

KI-HIPP Questions

VOLUNTARY VS. MANDATORY

- KI-HIPP materials, including the slide deck from the June 9 Stakeholder Forum in London, state KI-HIPP is a “voluntary program”, which would imply voluntary at all phases. However, the regulation uses the term “shall”.
 - QUESTION: Is this a completely voluntary program that a Medicaid beneficiary can choose to enroll in and leave at any time? Is any part of KI-HIPP mandatory after initial enrollment?
- According to the regulation, beneficiaries interested in the program must provide documentation to determine cost-effectiveness or face termination from Medicaid (Section 2). Additionally, under the Cost Effectiveness Review section (Section 5), it states that KI-HIPP participants who do not provide required KI-HIPP documentation to determine ongoing cost effectiveness will be terminated from Medicaid.
- The “Notice Guide”, on the “Notice of Incomplete/Invalid Document” page, says that KI-HIPP participants who do not send documents “may have a reduction or loss of benefits”, while the consequence on the “Notice to Provide Premium Payment Proof” is “you may be disenrolled from KI-HIPP by the end of the month”.
- On the other hand, the KI-HIPP Member Handbook states “If you lose your health coverage or fail to meet the program requirements, you will transition out of the KI-HIPP program back to your previous Managed Care Organization”, implying there would be no termination of Medicaid benefits.
- The Authorization section of the application form does not provide an indication as to whether Medicaid benefits are terminated as a result of failing to comply with the review of cost effectiveness.
 - QUESTION: How much time does a beneficiary have to submit complete documentation for KI-HIPP enrollment or redetermination? When notified of incomplete documentation/RFI, how much time will they have to supply the requested documentation before they are terminated?
 - QUESTION: Can you clarify what happens when a KI-HIPP enrollee is no longer compliant/eligible for the KI-HIPP program, but is still Medicaid eligible?
- Additionally, if KI-HIPP is a totally voluntary program, there does not appear to be an opt-out provision if the beneficiary decides they no longer wish to participate for any reason.
 - QUESTION: Can you provide examples of when/how a participant may opt out of participation in the program?

NETWORKS/COVERED SERVICES

- For wrap-around services, Section 3 of the regulation states “the department shall reimburse for the service” not covered by ESI (for example, dental services). Although not explicitly stated, it is assumed the beneficiary would need to access such services from a Medicaid provider, which the Handbook seems to clarify on page 7.

- QUESTION: Will KI-HIPP enrollees only be able to access wrap-around services from Medicaid providers? If that is not the case, who is responsible for the difference between the amount charged by an ESI-network provider and the Medicaid reimbursement rate?
- QUESTION: How does the Medicaid FFS provider network and formulary differ from the MCOs? Does the FFS network automatically include any MCO credentialed providers?
- The second part of this statement on page 7 of the Handbook is confusing because the link to the guide is only for Medicaid providers, not ESI network providers: “Follow the steps below to check if your provider is a Medicaid Provider (In-Network and ESI Network providers)”.
 - QUESTION: If a participant so chooses, is he or she allowed to continue to be seen by a provider who accepts Medicaid but does not accept the participant’s ESI? Will this be a factor during the annual redetermination of cost effectiveness?
 - If a KI-HIPP participant sees an ESI provider who does not accept Medicaid, who will be responsible for any out-of-pocket costs?
- Surprise medical bills occur when a person receives a medical service involving multiple providers, one or more of which may not participate in the person’s private insurance plan (for example: during a surgery, an anesthetist does not have a contract with that insurance plan, and the cost of their role is not covered).
 - QUESTION: If that non-participating provider also does not accept Medicaid, how will that situation be handled?

PAYMENTS/REIMBURSEMENTS

- The regulation (Section 4) states that DMS will take all costs—including premiums, deductibles, coinsurance, and “other cost sharing obligations”—into consideration when determining cost effectiveness. However, none of the materials provided on the KI-HIPP page detail the process beneficiaries use to claim reimbursement for out-of-pocket expenses; they only focus on reimbursements for premiums and how to ensure continued eligibility.
 - QUESTION: Do beneficiaries submit proof of out-of-pocket expenses the same way they submit proof of premium payment? If so, how long does it take for an individual to receive reimbursements for premiums and other out-of-pocket expenses?
 - QUESTION: If KI-HIPP does not cover out-of-pocket expenses for non-Medicaid providers, how is this being communicated to KI-HIPP enrollees in marketing materials, the KI-HIPP application, the member handbook, and/or notices?
 - QUESTION: What will the appeals process be for KI-HIPP for disputing denied services, out-of-pocket costs, surprise bills, etc?
- The KI-HIPP Notice of Eligibility Insert contains this statement: “You may see a \$1 deduction from your first KI-HIPP payment of the month if your health insurance plan covers a non-allowable service under Medicaid.” This is not mentioned anywhere in the regulation.
 - QUESTION: What services does this include? Why is this a penalty to the participant? Can examples be provided?