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REGULATIONS COMPILER

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Provider Integrity

4 (Amended After Comments)

5 907 KAR 5:005. Health Insurance Premium Payment (HIPP) Program.

6 RELATES TO: 42 C.F.R. 400.203, 430.10, 26 U.S.C. 4980B, 5000(b)(1), 29 U.S.C. 1161-
7 1169, 42 U.S.C. 1396e(a)-(e)

8 STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1), 205.520(3),
9 205.560(2), 42 U.S.C. 1396e(a)-(e)

10 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
11 Services, Department for Medicaid Services has responsibility to administer the Medicaid
12 Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a
13 requirement that may be imposed or opportunity presented by federal law for the provision of
14 medical assistance to Kentucky's indigent citizenry. 42 U.S.C. 1396e(a) through (e) authorizes
15 states to establish a health insurance premium payment, or HIPP, program to provide health
16 insurance coverage outside of Medicaid to Medicaid enrollees, and any family member of
17 Medicaid enrollees, if the department determines that HIPP program participation would be cost
18 effective for the department. This administrative regulation establishes the Kentucky integrated
19 health insurance premium payment program requirements as authorized by 42 U.S.C. 1396e(a)
20 through (e).

21 Section 1. Definitions.

- 1 (1) "Buying in" means purchasing benefits from Medicare on behalf of an individual.
- 2 (2) "Department" means the Department for Medicaid Services or its designee.
- 3 (3) "Federal financial participation" is defined in 42 C.F.R. 400.203.
- 4 (4) "Group health insurance plan" means any plan, including a self-insured plan, of, or
5 contributed to by, an employer to provide health care directly or otherwise to the employer's
6 employees, former employees, or the families of the employees or former employees, if the plan:
- 7 (a) Meets the criteria established in 26 U.S.C. 5000(b)(1); and
- 8 (b) Includes continuation coverage pursuant to 26 U.S.C. 4980B or 29 U.S.C. 1161 to 1169.
- 9 (5) "Income" means:
- 10 (a) Wages, salary, or compensation for labor or services;
- 11 (b) Money received from a statutory benefit including Social Security, Veteran's
12 Administration pension, black lung benefit, or railroad retirement benefit; or
- 13 (c) Money received from any pension plan, rental property, or an investment including interest
14 or dividends.
- 15 (6) "Income deduction" means a deduction from an individual's income for the
16 purpose of obtaining or trying to obtain Medicaid eligibility.
- 17 (7) "Kentucky integrated health insurance premium payment program participant" or "KI-HIPP
18 program participant" means an individual receiving health insurance benefits in accordance with
19 this administrative regulation.
- 20 (8) "Medicaid" means the Kentucky Medicaid program.
- 21 (9) "Medicaid enrollee" means an individual eligible for and participating in Medicaid pursuant
22 to 907 KAR 1:005, 907 KAR 20:010, 907 KAR 20:020, and 907 KAR 20:025.
- 23 (10) "Spend-down program" means a program by which an individual becomes eligible for

1 Medicaid benefits:

2 (a) By spending down income in excess of the Medicaid income threshold; and

3 (b) In accordance with 907 KAR 20:020.

4 (11) "State plan" is defined in 42 C.F.R. 430.10.

5 (12) "Wrap-around coverage" means coverage of a benefit not covered by an individual's group
6 health insurance plan.

7 Section 2. KI-HIPP Program Eligibility and Enrollment.

8 (1) **If** a Medicaid enrollee, or a person acting on the Medicaid enrollee's behalf, **elects to**
9 **participate, or attempt to participate, in the KI-HIPP program, the enrollee or person acting**
10 **on the Medicaid enrollee's behalf** shall cooperate in providing information to the department
11 necessary for the department to establish availability and cost effectiveness of a group health
12 insurance plan by:

13 (a) Completing the Kentucky Health Insurance Premium Payment Program Application; and

14 (b) Submitting the Kentucky Health Insurance Premium Payment Program Application to the
15 individual's local Department for Community Based Services office, the office administering the
16 Kentucky integrated health insurance premium payment program, or on-line via the Kentucky
17 Online Gateway self-service portal.

18 (2) A Medicaid enrollee or beneficiary **may[shall]** participate in the KI-HIPP program if the
19 department determines in accordance with this administrative regulation that the Medicaid enrollee
20 or beneficiary's participation in the KI-HIPP program would be cost-effective.

