsored coverage. People who are lawfully present non-citizens who have income that does not exceed 133 percent of the FPL but who are unable to qualify for Medicaid due to such non-citizen status, are also eligible to enroll. Federal funding is available for BHP based on the amount of premium tax credit (PTC) and cost-sharing reductions (CSR) that BHP enrollees would have received had they been enrolled in Qualified Health Plans (QHPs) through the Marketplace. The Centers for Medicare & Medicaid Services (CMS) published a BHP final rule and a payment methodology, the "Basic Health Program; Federal Funding Methodology for Program Year 2015" on March 12, 2014 (CMS-2380-FN) that outlines more specifics of the BHP program requirements and the funding methods.

As described further in the BHP final rule, CMS will publish, on an annual basis, a proposed and final payment notice with the federal funding methodology for a given BHP program year. The notices will contain the methodology and data sources CMS will use to determine the federal BHP payments for the year. To date, CMS has published a payment notice for 2015 and 2016.[1]

Based on the most recent payment methodologies, the federal BHP payment will be calculated by "rate cells." Each rate cell will represent a unique combination of the following factors:

- age range;
- geographic rating area;
- coverage category (for example, self-only, two-adult coverage or two-adults with one or more adult children);
- household size; and
- income range as a percentage of the federal poverty level (FPL).

The total federal BHP payment will be equal to the sum of the number of enrollees in each rate cell multiplied by the federal BHP payment rate for that rate cell.

CMS is requesting enrollment data from each state on a quarterly basis that contains the data elements that will be needed to calculate the federal BHP payment. In addition, a limited amount of other information to verify and to organize the data is also requested.

[1] Basic Health Program; Federal Funding Methodology for Program Year 2015. http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05257.pdf
Basic Health Program; Federal Funding Methodology for Program Year 2016. http://www.gpo.gov/fdsys/pkg/FR-2015-02-24/pdf/2015-03662.pdf

Instructions

1. States must report data for all individuals for whom the state has made a complete and accurate eligibility determination in accordance with BHP regulations at 42 C.F.R. § 600.320, 340 & 345 and who were enrolled in BHP in the previous quarter.
2. Recognizing that data elements can change for an enrollee over the course of a quarter (e.g., due to a change in household income, move to another county of residence, etc.), states should report data from the first calendar day of the quarter. For persons who become enrolled in the second or third month of the quarter, states should report data from the first calendar day of the first month of the quarter in which the person was enrolled.
3. States must retain records to support a claim that an individual is BHP-eligible and enrolled in a Standard Health Plan. This could include records of an eligibility determination or redetermination, using the standards described in the state's BHP Blueprint, and monthly BHP enrollment records that include the individual.
4. CMS will provide an Excel workbook that can be used to report the data for 2015 and will work with states to consider other possible means to report this data in future years. The workbook will display all requested data elements.
5. Please include a description of each Data Element on the Data Dictionary tab of the workbook.
6. States must comply with CMS Enterprise File Transfer (EFT) system requirements, including all privacy and security standards, as described in the Information Exchange Agreement Between The Centers for Medicare & Medicaid Services And Medicaid/CHIP Agencies For The Disclosure of Information for Administration of Insurance Affordability Programs.
7. State reports are due to CMS no later than 60 days after the close of the quarter.
8. States must submit a signed and dated BHP Enrollment Data State Attestation Form, included here as Attachment A, with their data submissions.

Enrollment data elements

CMS is requesting that states submit quarterly enrollment data for each person covered by BHP, including the following specific data elements. Where possible, CMS is requesting data elements that are already collected and defined by the health insurance exchanges or state Medicaid programs. Sample specifications for these data elements have been provided below; however, states may suggest alternatives subject to CMS approval.

1. Personal identifier

A personal identifier would allow CMS to have a specific count of the number of enrollees and ensure that there are no duplicate enrollees in the BHP program. An appropriate personal identifier might include an enrollee's Social Security Number or a unique Marketplace or Medicaid identification number. Please specify in the Data Dictionary whether the personal identifier is the same identifier as is used in the Exchange or Medicaid. A person should retain the same personal identifier throughout the duration of their BHP eligibility.

2. Family identifier

The family identifier for each person enrolled in BHP in the household will allow individuals to be matched to a specific household. The personal identifier of the head of the household may be used as the family identifier. This would be used to calculate the estimated premium tax credit the household would have received if enrolled in a QHP in the Exchange.

3. Date of birth

The date of birth of the enrollee is needed in order to determine the age of the enrollee. This is used to confirm eligibility and determine the appropriate rate cell for payment purposes. This may be reported as month, day, and year of birth (e.g., xx/xx/xxxx).

4. County of residence

The county of residence of the enrollee is required in order to determine the geographic rating area of the enrollee. States must report the name of the enrollee's county of residence and its National Bureau of Standards Federal Information Processing Standards (FIPS) numeric code.

