TO:	Local District Commissioners, Medicaid Directors
FROM:	Judith Arnold, Director Division of Eligibility and Marketplace Integration
SUBJECT:	Public Assistance Reporting Information System (PARIS) Match and Retroactive Managed Care Disenrollments
ATTACHMENT:	Guidelines for PARIS Matches
EFFECTIVE DATE:	Immediately
CONTACT PERSON:	Local District Support Units Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to remind local departments of social services (LDSS) of the requirements for processing matches identified through the Public Assistance Reporting Information System (PARIS), including procedures for processing retroactive managed care disenrollments.

In accordance with Section 1903(r) of the Social Security Act, all states are required to have eligibility determination systems that provide for data matching through PARIS. Since October 1, 2009, participation in PARIS is also a condition of receiving Medicaid funding for automated data systems (including the Medicaid Management Information System). PARIS is a data matching service used to check if consumers are receiving duplicate benefits in two or more states. PARIS matches help to identify improper payments and minimize fraud and abuse.

A Medicaid consumer may not know that costs are being incurred on his or her behalf (monthly capitation payments) due to a move to another state. Many Medicaid matches are on children.

Each local district is responsible for processing PARIS matches for consumers whose Medicaid case is administered by the LDSS. The established requirements, process and procedure of posting PARIS matches on the New York State (NYS), Office of Health Insurance Programs (OHIP), database have not changed. OHIP continues to post quarterly PARIS matches and local districts are required to process the cases and report resolutions back to OHIP via the database within 60 days.

To assist local districts in resolving PARIS matches, the attachment to this GIS message includes a compilation and recommendation of “Best Practices” for determining a consumer’s current state of residence. The attachment provides guidance in the development of procedures for conducting case investigations and research, and taking case actions upon resolution of the PARIS match. Guidance concerning the documentation that should be in the case record is also included.

Retroactive Managed Care Disenrollments

Past audit reviews indicate delays by the local districts in identifying and notifying managed care plans of retroactive disenrollments of consumers. While most managed care disenrollments are prospective, certain circumstances, including a PARIS match, require that a consumer be retroactively disenrolled from a managed care plan. This includes a Medicaid managed care plan, a Special Need Plan (SNP), Managed Long-Term Care (MLTC), Fully Integrated Dual Advantage (FIDA), Fully Integrated Dual

Advantage for Individuals with Developmental Disabilities (FIDA-IDD), Health and Recovery Plans (HARP), Medicaid Advantage Plus (MAP) and Program of All-Inclusive Care for the Elderly (PACE).

Once a PARIS match has been resolved, the local district must conduct additional analysis to determine if the consumer received concurrent Medicaid benefits for an entire month, in both New York State and another state. As part of the analysis, the local district must determine if a retroactive managed care disenrollment is warranted. Fee-for-service consumers are exceptions to this rule. If a consumer has moved back to New York, retroactive disenrollment and capitation payments may still be pursued for any period the consumer resided out of State and received concurrent benefits for an entire month.

Local districts are responsible for notifying managed care plans and the Office of the Medicaid Inspector General (OMIG) of a consumer's retroactive disenrollment, including the retroactive effective date. The effective date of disenrollment is based on the first day of the month in which the consumer received concurrent benefits for the entire month. Local districts must notify OMIG on the same day that they notify the managed care plan of the consumer's retroactive disenrollment. To notify OMIG, the local district should process a retroactive disenrollment notification and enter the required consumer and managed care plan information. Local districts may contact retrodata@omig.ny.gov for the retroactive disenrollment notification template.

Note: For enrollees in a FIDA-IDD plan, retroactive disenrollments must go through the Office for People with Developmental Disabilities. Similarly, disenrollments from a FIDA plan must go through Medicaid Choice. Both types of plan disenrollments require coordination with the Medicare managed care disenrollment.

For detailed information on the retroactive disenrollment process and completing retroactive disenrollment notifications to OMIG and managed care plans, local districts can refer to a webinar developed by OMIG entitled, "Retroactive Disenrollment Notification Process." To view the webinar, click on the following link: https://www.youtube.com/watch?v=X662RNJNT7s&feature=youtu.be.

The webinar presentation is also available in PDF format by accessing the "Quick Links" section of the OMIG home page on the internet. Since the Centers for Medicaid and Medicare (CMS) approval of the amended MMC/FHP/HIV SNP/HARP model contract effective October 1, 2015, some slides in the current webinar are outdated, e.g., the retroactive disenrollment codes have been expanded and revised. OMIG is in the process of updating the webinar. In the interim, local districts may contact retrodata@omig.ny.gov for a revised list of retroactive disenrollment codes.

Managed care premiums must be returned whenever a retroactive disenrollment has been processed unless the plan provided services to the enrollee. Plans have 30 days from the date of retroactive disenrollment notification to void/return the capitation payments. If the retroactive disenrollment qualifies for the Department of Health encounter reimbursement process, the 30-day requirement does not apply. OMIG conducts reviews to verify that the managed care capitation payment has been voided/returned by the plan.

Once a managed care plan has been notified of a retroactive disenrollment, they have 10 days to dispute the decision based on a PARIS match. Upstate managed care plans can submit their disputes to the local district. New York City (NYC) mainstream plans, SNP and HARP plans can submit their disputes to retrodisenroll@health.ny.gov. NYC MLTC, FIDA and PACE plans may submit their disputes to mltcretrodisputes@health.ny.gov. The local district has 10 business days to resolve the dispute with the plan. If the local district and the managed care plan are unable to resolve the dispute, the local district may contact the Division of Health Plan Contracting and Oversight or The Division of Long Term Care at the above email addresses.

Questions or requests for additional information related to the retroactive disenrollment notification process may be sent to retrodata@omig.ny.gov.

Questions related to PARIS matches can be directed to your local district support liaison.