21 (3) If a Medicaid enrollee, KI-HIPP program applicant, participant, parent, guardian, or
22 caretaker fails to provide information to the department, within thirty (30) days of the department's
23 request, necessary to determine availability and cost effectiveness of a group health insurance plan,

1 the department shall[;

2 ~~—(a)] not enroll the applicant in the KI-HIPP program unless good cause for failure to cooperate~~
3 ~~is demonstrated to the department within thirty (30) days of the department’s denial[; and~~

4 ~~—(b) Terminate the individual from the Medicaid program pursuant to 907 KAR 20:060].~~

5 (4) Good cause for failure to cooperate shall exist if:

6 (a) There was a serious illness or death of the applicant, participant, parent, guardian, or
7 caretaker or of a member of the applicant’s, participant’s, parent’s, guardian’s, or caretaker’s
8 immediate family;

9 (b) There was a fire, tornado, flood, or similar family emergency or household disaster affecting
10 the applicant, participant, parent, guardian, or caretaker or member of his or her immediate family;

11 (c) The applicant, participant, parent, guardian, or caretaker demonstrates that a good cause
12 beyond that individual’s control has occurred; or

13 (d) There was a failure to receive the department’s request for information or notification for a
14 reason not attributable to the applicant, participant, parent, guardian, or caretaker. The lack of a
15 forwarding address shall be attributable to the applicant, participant, parent, guardian, or caretaker.

16 (5) For a Medicaid enrollee who is a KI-HIPP program participant:

17 (a) The department shall pay all group health insurance plan premiums and deductibles,
18 coinsurance and other cost-sharing obligations for items and services otherwise covered under
19 Medicaid, up to the Medicaid allowed amount, minus any Medicaid cost-sharing that would
20 normally be paid, including the cost-sharing required under ~~[895 KAR 1:010, 1:015, and]~~ 907
21 KAR 1:604, as applicable; and

22 (b)1. The individual’s group health insurance plan shall be the primary payer; and

23 2. The department shall be the payer of last resort.

1 (6) For a KI-HIPP program participating family member who is not a Medicaid enrollee:

2 (a) The department shall pay a KI-HIPP program premium; and

3 (b) The department shall not pay a deductible, coinsurance or other cost-sharing obligation.

4 (7) If an individual who was a Medicaid enrollee at the time the department initiated a KI-HIPP
5 program cost effectiveness review for the individual loses Medicaid eligibility by the time the cost
6 effectiveness review has been conducted, the department shall not enroll the individual or any
7 family member into the KI-HIPP program.

8 Section 3. Wrap-around Coverage.

9 (1) If a service to which a health insurance premium payment program participant would be
10 entitled via Medicaid is not provided by the individual's group health insurance plan, the
11 department shall reimburse for the service.

12 (2) For a service referenced in subsection (1) of this section, the department shall reimburse:

13 (a) The provider of the service; and

14 (b) In accordance with the department's administrative regulation governing reimbursement for
15 the given service. For example, a wrap-around dental service shall be reimbursed in accordance
16 with 907 KAR 1:626.

17 Section 4. Cost Effectiveness.

18 (1) Enrollment in a group health insurance plan shall be considered cost effective if the cost of
19 paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional
20 administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid
21 services.

22 (2) When determining cost effectiveness of a group health insurance plan, the department shall
23 consider the following information:

- 1 (a) The cost of:
- 2 1. The insurance premium,
- 3 2. The coinsurance,
- 4 3. Medicaid's anticipated expenses for the:
- 5 a. KI-HIPP program participant;
- 6 b. KI-HIPP program participant's household; or
- 7 c. KI-HIPP program participant's subdivision of a household, and
- 8 4. The deductible;
- 9 (b) The scope of services covered under the insurance plan, including exclusions for pre-
- 10 existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;
- 11 (c) The average anticipated Medicaid utilization:
- 12 1. By age, sex, and coverage group for persons covered under the insurance plan; and
- 13 2. Using a statewide average for the geographic component; and
- 14 (d) Annual administrative expenditures of an amount determined by the department per
- 15 Medicaid participant covered under the group health insurance plan.

16 **(3)(a) An eligible recipient shall be provided the opportunity to:**

- 17 **1. Ask the employer to complete a Loss of Medicaid or KI-HIPP Eligibility as a Qualifying**
- 18 **Event to End Coverage form;**
- 19 **2. Submit the completed form to the department; and**
- 20 **3. Retain a copy of the completed form.**

21 **(b) If the recipient loses Medicaid or KI-HIPP eligibility, and no longer wishes to**

22 **participate in the employer sponsored insurance plan, the recipient may use the completed**

23 **form to end coverage in the employer sponsored insurance plan by providing written notice**

1 **to the employer.**

2 **(c) The department shall inform KI-HIPP applicants of the potential financial risks of**
3 **participation if loss of Medicaid or KI-HIPP eligibility is not treated as a qualifying event to**
4 **end coverage by the employer of the recipient.**

5 **(4) An employer may complete and submit an Employer Certification that Loss of**
6 **Medicaid or KI-HIPP Eligibility is a Qualifying Event to End Coverage form to the**
7 **Department for Medicaid Services for all employees or future employees.**

8 Section 5. Cost Effectiveness Review.

9 (1) The department shall complete a cost effectiveness review at least annually for an employer-
10 related group health insurance plan or a non-employer-related group health insurance plan.

