Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program

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Welcome

Welcome to the Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program!

KI-HIPP is a voluntary Medicaid program offered to Medicaid members to help pay for the cost of an Employer-Sponsored Insurance (ESI) plan. In addition, enrolled members may also include Non-Medicaid policy holders with at least one Medicaid member on the plan.

This Member Handbook is designed to answer questions related to KI-HIPP and acts as a reference guide for understanding KI-HIPP benefits.

Please review this KI-HIPP Member Handbook and keep a copy with your records.

Thank you for letting us be a part of your healthcare team!

For any questions about the KI-HIPP program, please contact the **KI-HIPP Call Center** at **855-459-6328**.

Glossary of Terms

Term	Definition
kynect benefits	The website where an Individual, Authorized Representative (AR), or Assister may complete an application for benefits.
Copays	A fixed dollar amount paid to the provider for a covered healthcare service.
Deductible	The dollar amount paid for a covered healthcare service before the plan starts to pay.
Employer-Sponsored Insurance (ESI)	Health insurance offered through an employer.
In-Network	Providers that are contracted with the health plan in order to provide healthcare services for enrolled plan members.
Managed Care Organization (MCO)	A health care organization providing a wide range of healthcare services and benefits. If a Medicaid member is enrolled in an MCO, they will also receive an insurance card from the MCO. Current MCO's include Aetna, Anthem, Humana Caresource, Passport, and WellCare.
Medicaid Card	Kentucky Medicaid members are issued Medicaid ID cards which include the member's name and Medicaid ID number on the front of the card. ***For reference, please review the Medicaid Card image below.***
Out-Of-Pocket Costs	Expenses for medical care that are not reimbursed by health insurance, including copays and deductibles.
Policy Holder	The person who purchases insurance through his/her employer.
Premium	The fixed dollar amount that the policy holder must pay each month in order to receive health insurance coverage.
Provider	An individual, group, or entity that provides healthcare services.
Waiver Services Member	A Medicaid member enrolled in a Medicaid waiver program, such as Home and Community Based (HCB).

***Kentucky Medicaid Card**

KI HIPP
Kentucky Integrated Health Insurance Premium Payment Program

Program Overview

What are the benefits of KI-HIPP?

The KI-HIPP program provides payments to help its members pay for Employer-Sponsored Insurance (ESI) while providing access to all providers within the **Medicaid network**. The benefits offered by an employer's health insurance plan may be very similar to Medicaid benefits.

May widen healthcare network by providing access to providers and healthcare services through the full Medicaid network

May help make employer health insurance affordable by reimbursing the policy holder for the ongoing insurance premiums

May allow an entire family to be on the same health insurance plan and access the same providers

Who is eligible for KI-HIPP?

Eligibility for the KI-HIPP program is based on the following criteria:

The types of health insurance plan that may be used for KI-HIPP include:

- Insurance through an **Employer (ESI) Plan**

- **United Mine Workers**
- **Retiree Health Plan**
- **COBRA**

Member Responsibilities

What do I need to do after I enroll in KI-HIPP?

ALL of the actions below must be taken in order to remain enrolled in KI-HIPP:

Have a Medicaid member on the policy. Have at least one member on the plan enrolled in Medicaid in order to stay in the KI-HIPP program.

Remain enrolled in Employer-Sponsored Insurance (ESI). If there are changes to the insurance plan, such as a premium change or the policy holder is no longer enrolled in the plan, the policy holder must "report a change" to **kynect benefits** at kynect.ky.gov or email **KIHIPP.Program@ky.gov**

Pay the health insurance premium. For those with Employer-Sponsored Insurance (ESI), the premium may automatically be taken out of each paycheck to pay for health insurance coverage.

Submit proof of premium payment when notified. In order to receive ongoing KI-HIPP payments, the policy holder must submit proof of premium payment when they receive a reminder notice from the KI-HIPP Team. It is important to **pay attention to KI-HIPP notices** to know when to **submit proof of premium payment**. Policy holders typically receive the Notice to Provide Premium Payment Proof and/or Notice of Renewal as reminders.

- The policy holder may submit a **paystub** or **letter from their health insurance company** as proof of premium payment.
- If the policy holder does not submit proof of premium payment on time, they have **up to 60 days** to submit proof to receive the KI-HIPP payment.
- KI-HIPP Notices are sent to the policy holder.

