

**Basic Health Program (BHP)
Learning Collaborative:**
BHP Planning & Implementation –
State Experiences to Date
September 2015

BHP Learning Collaborative (LC) Overview

- Established by CMS in 2013 as a forum for discussion among states and officials from the Center for Medicaid and CHIP Services (CMCS) for the purpose of shaping BHP guidance and supporting program implementation
- Led by CMS and supported by Manatt and Mathematica

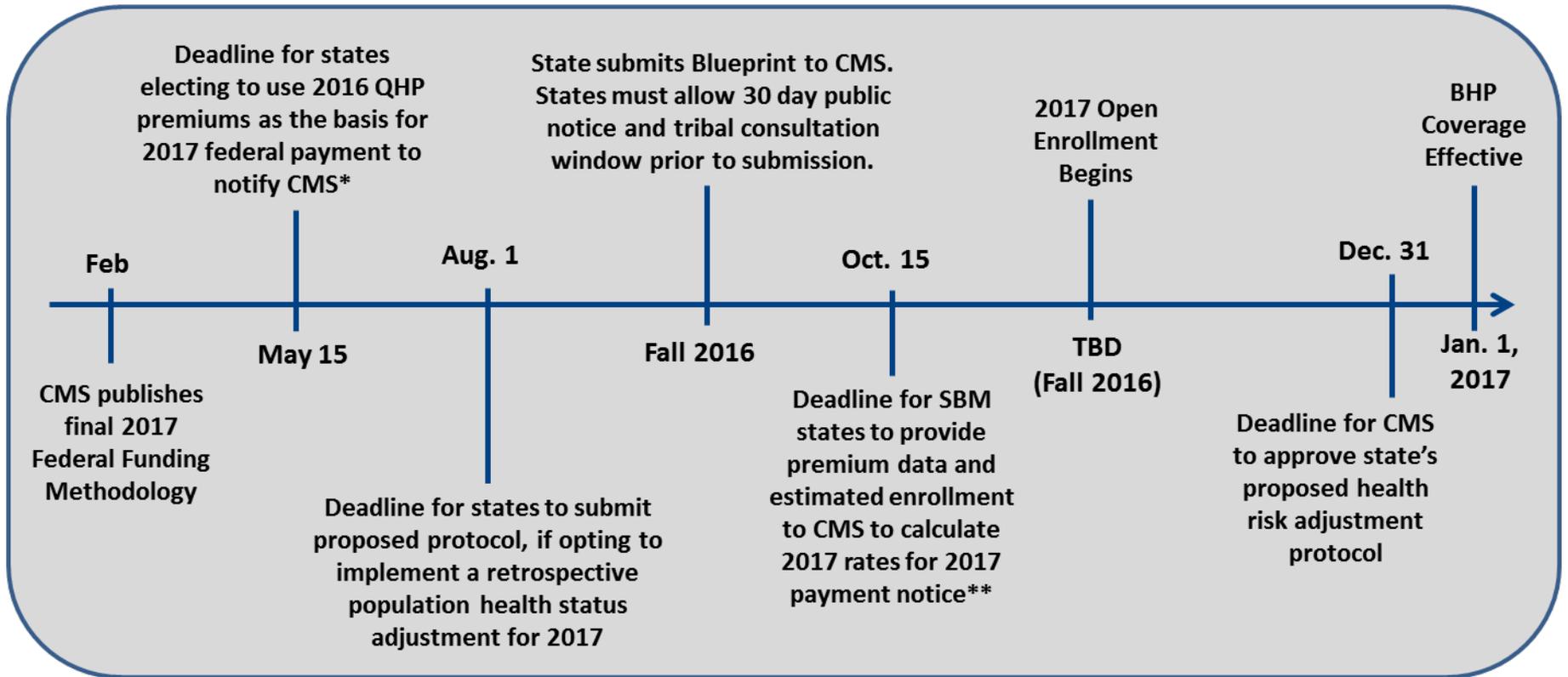
Basic Health Program Refresher

Basic Health Program Summary

- ACA gives states the option to establish a Basic Health Program (BHP) to provide subsidized coverage to low-income individuals who are ineligible for Medicaid, CHIP, other MEC, and do not have access to affordable employer coverage
- People with incomes 133-200% FPL and lawfully present non-citizens with incomes 0-200% FPL who are ineligible for Medicaid due to citizenship status are eligible for BHP
- Federal government gives states 95% of what would have been spent on APTC/CSR in the Marketplace
- Health plans must at a minimum include essential health benefits
- Monthly premiums and cost sharing cannot exceed the amount the individual would have been required to pay if the individual had received coverage in the Marketplace