11 (2) The department shall perform a cost effectiveness re-determination if:

12 (a) A predetermined premium rate, deductible, or coinsurance increases;

13 (b) Any of the individuals covered under the group health insurance plan lose full Medicaid
14 eligibility; or

15 (c) There is a:

16 1. Change in Medicaid eligibility;

17 2. Loss of employment if the insurance is through an employer; or

18 3. Decrease in the services covered under the policy.

19 (3)(a) A health insurance premium payment program participant who is a Medicaid enrollee, or
20 a person on that individual's behalf, shall report all changes concerning health insurance coverage
21 to the Third Party Liability Branch office within the Department for Medicaid Services that
22 administers the Kentucky Integrated Health Insurance Premium Payment program, or to the
23 participant's local Department for Community Based Services (DCBS), Division of Family

1 Support, within thirty (30) days of the change.

2 (b) Except as allowed in subsection (4) of this section, if a Medicaid enrollee who is a health
3 insurance premium payment program participant fails to comply with paragraph (a) of this
4 subsection, the department shall[:

5 ~~1.] disenroll the KI-HIPP program participating Medicaid enrollee, and any family member~~
6 ~~enrolled in the KI-HIPP program directly through the individual, if applicable, from the KI-HIPP~~
7 ~~program[; and~~

8 ~~2. Terminate the KI-HIPP program participating enrollee, and any family member enrolled in~~
9 ~~the KI-HIPP program directly through the individual from the Medicaid program unless the family~~
10 ~~member qualifies for Medicaid eligibility independently of the KI-HIPP participating enrollee].~~

11 (4) The department shall not disenroll [~~or terminate~~] an individual, or any family member
12 enrolled in the KI-HIPP program directly through the individual, from KI-HIPP program
13 participation if the individual demonstrates to the department, within thirty (30) days of notice of
14 KI-HIPP program disenrollment, good cause for failing to comply with subsection (3) of this
15 section.

16 (5) Good cause for failing to comply with subsection (3) of this section shall exist if:

17 (a) There was a serious illness or death of the individual, parent, guardian, or caretaker or a
18 member of the individual's, parent's guardian's, or caretaker's immediate family;

19 (b) There was a fire, tornado, flood, or similar family emergency or household disaster affecting
20 the applicant, participant, parent, guardian, or caretaker or member of his or her immediate family;

21 (c) The individual, parent, guardian, or caretaker demonstrates that a good cause beyond that
22 individual's control has occurred; or

23 (d) There was a failure to receive the department's request for information or notification for a

1 reason not attributable to the individual, parent, guardian, or caretaker. The lack of a forwarding
2 address shall be attributable to the individual, parent, guardian, or caretaker.

3 Section 6. **Provider Participation. A Medicaid enrolled provider shall not refuse to accept**
4 **a new patient who is a KI-HIPP participating Medicaid member if the provider is:**

5 **(1) Accepting any new:**

6 **(a) Medicaid patients; or**

7 **(b) Patients who have coverage under the group health insurance plan that meets criteria**
8 **for KI-HIPP participation;**

9 **(2) Enrolled with the department;**

10 **(3) Listed on the most recent version of the Medicaid Provider Directory; and**

11 **(4) A participating provider within the group health insurance plan determined to meet**
12 **criteria for KI-HIPP participation**~~Kentucky HEALTH participation in KI-HIPP.~~

13 ~~—(1) A Kentucky HEALTH member who has access to employer-sponsored health~~
14 ~~insurance through an employer shall be eligible for mandatory enrollment within KI-HIPP~~
15 ~~as follows:~~

16 ~~—(a) After concurrently or consecutively completing:~~

17 ~~—1. Twelve (12) months of Kentucky HEALTH enrollment; and~~

18 ~~—2. Twelve (12) months of employment with access to compatible employer-sponsored~~
19 ~~health insurance;~~

20 ~~—(b) If the employer-sponsored health insurance is compatible with the KI-HIPP program;~~

21 ~~and~~

22 ~~—(c) If the employer-sponsored health insurance is cost-effective for the entire household.~~

23 ~~—(2) A Kentucky HEALTH member who is not currently required to participate in KI-~~

1 ~~HIPP pursuant to subsection (1) of this section may elect to participate in KI-HIPP and~~
2 ~~submit documentation for an eligibility determination as provided in Section 2 of this~~
3 ~~administrative regulation.~~

4 ~~—(3)(a) A Kentucky HEALTH member may elect to participate in KI-HIPP as an employee~~
5 ~~if the beneficiary's employer sponsored insurance program is determined to be cost effective~~
6 ~~for the employee, but not for the entire household; or~~

7 ~~—(b) A Kentucky HEALTH member may elect to participate in KI-HIPP as a cost effective~~
8 ~~subdivision of the beneficiary's household if the employee participates in KI-HIPP but the~~
9 ~~entire household is determined to not be cost effective.~~

10 ~~—(4) A Kentucky HEALTH beneficiary participating in the KI-HIPP program shall:~~

11 ~~—(a) Receive a MyRewards Account pursuant to 895 KAR 1:030;~~

12 ~~—(b) Accrue dollars in a MyRewards account by completing any applicable activities~~
13 ~~pursuant to 895 KAR 1:030;~~