These are the different ways to submit documents:

Upload:
kynect.ky.gov/benefits

Mail:
CHFS KI-HIPP Unit
275 East Main Street, 6C-A
Frankfort, KY 40621

Email:
KIHIPP.Program@ky.gov

If the actions listed above are not taken and KI-HIPP benefits are lost, the Medicaid member will stay enrolled in the ESI plan until they are disenrolled by the policy holder. The policy holder will **no longer** receive the ongoing KI-HIPP payments that help pay for the cost of ESI premiums.

Member Responsibilities Cont.

KI HIPP
Kentucky Integrated Health Insurance Premium Payment

How do I report a change?

If the Medicaid member on the policy has any changes that may impact **eligibility for Medicaid**, the member needs to "report a change" on **kynect benefits** at kynect.ky.gov or contact **DCBS** at **855-306-8959**. The Medicaid member must "report a change" if any of the changes below apply:

Income	Employer	Health Plan
Household Size	Address	Tax Filing Status

When do I report a health insurance change?

If there is a change to the health insurance plan, the policy holder must report a change to continue receiving KI-HIPP benefits. If health insurance plan changes are not reported, there may be a **loss or reduction in the ongoing KI-HIPP payments**.

The policy holder must report a change if any of the changes below apply to the health insurance plan:

- **Loss of Health Insurance Plan**
- **Changes to the Premium Cost for Health Insurance Plan**
- **Adding or Removing Members on Health Insurance Plan**

The policy holder may report these changes to the KI-HIPP Team via:

Visit kynect benefits:
kynect.ky.gov

Call the KI-HIPP Call Center:
855-459-6328

If the policy holder does **not** report a loss in health insurance coverage but continues to receive KI-HIPP payments, the **policy holder will be responsible for repayment**. This means that the policy holder must pay back the KI-HIPP payments they received.

Member Responsibilities Cont.

KI-HIPP
Kentucky Integrated Health Insurance Premium Payment

When should I submit proof of premium payment?

Starting on **June 1, 2020**, enrolled KI-HIPP members must submit proof of premium payment **when notified**. KI-HIPP members must **pay attention to notices from the KI-HIPP mailbox** to know when it is time to submit.

Please Note: Depending on the health insurance plan, some KI-HIPP members may be required to provide additional proof of premium payment when notified. This typically occurs on:

Plan End Date	As Needed
The end of the health insurance plan coverage period	The KI-HIPP Team may request proof of payment outside of the Plan End Date

What happens if I'm disenrolled from KI-HIPP?

If disenrolled from KI-HIPP due to **failure to submit documents** to the KI-HIPP team, the policy holder will no longer receive premium payments and will be responsible to pay for the ESI plan.

Example of Notice Timeline for December 31, 2020 Plan End Date:

Notice to Provide Proof of Premium Payment

The member must submit proof of premium payment (paystub) before the Plan Midpoint Date of June 30, 2020.

Notice of Renewal

The member must submit a recent paystub and enrollment documents for their 2021 health plan before the Plan End Date.

Member disenrolled from KI-HIPP

The member **did not** submit a recent paystub and 2021 plan enrollment documents by the Plan End Date.

Member transitions back to MCO

Members that transitioned from a Managed Care Organization (MCO) are re-enrolled.

For Medicaid members previously enrolled in an MCO, if **ESI coverage is lost**, the Medicaid member will transition out of the KI-HIPP program and back to an MCO.

Individuals who are disenrolled from KI-HIPP may request their employer to disenroll them from the ESI plan. It is at **the employer's discretion** to consider KI-HIPP disenrollment or loss of Medicaid eligibility as a **qualifying event** to disenroll from ESI.

Coverage Details

What medical costs are covered by KI-HIPP?

The choice of provider impacts the cost of services. The KI-HIPP program does **NOT** cover out-of-pocket costs for the Medicaid member if the provider is a Non-Medicaid Provider.

KI-HIPP will cover costs if:

The Member visits a Medicaid Provider

KI-HIPP will NOT cover costs if:

For Medicaid member(s) on the policy, be sure to give the provider or pharmacist **both** the ***Medicaid Card*** AND ***Insurance Card*** when paying for services or a prescription.