ACA Section 1331; Full list of regulatory guidance at Appendix A

2016 BHP Planning Timeline for January 1, 2017 BHP Implementation



* To allow greater certainty regarding total BHP payments for 2017, states are provided the option to have final 2017 federal BHP payment rates calculated using the projected 2016 adjusted reference premium (i.e., to use 2016 premium data multiplied by a defined premium trend factor to calculate payment rates). States that elect to use 2016 premiums as the basis for the 2017 BHP federal payment must inform CMS no later than May 15, 2016.

** States implementing BHP must submit actual enrollment data to CMS each quarter.

Key Implementation Steps

Standard Health Plan Contracting & Management

- Define plan requirements (e.g., quality, local provider availability, actuarial value, premiums, innovative features etc.)
- Conduct plan procurement
- Protect against discrimination
- Establish infrastructure for on-going oversight

Eligibility & Enrollment Standards

- Determine whether to align the following with Marketplace or Medicaid standards:
- Authorized representatives and certified application counselors, if permitted
 - Enrollment period (open vs. continuous)
 - Effective date for eligibility
 - Redeterminations
 - Appeals
 - Verification procedures
 - Disenrollment procedures due to premium non-payment

Administration

- Configure IT systems
- Establish Trust Fund and appoint trustees
- Select administering agency and officials
- Submit required reports
- Develop, submit and oversee Blueprint
- Provide public access to premium and cost-sharing information

Financing

- Analyze program costs and available financing
- Evaluate affordability
- Submit premium data to CMS (for SBM states)
- Submit projected enrollment data to CMS
- Determine use of health risk adjustment

Federal Guidance on Health Risk Adjustment

- State option to propose and implement a retrospective adjustment to federal BHP payments to reflect the actual value that would be assigned to the population health factor based on 2016 program data
- States electing this option must develop proposed protocol, including description of how state will collect necessary data to determine adjustment
- Following 2016 program year, CMS will review state's findings and adjust state's BHP federal payment amount, as necessary
- Absent state election to pursue a retrospective adjustment, CMS assumes no health status differences between BHP and QHP enrollees

BHP Planning and Implementation: State Experiences to Date

State Approaches to BHP

	Minnesota	New York
Program Administration & Financing	<ul style="list-style-type: none"> Administered by MN Dept of Human Services (DHS) Funded via Health Care Access Fund 	<ul style="list-style-type: none"> Administered by NY Dept of Health (DOH) Funded via state budget appropriation based on state savings
Timing for Launch	<ul style="list-style-type: none"> Implemented BHP on January 1, 2015 	<ul style="list-style-type: none"> Phasing in BHP beginning on April 1, 2015; full implementation planned for January 1, 2016
BHP Population	<ul style="list-style-type: none"> Individuals with household incomes between 133 – 200% FPL Lawfully present non-citizens with household incomes 0-200% FPL 	<p>Transition Period:</p> <ul style="list-style-type: none"> Lawfully present non-citizens with household incomes 0-133% FPL <p>Full Launch:</p> <ul style="list-style-type: none"> Individuals with household incomes between 133 – 200% FPL Lawfully present non-citizens with household incomes 0-200% FPL
Avg. Enrollment	<ul style="list-style-type: none"> Approximately 100 – 117,000/month 	<ul style="list-style-type: none"> Projected annual enrollment following full implementation: 470,000+
Standard Health Plans	<ul style="list-style-type: none"> 2014 MinnesotaCare managed care plans providing coverage in 2015; full procurement for 2016 coverage year 	<ul style="list-style-type: none"> MMC plans providing coverage for 2015 transition population; completing full procurement for 2016 coverage year

State Reasons for Pursuing BHP

- Build on previous innovative state coverage initiatives
- Increase in federal funding flows to cover existing coverage populations
- More affordable premiums and cost-sharing for enrollees
- Administrative simplification/avoidance of churn in 2015



New York's Implementation Experience

New York's BHP Experience: Program Administration



Approach

- New York State Department of Health (DOH) administers its BHP (known as the “Essential Plan,” or “EP” in New York), as well as the state’s Medicaid and CHIP programs and NY State of Health (the State-based Marketplace)
- Commissioner of the DOH is the State Administrative Officer who is responsible for program oversight
- EP being implemented by interdisciplinary team pulled from Medicaid and Marketplace
 - Despite interdepartmental nature, team fully integrated