14 ~~—(c) Receive an exemption from the PATH requirement established in 895 KAR 1:020;~~

15 ~~—(d) Receive wraparound services as provided pursuant to 895 KAR 1:010 depending on~~
16 ~~the beneficiary's benefits under the beneficiary's employer sponsored insurance program;~~
17 ~~and~~

18 ~~—(e) Comply with any cost sharing requirement established pursuant to KAR Title 895 or~~
19 ~~907 KAR 1:604].~~

20 Section 7. Coverage of Non-Medicaid Family Members.

21 (1) If determined to be cost effective, the department shall enroll a family member who is not
22 a Medicaid enrollee into the KI-HIPP program if the family member has group health insurance
23 plan coverage through which the department can obtain health insurance coverage for a Medicaid-

1 enrollee in the family.

2 (2) The needs of a family member who is not a Medicaid enrollee shall not be taken into
3 consideration when determining cost effectiveness of a group health insurance plan.

4 (3) The department shall:

5 (a) Pay a KI-HIPP program premium on behalf of a KI-HIPP program participating family
6 member who is not a Medicaid enrollee; and

7 (b) Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a KI-HIPP
8 program participating family member who is not a Medicaid enrollee.

9 Section 8. Exceptions. The department shall not pay a premium:

10 (1) For a group health insurance plan if the plan is designed to provide coverage for a period of
11 time less than the standard one-year coverage period;

12 (2) For a group health insurance plan if the plan is a school plan offered on the basis of
13 attendance or enrollment at the school;

14 (3) If the premium is used to meet a spend-down obligation and all persons in the household
15 are eligible or potentially eligible only under the spend-down program pursuant to 907 KAR
16 20:020. If any household member is eligible for full Medicaid benefits, the premium shall:

17 (a) Be paid if it is determined to be cost effective when considering only the household members
18 receiving full Medicaid coverage; and

19 (b) Not be allowed as a deduction to meet the spend-down obligation for those household
20 members participating in the spend-down program.

21 (4) For a group health insurance plan if the plan is an indemnity policy which supplements the
22 policy holder's income or pays only a predetermined amount for services covered under the policy.

23 Section 9. Duplicate Policies.

1 (1) If more than one (1) group health insurance plan or policy is available, the department shall
2 pay only for the most cost-effective plan except as allowed in subsection (2) of this section.

3 (2) If the department is buying in to the cost of Medicare Part A or Part B for an eligible
4 Medicare beneficiary, the cost of premiums for a Medicare supplemental insurance policy shall
5 also be paid if the department determines that it is likely to be cost effective to do so.

6 Section 10. Discontinuance of Premium Payments.

7 (1) If all Medicaid-enrollee household members covered under a group health insurance plan
8 lose Medicaid eligibility, the department shall discontinue KI-HIPP program payments as of the
9 month of Medicaid ineligibility.

10 (2) If one (1) or more, but not all, of a household's Medicaid-enrollee members covered under
11 a group health insurance plan lose Medicaid eligibility, the department shall re-determine cost
12 effectiveness of the group health insurance plan in accordance with Section 5(2) of this
13 administrative regulation.

14 Section 11. Kentucky Integrated Health Insurance Premium Payment Program Payment
15 Effective Date.

16 (1)(a) KI-HIPP program payments for cost-effective group health insurance plans shall begin
17 with the month the health insurance premium payment program application is received by the
18 department, or the effective date of Medicaid eligibility, whichever is later.

19 (b) If an individual is not currently enrolled in a cost effective group health insurance plan,
20 premium payments shall begin in the month in which the first premium payment is due after
21 enrollment occurs.

22 (2) The department shall not make a payment for a premium which is used as an income
23 deduction when determining individual eligibility for Medicaid.

1 Section 12. Premium Refunds. The department shall be entitled to any premium refund due to:

2 (1) Overpayment of a premium; or

3 (2) Payment for an inactive policy for any time period for which the department paid the
4 premium.

5 Section 13. Notice. The department shall inform a Kentucky integrated health insurance
6 premium payment program:

7 (1) Applicant, in writing, of the department's initial decision regarding cost effectiveness of a
8 group health insurance plan and KI-HIPP program payment; or

9 (2) Participating household, in writing:

10 (a) If KI-HIPP program payments are being discontinued due to Medicaid eligibility being lost
11 by all individuals covered under the group health insurance plan;

12 (b) If the group health insurance plan is no longer available to the family; or

13 (c) Of a decision to discontinue KI-HIPP program payment due to the department's
14 determination that the policy is no longer cost effective.

15 Section 14. Federal Financial Participation.

16 (1) The Kentucky integrated health insurance premium program shall be contingent upon the
17 receipt of federal financial participation for the program.

18 (2) If federal financial participation is not provided to the department for the Kentucky
19 integrated health insurance premium program, the program shall cease to exist.