5. Indian Status

The Indian status of the enrollee is needed because Indians receive different levels of cost-sharing reduction subsidies in the Exchange. The state should report whether an individual has an Indian status consistent with the definition used for the Exchange at 45 C.F.R. § 155.300 and defined as follows:

- a member of any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians; and,
- would be eligible under the special eligibility standards and process for Indians as described in 45 C.F.R. §155.350(a) (with the exception that they are enrolled in a Standard Health Plan rather than a Qualified Health Plan).

This may be reported as “Y” for enrollees who indicate that they are members of a federally-recognized tribe and “N” for all other enrollees.

6. Family size

The state must report the size of the enrollee’s family.

For tax filer households, family size should be consistent with the definition used for the Exchange at Section 36B(d)(1) of the Internal Revenue Code (42 C.F.R. § 600.5). That is, a tax filer’s household must include the taxpayer, his or her spouse when filing jointly, and whoever the taxpayer expects to claim as a tax dependent in his or her federal income tax return in the coverage year. A tax dependent’s household includes the enrollee who expects to be claimed as a tax dependent for the coverage year and whoever is claiming him or her as a tax dependent.

For non-filer households for this reporting period, household size definition should be consistent with that used in the Medicaid non-filer rules as defined at 42 C.F.R. § 435.603(f)(3). That is, for an adult enrolling in coverage, the household must include: the adult; the adult’s married spouse if living with the individual; and the adult’s natural, adopted, and step-children under age 19 (or at state option, age 19 or 20 if a full time student) if living with the adult. For a child enrolling coverage, the household must include: the child under age 19 (or at state option, age 19 or 20 if a full time student); any of the child’s parents (biological, adoptive and step-parents), if living with the child; and any of the child’s siblings (biological, adoptive and step-siblings), who are under age 19 (or at state option age 19 or 20 if a full-time student). CMS is further analyzing the impact of non-filer rules on payment and additional data and/or a payment adjustment may be required in the future.

For both filers and non-filers, this data element may be reported as a numeric value representing the household count (e.g., 1, 2, 3).

7. Household income

The annual MAGI household income of the enrollee’s household is needed to determine premium tax credits and cost-sharing reduction subsidies in the exchanges. The state should submit verified household income from the enrollee’s last eligibility determination, unless the enrollee reports a change in income during the quarter. In that instance, the new income amount should be reported at start of the next quarter. The income reported should be as consistent as possible with their income if they had applied to enroll in coverage in the marketplace.

For tax filer households, the MAGI household income definition should be consistent with that used for the Exchange in Section 36B(d)(2) of the Internal Revenue Code. That is,

‘household income’ means, with respect to any taxpayer, an amount equal to the sum of the MAGI income for all the members of the household.

For non-filer households for this reporting period, CMS is permitting use of Medicaid non-filer rules. Household size and income definitions should be consistent with that used in the Medicaid non-filer rules as defined at 42 C.F.R. § 435.603(d) & (e).

For both filers and non-filers, this data element may be reported as a numeric value representing the annual MAGI income used to determine eligibility for BHP enrollees (e.g., dollar amount to two decimal points).

8. Number of persons in household enrolled in BHP (Coverage Family)

The number of persons in the household who are enrolled in BHP should be reported to determine the cost of the premium for the household. This must be reported as a numeric value representing the number of individuals in the household enrolled in BHP (e.g., 1, 2, 3).

9. Months of coverage

The enrollment status for each month of BHP-eligible coverage of the quarter should be reported. The state can report whether or not a person was enrolled in BHP for each month of the year.

Months of coverage means, any month where, as of the first day of the month, the individual or family is eligible, enrolled and covered by a BHP standard health plan described in Subpart E of Part 600 of 42 CFR and the premium for such coverage is paid by the state. This data must be provided as a sequential binary indicator showing the enrollment status in each month of the quarter (e.g., 1 = enrolled, 0 = not enrolled).

10. Plan information

Some information about the standard health plan in which the beneficiary is enrolled must be reported for the purposes of oversight/program integrity activities. This may include the issuer name, plan name, and, where available, a standard plan identification number (e.g., HIOS ID, NAIC-issued Payer ID). The state must describe which elements they are providing in the Data Dictionary tab of the workbook.

Sample Spreadsheet

CMS has developed a sample spreadsheet for data submissions during the periods that the state reports estimated and actual enrollment. CMS will prepare a workbook that can be used to report this data for 2015 and will work with states to consider other possible means to report this data.

Attachment A: BHP Enrollment Data State Attestation Form

I certify that:

1. I am the Governor of the state or his/her authorized designee to submit this BHP Enrollment Data File (hereinafter "File").
2. This File contains enrollment data only for individuals eligible for and enrolled in the Basic Health Program under Section 1331 of the Affordable Care Act and as such are eligible for payment to the BHP Trust Fund for the quarter indicated on the spreadsheet.
3. The data contained in this File are based on actual recorded BHP-enrolled individuals in the state and are not based on estimates.
4. The information in this File is correct to the best of my knowledge and belief.

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Signature/Date

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Name/Title