Key Insights

- NY’s fully integrated administrative structure has facilitated some administrative simplifications/efficiencies across coverage programs (e.g., EP procurement built off QHP procurement, EP rate development leveraged actuarial support for Medicaid rate development)
- Ability to leverage both Medicaid and Marketplace expertise very helpful to EP planning and implementation

New York's BHP Experience: Program Financing



Approach

- EP Cost Projections (April 2015 – March 2016)¹
 - Total EP Costs: \$1.7B
 - Federally Funded Trust Fund: \$1.57B
 - NYS Funds: \$155M
- Program administration costs are funded through state savings
- Between 2015 (transition period) and 2016 (full program launch):
 - Per enrollee costs expected to increase from \$445 to \$498 PMPM (about 12%), potentially due to general increases in health care costs and utilization
 - Federal per enrollee costs expected to decrease from \$430 to \$413 PMPM (about 4%) as new EP enrollees likely to have lower federal payments due to relatively higher incomes and smaller PTC/CSR amounts
- Estimated administrative costs to be revisited following full launch



Key Insights

- Ability to generate state savings by transitioning state-only financed populations to EP critical to securing state funds for program administration

New York's BHP Experience: BHP Population



Approach

- Phased implementation approach:¹
 - Transition Period (April 1 – December 31, 2015)
 - Lawfully present non-citizens with household incomes 0-133% FPL
 - Full Launch (January 1, 2016)
 - Individuals with household incomes between 133 – 200% FPL
 - Lawfully present non-citizens with household incomes 0-200% FPL
- Projected full annual enrollment following full implementation: 470,000+



Key Insights

- State was providing coverage to 250,000 lawfully present non-citizens with state-only dollars prior to transitioning this population to EP in April 2015

1) Lawfully present non-citizens who are children, pregnant women, or those in need of long-term care services remain in state-funded Medicaid coverage

New York's BHP Experience: BHP Launch



Approach

- Timing of full launch tied to Marketplace 2016 OEP due to large number of anticipated enrollees who will transition from QHP coverage
 - Using administrative renewal where possible for current QHP enrollees and their families
 - Those determined newly EP-eligible will be auto-enrolled into their QHP issuer's EP product if the EP network is comparable to the QHP network; otherwise, enrollee will be notified to select a new EP plan/product
 - State currently conducting review to compare EP and QHP networks
- Transition population will be converted from transition plans (MMC plans) to newly-procured EP products effective January 1, 2016
 - Enrollees will be auto-enrolled in MMC plan's EP product where available; if the MMC plan is not participating in newly-procured EP, consumer will be notified to select a new EP plan/product



Key Insights

- Phased-in approach to implementation allowed for:
 - near-term use of federal funding for existing coverage populations
 - alignment of full program launch with Marketplace OEP to smooth transitions for newly EP-eligible QHP enrollees and their families
 - additional time to ensure seamless conversion of transition population to EP
 - correlation of program launch with EP contracts

New York's BHP Experience: Standard Health Plans



Approach

- Contracted with MMC plans to provide EP coverage for 2015 transition population; completing new procurement for 2016 coverage
 - Targeted outreach to both MMC plans and QHP issuers to participate in 2016 EP procurement
- Waived requirements that each enrollee has a choice of at least 2 plans in 2015; will offer enrollee choice for 2016 coverage year
- DOH will oversee EPs
 - DOH MMC team overseeing 2015 transition plans
 - Marketplace team selecting and overseeing EPs from 2016 onward
- Rates are hybrid of Medicaid/Marketplace rate for 2016



Key Insights

- Rate setting required detailed analysis of differences in plan design/covered services across coverage programs

New York's BHP Experience: Standard Health Plans (cont.)