20 (3) If the Centers for Medicare and Medicaid Services (CMS) disapproves a provision stated in
21 an amendment to the state plan, which is also stated in this administrative regulation, the provision
22 shall be null and void.

23 Section 15. Incorporation by Reference.

1 (1) **The following material is incorporated by reference:**

2 (a) "Kentucky Health Insurance Premium Payment Program Application", KIHIPP-100, April
3 2019;

4 (b) **"Loss of Medicaid or KI-HIPP Eligibility as a Qualifying Event to End Coverage",**
5 **KIHIPP-024, January 2020; and**

6 (c) **"Employer Certification that Loss of Medicaid or KI-HIPP Eligibility is a Qualifying**
7 **Event to End Coverage", KIHIPP-025, January 2020**~~[edition, is incorporated by reference]~~.

8 (2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at
9 the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday
10 through Friday, 8 a.m. to 4:30 p.m., or from the department's Web site at
11 **<https://chfs.ky.gov/agencies/dms/Pages/regsmaterials.aspx>**
12 **[\[http://www.chfs.ky.gov/dms/incorporated.htm\]](http://www.chfs.ky.gov/dms/incorporated.htm)**.

907 KAR 5:005

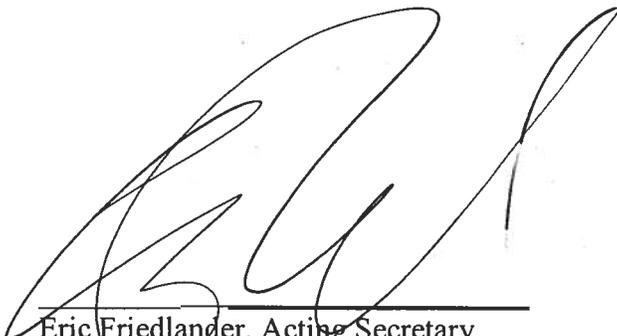
REVIEWED:

1-16-2020
Date


Lisa Lee, Commissioner
Department for Medicaid Services

APPROVED:

2/13/2020
Date


Eric Friedlander, Acting Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 5:005

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov;
and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This administrative regulation establishes the Department for Medicaid Services' (DMS's) Kentucky integrated health insurance premium payment (KI-HIPP) program provisions. The KI-HIPP program is a program by which DMS purchases health insurance coverage for an individual by paying the individual's (and family members if applicable) health insurance premiums, deductibles and coinsurance if doing so would be cost effective to DMS. To qualify for the KI-HIPP program, an individual (or at least one individual in the case of a family enrolling in the KI-HIPP program) must be Medicaid eligible; however, the actual benefits are provided by the individual's group health insurance carrier.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to provide cost-effective medical benefits to Medicaid beneficiaries; thus, prudently utilizing DMS's resources.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by providing cost-effective medical benefits to Medicaid individuals.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by providing cost-effective medical benefits to Medicaid beneficiaries.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: The amendments change this administrative regulation by removing a requirement that individuals be terminated from Medicaid coverage if they are eligible for participation in the KI-HIPP program but do not participate. DMS currently does not terminate individuals for failure to participate with Employer Sponsored Insurance (ESI), and is amending this regulation text to conform.

The Amended After Comments version of this administrative regulation establishes two forms for an eligible recipient to request an employer to complete that will allow the recipient to leave the employer sponsored insurance program if the recipient loses Medicaid eligibility. The department is also establishing a new Section 6 that will govern provider participation and requires providers to not refuse to accept a new KI-HIPP participating patient under certain circumstances. The department is also amending Section 2 of the administrative regulation to more clearly state that the

- program is voluntary. Finally, the department is removing a section relating to premium assistance and the Kentucky HEALTH program to reflect the repeal of Title 895 KAR and correcting a Web site address.
- (b) The necessity of the amendment to this administrative regulation: The amendments are necessary to reflect the current operation of the KI-HIPP program, and to remove reference to the nonfunctioning Kentucky HEALTH program.
 - (c) How the amendment conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by providing cost-effective medical benefits to Medicaid beneficiaries.
 - (d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by providing cost-effective medical benefits to Medicaid beneficiaries, and to remove reference to a nonfunctioning program.
- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid beneficiaries, MCOs, providers, and employers who employ Medicaid beneficiaries.
- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Potential KI-HIPP program enrollees will need to provide all required information, including their health insurance carrier's information, to DMS.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed on the regulated entities.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid beneficiaries who have access to private health insurance via their employers will still receive the full benefits provided through the Medicaid program as well as payment of the premiums for the health insurance through the Medicaid program.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: The Department for Medicaid Services (DMS) estimates savings of \$350 per KI-HIPP participant per month. The Department is reviewing the actuarial analysis to determine the veracity of this figure. Any actuarial savings can only be determined on a case-by-case basis.
 - (b) On a continuing basis: The Department for Medicaid Services (DMS) estimates savings of \$350 per KI-HIPP participant per month. The Department is reviewing the actuarial analysis to determine the veracity of this figure. Any actuarial savings can only be determined on a case-by-case basis.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and

enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX, and matching funds from state general fund appropriations.

- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.
- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering is applied as children are exempt from Medicaid disenrollment pursuant to 42 USC 1396e(b)(2).

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 5:005

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov; and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.
2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 205.520(3), 205.560(2), 194A.030(2), 194A.050(1), 194A.010(1), and 42 U.S.C. 1396e(a) through (e).
3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
 - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The Department for Medicaid Services projects no revenue to be generated by the administrative regulation.
 - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The Department for Medicaid Services projects no revenue to be generated by the administrative regulation.
 - (c) How much will it cost to administer this program for the first year? The Department for Medicaid Services anticipates no additional costs in the administration of this program in the first year. The Department for Medicaid Services estimates savings of three-hundred and fifty dollars (\$350) per KI-HIPP participant per month. The Department is reviewing the actuarial analysis to determine the veracity of this figure. Any actuarial savings can only be determined on a case-by-case basis. This analysis does not take into account any potential impact on increased costs for local governments and employer groups that may see increased costs related to employee covered premium assistance.
 - (d) How much will it cost to administer this program for subsequent years? The Department for Medicaid Services anticipates no additional costs in the administration of this program in subsequent years. The Department for Medicaid Services estimates savings of \$350 per KI-HIPP participant per month. The Department is reviewing the actuarial analysis to determine the veracity of this figure. Any actuarial savings can only be determined on a case-by-case basis.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation:

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 5:005

Agency Contact Persons: Jonathan Scott, (502) 564-4321, ext. 2015, jonathant.scott@ky.gov;
and Donna Little, (502) 564-6746, CHFSRegs@ky.gov

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396e(a) through (e).
2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."
3. Minimum or uniform standards contained in the federal mandate. 42 U.S.C. 1396a(a)(10)(B) requires the Medicaid program to ensure that services are available to Medicaid recipients in the same amount, duration, and scope as available to other individuals (non-Medicaid).
4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter or different responsibilities than the federal requirements.
5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter or different responsibilities than the federal requirements.

SUMMARY OF MATERIAL INCORPORATED BY REFERENCE

(1) “Loss of Medicaid or KI-HIPP Eligibility as a Qualifying Event to End Coverage”, KIHIPP-024, January 2020, is a new form incorporated by reference in the Amended After Comments version. An eligible recipient shall be provided the opportunity to ask the employer to complete this form, submit the completed form to the department, and retain a copy of the completed form. This form is one (1) page.

(2) “Employer Certification that Loss of Medicaid of KI-HIPP Eligibility is a Qualifying Event to End Coverage”, KIHIPP-025, January 2020, is a new form incorporated by reference in the Amended After Comments version. An employer may complete and submit this form to the department to certify that loss of Medicaid or KI-HIPP eligibility is a qualifying event to end coverage for all employees or future employees. This form is one (1) page.

The total number of pages incorporated by reference in the Amended After Comments version is two (2) pages.

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 5:005

CABINET FOR HEALTH AND FAMILY SERVICES
Department for Medicaid Services
Division of Program Integrity

Amended After Comments

I. A public hearing on 907 KAR 5:005 was not requested, and therefore, not held. However, written comments were received during the public comment period.

II. The following individuals submitted comments during the public comment period:

<u>Name and Title</u>	<u>Agency/Organization/Entity/Other</u>
Jason Dunn, Policy Analyst	Kentucky Voices for Health
Kathy Adams, Director of Public Policy	Children’s Alliance
Lili Lutgens, JD, LCSW, and Owner	Therapeutic Intervention Services, PLLC
Jonathan Scott, Regulatory and Legislative Advisor	Department for Medicaid Services

III. The following individuals from the promulgating agency responded to comments received regarding 907 KAR 5:005:

<u>Name and Title</u>	<u>Agency/Organization/Entity/Other</u>
Stephanie Bates, Deputy Commissioner	Department for Medicaid Services, Commissioner’s Office
Lee Guice, Director	Division of Policy and Operations, Department for Medicaid Services
Teresa Shields, Branch Manager	Division of Program Integrity, Department for Medicaid Services,
Jonathan Scott, Regulatory and Legislative Advisor	Department for Medicaid Services, Commissioner’s Office

IV. SUMMARY OF COMMENTS AND AGENCY’S RESPONSES

(1) Subject: Voluntary participation in the KI-HIPP program

(a) Comment: Jason Dunn, Policy Analyst for Kentucky Voices for Health, and Kathy Adams, Director of Public Policy for the Children’s Alliance, submitted comments highlighting

additional areas of the administrative regulation that should be modified to clarify that participation in the KI-HIPP program is voluntary in nature.

(b) Response: The department agrees with the concept that the KI-HIPP program is a voluntary program and will amend the administrative regulation in Section 2(1) and (2) to clarify that the program is voluntary. As a result of these changes, Section 2(2) will be modified to state “may” instead of “shall” in one instance. In addition, Section 2(1) will be amended to clarify that only those individuals who wish to participate in the KI-HIPP program need to submit an application to the KI-HIPP program.