A Card from the Employer's Health Insurance Company

The employer's health insurance company will send a health insurance card. This card will be **active** as long as the member is enrolled in the ESI plan.

- If there is something wrong on the insurance card, contact the health insurance company directly with the phone number listed on the back of the card.
- There may also be separate cards for vision or dental plans.

A Kentucky Medicaid Card

Medicaid members should keep their existing Kentucky Medicaid Card. It has the member name and Kentucky Medicaid Identification (ID) number on the front.

- Do **not** throw this Medicaid card away!
- If the member loses the Medicaid card or sees something wrong on it, contact **DCBS** at **855-306-8959** to ask for another one.
- The card is **active** as long as the member is enrolled in Medicaid.

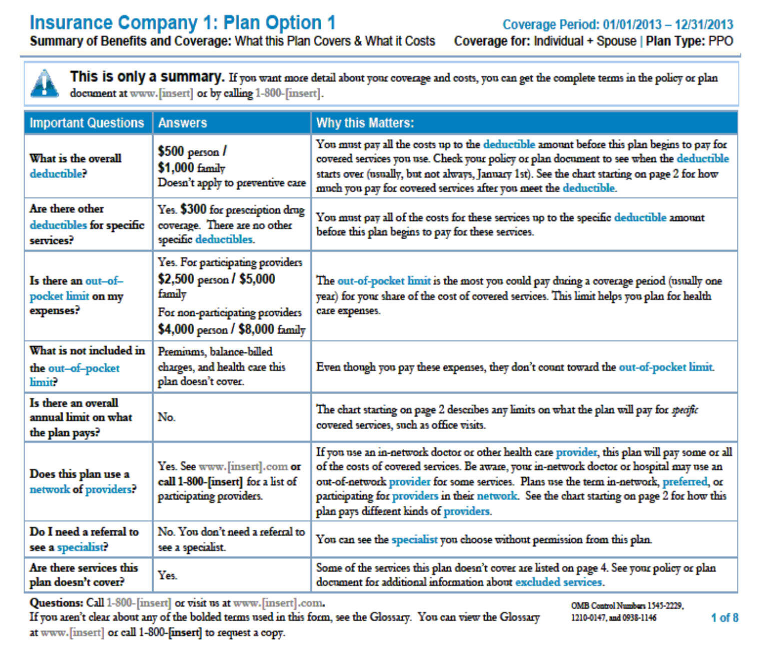
If dental and vision coverage fall under the Medicaid member's **current Medicaid benefits,** these benefits are still available. KI-HIPP does not provide payments for separate employer dental and vision coverage plans.

Coverage Details Cont.

Where can I find information about my plan details?

The **Summary of Benefits and Coverage (SBC)** shows the employer's health insurance benefits and lists some of the out-of-pocket costs. It is important to check the ESI plan to understand possible co-pays and the deductible for seeing a Non-Medicaid Provider.

Request a copy of the SBC from the employer or health insurance company to review all of the benefits within the health insurance plan.



Insurance Company 1: Plan Option 1
Summary of Benefits and Coverage: What this Plan Covers & What it Costs
Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Individual + Spouse | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 person / $1,000 family. Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers $2,500 person / $5,000 family. For non-participating providers $4,000 person / $8,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-[insert] or visit us at www.[insert].com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.
OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
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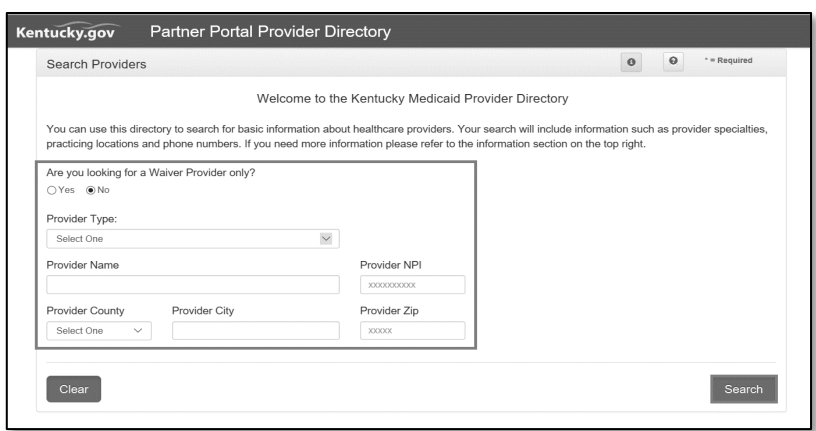
There are no changes to the billing process. Providers use the same process previously used for individuals with Medicaid and additional insurance or third party liability.