Approach

- EP modeled after standard Silver product on Marketplace with two premium and cost-sharing tiers:
 - At or below 150% FPL: No premium contribution, cost-sharing at Medicaid levels
 - 151 – 200% FPL: \$20 monthly premium contribution and higher cost-sharing (but lower than for standard Silver QHP)
- Individuals will have option to purchase an adult dental/vision add-on as part of EP
- Due to state law, transition population up to 133% FPL receives additional wrap-around benefits for which they would otherwise be eligible if enrolled in Medicaid (including adult vision/dental), as well as retroactive Medicaid eligibility, funded with state dollars



Key Insights

- Differences in plan design requirements added complexity to design process

New York's BHP Experience: Eligibility & Enrollment



Approach

- Integrated, automated eligibility system for Medicaid, CHIP and Marketplace programs
- Opting to implement continuous open enrollment and re-determine eligibility every 12 months
- In areas where states were granted flexibility, primarily follows Marketplace rules with some exceptions (e.g., Medicaid non-filer rules)
- Availability of multiple coverage options (wrap benefits for transition population, two-tiers of co-premiums/cost-sharing, availability of vision/dental wrap) adds complexity to the enrollment experience
- State not conducting outreach specific to EP – some targeted materials to Navigators/Assisters/Brokers, but most materials branded under New York State of Health and encompass whole suite of available coverage programs



Key Insights

- To guide planning and implementation and ensure seamlessness in enrollee transitions, New York developed tools for internal staff use that chart differences across coverage programs (e.g., across program rules, benefit design)

New York's BHP Experience: Key Policy Issues for Implementation



Approach

Non-Filer Households

- Because non-filers may be eligible for EP, state using Medicaid non-filer rules with retrospective sampling and CMS to evaluate potential payment adjustments

Risk Adjustment

- Urban Institute analysis estimated impact of EP in New York and projected:
 - marginally healthier EP population
 - minimal impact on premiums in the individual market with EP implementation
 - significant number of new EP enrollees who previously couldn't afford QHP coverage
- Accordingly, state did **not** opt for risk adjustment as part of payment methodology



Minnesota's Implementation Experience

Minnesota's BHP Experience: Program Administration



Approach

- Administered by the Minnesota Department of Human Services (DHS) in collaboration with other state agencies (the State Exchange, Commissioner of Health, Department of Commerce)
- State Medicaid Director is BHP State Administrative Officer who is responsible for program oversight
- Leveraged existing administrative structure of prior 1115 MinnesotaCare program



Key Insights

- State was able to leverage prior administrative and operational structure; however, required education of existing staff and acquisition of new, specialized expertise (e.g., risk adjustment)

Minnesota's BHP Experience: Program Financing



Approach

- Cost Projections for CY 2015²
 - Total Medical Payments = ~\$633M
 - Premium Revenue = ~\$34M
 - Federal BHP Funding = ~\$229M
 - State Health Care Access Funding = ~\$370M
- Program administration costs funded through the state's Health Care Access Fund
 - Dedicated state funding source (separate from general funds) funded via broad-based tax on providers and insurance premiums



Key Insights

- Strong commitment to existing 1115 MinnesotaCare program and an influential advocacy community enabled use of state funds for program administration

Minnesota's BHP Experience: BHP Population



Approach

- Approximate monthly enrollment: 100 – 117,000 enrollees
 - New enrollees (versus transition population) account for approximately 25% of total
 - Too soon to determine differences in utilization or population demographics, but new applicants appear somewhat younger than average



Key Insights

- State was providing coverage to approximately 80,000 individuals through an existing 1115 MinnesotaCare program prior to launching BHP in January 2015

Minnesota's BHP Experience: BHP Launch



Approach

- Implemented BHP on January 1, 2015
- Employed block renewal process to convert 2014 MinnesotaCare enrollees transition population into BHP
- New applicants are able to submit online, phone or paper applications on a rolling basis year-round
- Utilized Navigators for consumer outreach and education regarding MinnesotaCare and application assistance



Key Insights

- Phased-in approach to implementation may be preferable to allow more time for system build, staff training, and verification of enrollees' continued eligibility under new program rules
- Consistent messaging at all levels (contact center, state/county staff, Navigators) critical, particularly at launch when systems/processes change to accommodate early lessons learned
- Navigators critical to maximizing enrollment and providing as seamless an experience as possible to the enrollee

Minnesota's BHP Experience: Standard Health Plans



Approach

- DHS oversees standard health plans (SHPs)
- Contracted with 8 plans for the 2015 coverage year
 - Due to state procurement cycle and timing of federal rulemaking process, leveraged existing 2014 MinnesotaCare contracts with health plans in 2015 to provide BHP coverage
 - New, statewide procurement conducted for 2016 SHPs; state has extended notices of intent to contract to selected plans, currently working to finalize contracts
- Waived requirements that each enrollee has a choice of at least 2 plans in 2015, will offer enrollee choice for 2016 coverage year
- SHP rates are developed using same process as used for state's Medicaid program, but based on MinnesotaCare enrollees' utilization and experience