(2) Subject: Ongoing paperwork requirements

(a) Comment: Jason Dunn, Policy Analyst for Kentucky Voices for Health, submitted comments pointing out that the monthly paperwork requirements of the KI-HIPP program could be difficult for certain members.

(b) Response: The department acknowledges that the ongoing paperwork requirements of a per pay period reimbursement verification system can be onerous to the member. As such, the department, in April 2020, plans to implement a system enhancement to require a quarterly verification instead of every pay period. The department will not be amending the administrative regulation in response to this comment.

(3) Subject: Direct KI-HIPP payments to employers

(a) Comment: Jason Dunn, Policy Analyst for Kentucky Voices for Health, submitted comments requesting that the department find a way to reimburse employers directly for the monthly premium due to the employer sponsored insurance.

(b) Response: The department acknowledges the difficulty involved for some members in a reimbursement model. Unfortunately, the department is not comfortable in pursuing a direct employer reimbursement model as there are concerns that some employers could keep the reimbursement from the department and also charge the recipient for the premium. Though such an approach could violate certain state or federal laws, the department would not be able to directly enforce any penalties against the employer, and would need to refer and hope that local, state, or federal law enforcement would act. In further discussions with Kentucky Voices for Health, the possibility of direct insurance carrier reimbursement by the department was raised. The department finds this concept interesting, and will establish a work group to further study and implement possible changes in this administrative regulation and others. At this time, the department will not be amending this administrative regulation in response to the comment.

(4) Subject: Provider access and KI-HIPP program

(a) Comment: Jason Dunn, Policy Analyst for Kentucky Voices for Health, submitted comments addressing the availability of providers to participants in the KI-HIPP program.

(b) Response: The department agrees that a provider that is enrolled in Medicaid and accepting new patients in either Medicaid or the employer sponsored insurance plan should not discriminate against KI-HIPP members. As such, a new Section 8 will be included in the

administrative regulation that requires a provider that is accepting new patients in either Medicaid or the employer sponsored insurance plan to accept KI-HIPP members. Furthermore, the department will amend 907 KAR 17:015 to require a provider that is enrolled with Medicaid to see Fee-for-Service recipients.

(5) Subject: Loss of Medicaid as a qualifying event to end employer-sponsored insurance coverage

(a) Comment: Jason Dunn, Policy Analyst for Kentucky Voices for Health, submitted comments requesting that the department refuse to pay a premium for an employee participating in the KI-HIPP program if the employer does not treat loss of Medicaid eligibility as a qualifying event to end coverage.

(b) Response: The department must allow a beneficiary the option to participate in a cost-effective ESI plan. As such, DMS does not believe that we can introduce a requirement that an employee not participate in the KI-HIPP program if the employer does not treat loss of Medicaid eligibility as a qualifying event to end coverage. However, the department agrees that it is important to provide as much protection as possible to members participating in the KI-HIPP program. Therefore, DMS is including a voluntary form that a member can give to an employer that constitutes an agreement that the employer will treat loss of Medicaid eligibility as a qualifying event to end the employee's participation in the ESI plan. An additional form will be included to allow for an employer to complete and file with the department a certification that any employee losing Medicaid eligibility or KI-HIPP eligibility will be treated as a qualifying event to terminate enrollment. As part of the work group discussed in Subjects 3 and 7, DMS will also further explore modifications that can be made – either via legislation or administrative regulation – to Kentucky law.

(6) Subject: Remove references to Kentucky HEALTH administrative regulations

(a) Comment: Jonathan Scott, Legislative and Regulatory Advisor for the Department for Medicaid Services, submitted comments requesting that the references to the Kentucky Health Program located in Section 6 of the administrative regulation be removed as a result of the filing of 895 KAR 1:002E, which repealed all administrative regulations in Title 895 KAR. Comments relating to suggested clarifications or amendments to Section 6 were received from Kathy Adams, Director of Public Policy for the Children's Alliance.

(b) Response: The department will remove the previous Section 6 in its entirety to reflect the repeal of all administrative regulations in Title 895 KAR.

(7) Subject: Medicaid billing for services not recognized by commercial carriers and Medicare

(a) Comment: Lili Lutgens, Therapeutic Intervention Services, PLLC, submitted comments highlighting concerns and difficulties with billing for services not recognized by commercial carriers or Medicare. The comments further requested that the department establish a work group to further discuss modifications to the Kentucky Medicaid Management System.

(b) Response: The department agrees that billing for services by providers participating with the KI-HIPP program should be reviewed and made as easy as possible. The department furthermore agrees that a work group should be created to study and highlight the ongoing implementation of the KI-HIPP program. As such, the department will create a work group to study this program and will include discussions relating to how to modify or enhance the Kentucky Medicaid Management Information System to address billing for services not recognized by commercial carriers or Medicare. The department will not be amending the administrative regulation in response to this comment.