To check if a provider is a Medicaid provider:

1. Go to the **Partner Portal Provider Directory** by typing this URL in the browser: https://prdweb.chfs.ky.gov/ProviderDirectory/PDSearch.aspx
2. Select **"No"** for *Are you looking for a Waiver Provider only?*
3. Select and fill in the appropriate information.
4. Click the **Search** button.
5. Once you select a provider, call to confirm they take "fee for service" Medicaid.



For help finding In-Network Providers that accept Medicaid, please call **855-459-6328**.

MCO Disenrollment

What does the MCO Disenrollment Letter mean?

Please Note: this page applies to Medicaid members enrolled in an MCO (e.g. Aetna, Anthem, Humana Caresource, Passport, and WellCare).

After enrolling in KI-HIPP, the Medicaid member receives an **MCO Disenrollment Letter**. The process below explains the purpose of this letter:

Enrollment in ESI

The Medicaid member receives the **Notice of Health Insurance Plan Review** saying which ESI plans are eligible for KI-HIPP after applying to the program. To complete KI-HIPP enrollment, the Medicaid member must enroll in an ESI plan that is eligible for KI-HIPP.

Enrollment in KI-HIPP

Once fully enrolled, the Medicaid member is transitioned from their Managed Care Organization (MCO) to traditional Medicaid to allow for KI-HIPP payments of the premium to occur. **The member will continue to receive all of the benefits of Medicaid.**

MCO Disenrollment

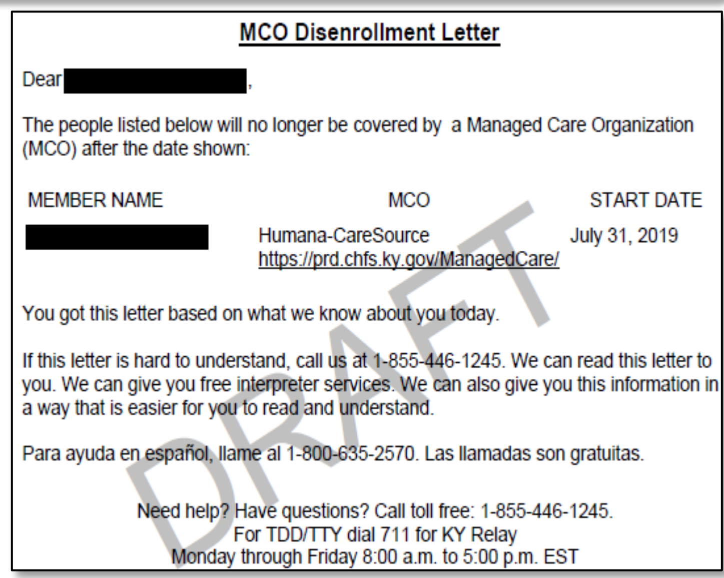
The member will then receive an **MCO Disenrollment Letter** because they are no longer covered by an MCO. However, now they have two sources of coverage: Primary coverage from the ESI plan AND secondary coverage from Medicaid.

Coverage of Enrolled KI-HIPP Members:

✗ **Managed Care Organization (MCO):** The Medicaid member may no longer have access to MCO-specific benefits or programs

✓ **Traditional Medicaid:** Provides access to the full network of Medicaid benefits and providers

✓ **Employer-Sponsored Insurance (ESI):** May provide access to another set of benefits and providers, although with potential co-pays and deductibles*



MCO Disenrollment Letter

Dear [redacted],

The people listed below will no longer be covered by a Managed Care Organization (MCO) after the date shown:

MEMBER NAME	MCO	START DATE
[redacted]	Humana-CareSource https://prd.chfs.ky.gov/ManagedCare/	July 31, 2019

You got this letter based on what we know about you today.

If this letter is hard to understand, call us at 1-855-446-1245. We can read this letter to you. We can give you free interpreter services. We can also give you this information in a way that is easier for you to read and understand.