Key Insights

- Program alignment between Medicaid and MinnesotaCare programs taken into consideration when selecting SHPs to receive notice of state's intent to contract for 2016

Minnesota's BHP Experience: Eligibility & Enrollment



Approach

- Single, shared eligibility system to determine eligibility for Medicaid, CHIP, BHP and Marketplace programs
- Opted to implement continuous enrollment and re-determine eligibility up to every 12 months with second year of enrollment synched to the calendar year
- In areas where states were granted flexibility to choose between Medicaid and Marketplace standards, primarily follows Medicaid rules with some exceptions



Key Insights

- Flexibility between Medicaid/Marketplace standards a positive, but also resulted in creation of complex set of “hybrid” program rules
- Improving the eligibility and enrollment process for mixed coverage households a key priority

Minnesota's BHP Experience: Key Policy Issues for Implementation



Approach

1332 Waiver

- Considering 1332 waiver as potential vehicle for promoting coordination and streamlining across Insurance Affordability Programs

Non-Filer Households

- Because non-filers may be eligible for MinnesotaCare, state using Medicaid non-filer rules

Risk Adjustment

- Opted to develop and implement a risk adjustment protocol as part of payment methodology



Key Insights

- Risk adjustment viewed as critical to financing and sustainability of MinnesotaCare

Development of Minnesota's Proposed Risk Adjustment Protocol

- Minnesota submitted initial proposed protocol to CMS in July 2014 and revised protocol in December 2014

Protocol describes state's proposed approach to:



Data
Model
Calculation
Population Health Factor
Health and Adjustment Process

Minnesota's Approach to Health Risk Adjustment



- **Data**

- Aggregated risk score information from final 2015 EDGE server submission for Minnesota's metallic individual market single risk pool
- Encounter data collected from standard health plan offerors under the MinnesotaCare program

- **Risk Adjustment Model**

- Federal HHS-HCC risk adjustment model
- Because same model adopted by state for individual market, ensures consistent risk measurement for MinnesotaCare and individual market populations, thereby simplifying calculation of the Population Health Factor (PHF)

Minnesota's Approach to Health Risk Adjustment



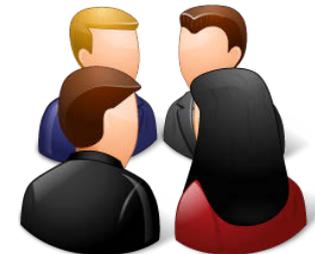
- **Calculation**

- Retrospective PHF adjustment intended to measure relative risk level of individual market including MinnesotaCare enrollees versus excluding MinnesotaCare enrollees
- PHF calculated as ratio of average risk score for individual market and MinnesotaCare populations combined, to average risk score for individual market population
- PHF calculation includes adjustment for differing levels of turnover in MinnesotaCare and individual market populations (as partial year members may have lower risk scores than they would had they been enrolled for the whole year)

Discussion on BHP State Planning & Implementation Experiences

Comments?

Questions?



BHP LC Contacts

CMS Contacts:

Stephanie Kaminsky

Stephanie.Kaminsky@cms.hhs.gov

Manning Pellanda

Manning.Pellanda@cms.hhs.gov

Appendix

BHP Final Guidance

- **Basic Health Program Final Rule**, published March 12, 2014. <http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05299.pdf>
- **Fact Sheet on Final Rule**, published March 2014. <http://medicaid.gov/Basic-Health-Program/Downloads/BHP-Final-Rule-Fact-Sheet.pdf>
- **Medicaid and CHIP FAQs: The Basic Health Program**, published May 8, 2014. <http://www.medicare.gov/basic-health-program/downloads/basic-health-program-faqs-5-7-14.pdf>
- **Considerations for Health Risk Adjustment in the Basic Health Program in Program Year 2015**, published June 2014. <http://medicaid.gov/Basic-Health-Program/Downloads/Risk-Adjustment-and-BHP-White-Paper.pdf>
- **Basic Health Program Federal Funding Methodology for Program Year 2016**, published February 2015. <https://www.federalregister.gov/articles/2015/02/24/2015-03662/basic-health-program-federal-funding-methodology-for-program-year-2016>
- **State Report for Health Insurance Exchange Premiums**, published October 2014. <http://medicaid.gov/basic-health-program/downloads/premium-data-collection-tool.zip>
- **BHP Blueprint**, published October 2014. <http://medicaid.gov/basic-health-program/downloads/bhp-blueprint.zip>