V. SUMMARY OF STATEMENT OF CONSIDERATION
AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 5:005. This administrative regulation is being amended after comments. DMS is amending the administrative regulations as follows:

Page 3

Section 2(1)

Line 8

After “(1)”, insert “If”.

Lowercase “A”.

After “enrollee’s behalf,”, insert the following:

elects to participate, or attempt to participate, in the KI-HIPP program, the enrollee or person acting on the Medicaid enrollee’s behalf

Page 3

Section 2(2)

Line 16

After “or beneficiary”, insert “may”.

Delete “shall”.

Page 4

Section 2(5)(a)

Line 20

After “required under”, delete the following:

895 KAR 1:010, 1:015, and

Page 6

Section 4(2)(d)

Line 15

After “under the group health insurance plan.”, insert the following:

(3)(a) An eligible recipient shall be provided the opportunity to:

1. Ask the employer to complete a Loss of Medicaid or KI-HIPP Eligibility as a Qualifying Event to End Coverage form;
 2. Submit the completed form to the department; and
 3. Retain a copy of the completed form.
- (b) If the recipient loses Medicaid or KI-HIPP eligibility, and no longer wishes to participate in the employer sponsored insurance plan, the recipient may use the completed form to end coverage in the employer sponsored insurance plan by providing written notice to the employer.
- (c) The department shall inform KI-HIPP applicants of the potential financial risks of participation if loss of Medicaid or KI-HIPP eligibility is not treated as a qualifying event to end coverage by the employer of the recipient.
- (4) An employer may complete and submit an Employer Certification that Loss of Medicaid or KI-HIPP Eligibility is a Qualifying Event to End Coverage form to the Department for Medicaid Services for all employees or future employees.

Pages 8-9

Section 6

Lines 14-23 and Lines 1-19.

After "Section 6." insert the following:

Provider Participation. A Medicaid enrolled provider shall not refuse to accept a new patient who is a KI-HIPP participating Medicaid member if the provider is:

(1) Accepting any new:

(a) Medicaid patients; or

(b) Patients who have coverage under the group health insurance plan that meets criteria for KI-HIPP participation;

(2) Enrolled with the department;

(3) Listed on the most recent version of the Medicaid Provider Directory; and

(4) A participating provider within the group health insurance plan determined to meet criteria for KI-HIPP participation

Delete the remaining language in Section 6, except the final period.

Page 13

Section 15(1)

Line 3

After "(1)" insert the following:

The following material is incorporated by reference:

(a)

Line 4

After "2019", insert the following:

i

(b) "Loss of Medicaid or KI-HIPP Eligibility as a Qualifying Event to End Coverage", KIHIPP-024, January 2020; and

(c) "Employer Certification that Loss of Medicaid or KI-HIPP Eligibility is a Qualifying

Event to End Coverage”, KIHIPP-025, January 2020

Delete “edition, is incorporated by reference”.

Page 13

Section 15(2)

Lines 7 and 8

After “Web site at”, insert the following:

<https://chfs.ky.gov/agencies/dms/Pages/regsmaterials.aspx>

Delete the following:

<http://www.chfs.ky.gov/dms/incorporated.htm>

KIHIPP-024 (January 2020)

LOSS OF MEDICAID OR KI-HIPP ELIGIBILITY AS A QUALIFYING EVENT TO END
COVERAGE

_____ is participating in the Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP). The Department for Medicaid Services will reimburse a KI-HIPP member's employee premium through this program. If this member loses Medicaid eligibility while enrolled in the KI-HIPP program or otherwise loses KI-HIPP eligibility, they will be required to pay the employee premium without Medicaid reimbursement.

As the employer, or the employer's representative for this purpose, I agree that this employing organization will treat this employee's loss of Medicaid eligibility or KI-HIPP eligibility as a qualifying event to terminate enrollment in the health benefit plan. This employer will allow the employee to terminate enrollment in the plan within sixty (60) days following receipt of a written request for disenrollment from the health benefit plan.

Signed: _____
(Employer, or Employer's representative with authority to establish an enrollment termination date for a health benefit plan)

Date: _____

KIHIPP-025 (January 2020)

**EMPLOYER CERTIFICATION THAT LOSS OF MEDICAID OR KI-HIPP ELIGIBILITY IS
A QUALIFYING EVENT TO END COVERAGE**

As an employer, or the employer's representative for this purpose, this letter serves as notice that this employing organization will treat an employee's loss of Medicaid eligibility or KI-HIPP eligibility as a qualifying event to terminate enrollment in any of our health benefit plans offered to employees.

Furthermore, this employer will allow employees who lose Medicaid eligibility or KI-HIPP eligibility to terminate enrollment in a health benefit plan within which the employee is participating within sixty (60) days following receipt of a written request for disenrollment from the health benefit plan.

Signed: _____
(Employer, or Employer's representative with authority to establish an enrollment termination date for a health benefit plan)

Date: _____