Para ayuda en español, llame al 1-800-635-2570. Las llamadas son gratuitas.

Need help? Have questions? Call toll free: 1-855-446-1245.
For TDD/TTY dial 711 for KY Relay
Monday through Friday 8:00 a.m. to 5:00 p.m. EST

DRAFT

The Medicaid member still has access to Medicaid benefits. Please review the Medicaid Member Handbook or call **855-459-6328** for any additional questions.

Renewal Process

When should I renew KI-HIPP enrollment?

Depending on the KI-HIPP Coverage End Date, the **Medicaid Recertification Date may change to the same date as the KI-HIPP Renewal Date**. This means that the policy holder may renew Medicaid coverage and KI-HIPP coverage at the same time.

If the Medicaid Recertification date is changed to align with the KI-HIPP Renewal Date, a notice will be sent to the policy holder. This notice is sent as a reminder to submit Medicaid and KI-HIPP renewal documents by the Medicaid Recertification Date/KI-HIPP Renewal Date.

How do I renew KI-HIPP and Medicaid benefits?

To continue receiving KI-HIPP and Medicaid benefits, the policy holder must **provide renewal documents to the appropriate departments**.

KI-HIPP Renewal Process

To renew KI-HIPP coverage, the policy holder must submit the following documents to the KI-HIPP Team:

- Paystub showing that the premium was paid on or before the health insurance plan end date
- Summary of Benefits and Coverage (SBC) for next benefit year
- Premium Rate Sheet for next benefit year
- Copy of Health Insurance Card as proof of changes in enrollment

Medicaid Renewal Process

To renew Medicaid coverage, the policy holder must report any household changes to the Department for Community Based Services (DCBS) in one of the following ways:

- Mail or fax the completed Renewal Form for Medical Coverage
- Contact **DCBS** at **855-306-8959** to report household changes
- Report changes in kynect benefits (kynect.ky.gov)
- In-Person at a DCBS office (To find a DCBS office near you, please visit https://prd.webapps.chfs.ky.gov/Office_Phone/)

Policy holders may receive KI-HIPP-related SMS text messages, such as reminders. To receive KI-HIPP-related SMS text messages, the policy holder must enter their cell phone number and mark electronic communication (SMS/email) as the preferred method of communication in kynect benefits (**kynect.ky.gov**).

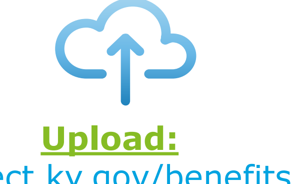
Resources

Resources

The resources below include important phone numbers and website links for additional information or assistance.

Report A Change	Go to **kynect benefits** at kynect.ky.gov or contact **DCBS** at **855-306-8959**.
Questions	For any questions about KI-HIPP, contact the **KI-HIPP Call Center** at **855-459-6328** or visit the KI-HIPP website at https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Medicaid Card	If the Medicaid member loses their Medicaid card or sees an error on the card, contact the **local DCBS office** or call **855-306-8959** to ask for another one.
Provider Directory	Search for **Medicaid Providers** via the **Partner Portal Provider Directory** at https://prdweb.chfs.ky.gov/ProviderDirectory/PDSearch.aspx
Waiver Programs	For general information on Medicaid waiver programs, please refer to the Medicaid Waiver Services Factsheet: https://chfs.ky.gov/agencies/dms/MAPForms/Map418.pdf.
Annual KI-HIPP Renewal	A Notice of Renewal is sent 90 days before the coverage end date of the current plan. This notice is a reminder to submit plan enrollment documents to the KI-HIPP Team if there are any changes to the health plan for the next year. The KI-HIPP Renewal is separate from the annual Medicaid Renewal Notice.

How to submit documents to the KI-HIPP team:



Upload:
kynect.ky.gov/benefits

Email:
KIHIPP.Program@ky.gov

Mail:
CHFS KI-HIPP Unit
275 East Main Street, 6C-A
Frankfort, KY 40621

For more information, including how to appeal denied claims or get approval for services before you get them, please see the **Medicaid Member Handbook** at: https://chfs.ky.gov/agencies/dms/dpo/epb/Documents/MedicaidMemberHandbook.pdf