



MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

November 30, 2018

The Honorable Edward J. Kasemeyer
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chairman
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2018 Joint Chairmen's Report (p. 93) – Report on the Impact of Data Matching and Return Mail Measures

Dear Chairs Kasemeyer and McIntosh:

Pursuant to the requirements of the 2018 Joint Chairmen's Report (p. 93), please find enclosed a report on the impact of data matching cost-containment initiatives as well as its proposed mail return policy. As you may recall, both initiatives were previously in the testing phase and there was not sufficient data available to compile a report in time to meet the September 1 due date for the initial report (the final report was due December 1). As a result, in July the Department submitted an extension request and received permission to submit one comprehensive report by December 1. The enclosed report encompasses both the interim and final report on this subject for submission by the Department.

Thank you for your consideration of this information. If you have questions or need more information on the subjects included in this report, please contact Webster Ye, Deputy Chief of Staff at (410) 767-6480 or webster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

I. Executive Summary

Pursuant to the requirements of the 2018 Joint Chairmen's Report (p. 93), the Maryland Department of Health (the Department) submits this report addressing the impact of two data matching initiatives, Public Assistance Reporting Information System (PARIS) data matches (See Appendix A) and Periodic Data Matching (See Appendix B), and the impact of the Department's proposed updates to its Mail Return Policy (See Appendix C). Specifically, this report addresses: the number of individuals removed from the Medicaid program in each month after implementation; if, and when, those individuals returned to the Medicaid program; and, the number of individuals who are re-categorized but remain on the Medicaid program.

The Maryland Medicaid Program serves approximately 1.3 million low income Marylanders. More than 85 percent of Maryland Medicaid participants receive their care through HealthChoice, Maryland's statewide mandatory managed care program implemented in 1997 under authority of Section 1115 of the Social Security Act. The HealthChoice program seeks to improve access and quality of care to participants by providing comprehensive, patient-focused, coordinated care.

Eligibility determinations for most HealthChoice participants are made through Maryland's state-based marketplace, the Maryland Health Connection. Medicaid participants eligibility must be redetermined once every 12 months. This process is also known as a "redetermination." For both initial and redetermined eligibility decisions, the information a participant attests to in their application is checked against electronic federal and state data sources. Approximately 60% of participants are automatically renewed for coverage each month because their applications can be redetermined using administrative data. The remaining 40% must update their application for benefits through the online redetermination process and provide verifications that prove their income or other eligibility factors if needed. Individuals who lose Medicaid coverage because they fail to meet eligibility or to complete their redeterminations timely and who subsequently re-apply for benefits and are found eligible are re-enrolled in the same managed care organization (MCO) when they return within four months. Additionally, when an individual loses Medicaid coverage, they may qualify for a Special Enrollment Period through Maryland Health Connection and be eligible to purchase a Qualified Health Plan.

Over the past year, the Department has been exploring two data-matching opportunities and a potential change to its mail return process. All three initiatives are designed to improve the integrity of the Medicaid program. Specifically, the two data matching initiatives are (1) federally required PARIS data matching, and (2) Periodic Data Matching with data in existing verification services (e.g., Federal Data Services Hub (FDSH) and Maryland Automated Benefits System (MABS)) to identify changes that may impact eligibility. The third initiative is a residency verification process tied to mail returns. The first of these initiatives, PARIS data matching, has been successfully implemented. The remaining two are still in the pilot phase.

Since January 2018, the Department has processed quarterly matches of Medicaid participants enrolled through Maryland Health Connection against PARIS. Of the 24,489 participants with a PARIS match in the December 2017 file, 48.7 percent had an eligibility cancellation event by

August 2018. Only 4.2 percent of individuals with cancelled eligibility re-enrolled by August. Notably, a high proportion of PARIS matches occur because although the participant is residing in Maryland, the other states are required to act in order for the participant to be removed from the match list. The Department has yet to formally implement comprehensive Periodic Data Matching and the change to its Mail Return Policy. Both initiatives remain in a pilot phase.

II. Conclusion

The Department has successfully implemented the PARIS matching. The Department plans to continue to analyze the remaining initiatives, Periodic Data Matching, and the change to its Mail Return Policy, before proceeding with full implementation. The Department remains dedicated to continually improving the integrity of the Medicaid program while ensuring low income Marylanders are able to access comprehensive, patient-focused, coordinated care.

Appendix

A. Public Assistance Reporting Information System (PARIS)

Since December 2017, the Department has performed quarterly matches of Medicaid participants enrolled through Maryland Health Connection against PARIS. The first match was processed beginning in January 2018. For purposes of this report, two files were analyzed—PARIS matches from the December 2017 quarterly match and the June 2018 quarterly match. From January to August 2018, 48.7 percent of PARIS matches had an eligibility cancellation event by August. Of the participants with a PARIS match in the June file, 28.1 percent of the PARIS matches had an eligibility cancellation event by August. Notably, a high proportion of PARIS matches occur because although the participant is residing in Maryland, the other states are required to act in order for the participant to be removed from the match list. The Department will continue to monitor these files closely. Over time, the Department expects the number of participants in the PARIS match files to decrease and level off from the high volume seen in December because current and future matches will include only newly match customers and because other states will take action to close the previously identified cases.

1. Overview of Public Assistance Reporting Information System (PARIS)

PARIS is a state and federal partnership that insures the integrity of public assistance programs (such as Temporary Assistance for Needy Families, Medicaid, Supplemental Nutrition Assistance Program, Supplemental Security Income and other federal and state public assistance programs) by detecting and deterring improper payments. States are mandated to conduct PARIS matches by the Social Security Act (SSA) and by guidance received in 2010 from the Centers for Medicare & Medicaid Services (CMS). PARIS works with all 50 states, the District of Columbia and Puerto Rico to assist them in maintaining the integrity of public programs. PARIS functions as a data matching service that checks whether participants of Medicaid are active for eligibility in two or more states. PARIS matches help identify improper payments as well as minimize waste, fraud and abuse.

PARIS was initiated in 1993 as a set of computer matches which enables state public assistance agencies (SPAAs) and federal agencies to share information about applicants for and recipients of certain benefits. SPAAs enroll in PARIS, which permits them to participate in quarterly matches of client eligibility and enrollment data files. These files are transmitted to the Department of Defense's Defense Manpower Data Center (DMDC). Since October 1, 2009, states must participate in PARIS as a condition of receiving Medicaid funding for automated data systems based on provisions of the QI Program Supplemental Funding Act.

The DMDC provides computer resources to support PARIS development and operation. DMDC produces a quarterly match file based on Social Security Numbers (SSN). States participating in the match submit their enrollment data to DMDC to determine if there is a match to the DMDC quarterly file. The majority of PARIS states allow staff 30-45 days to complete their work on a match and some allow staff up to 90 days; there is no required completion deadline.

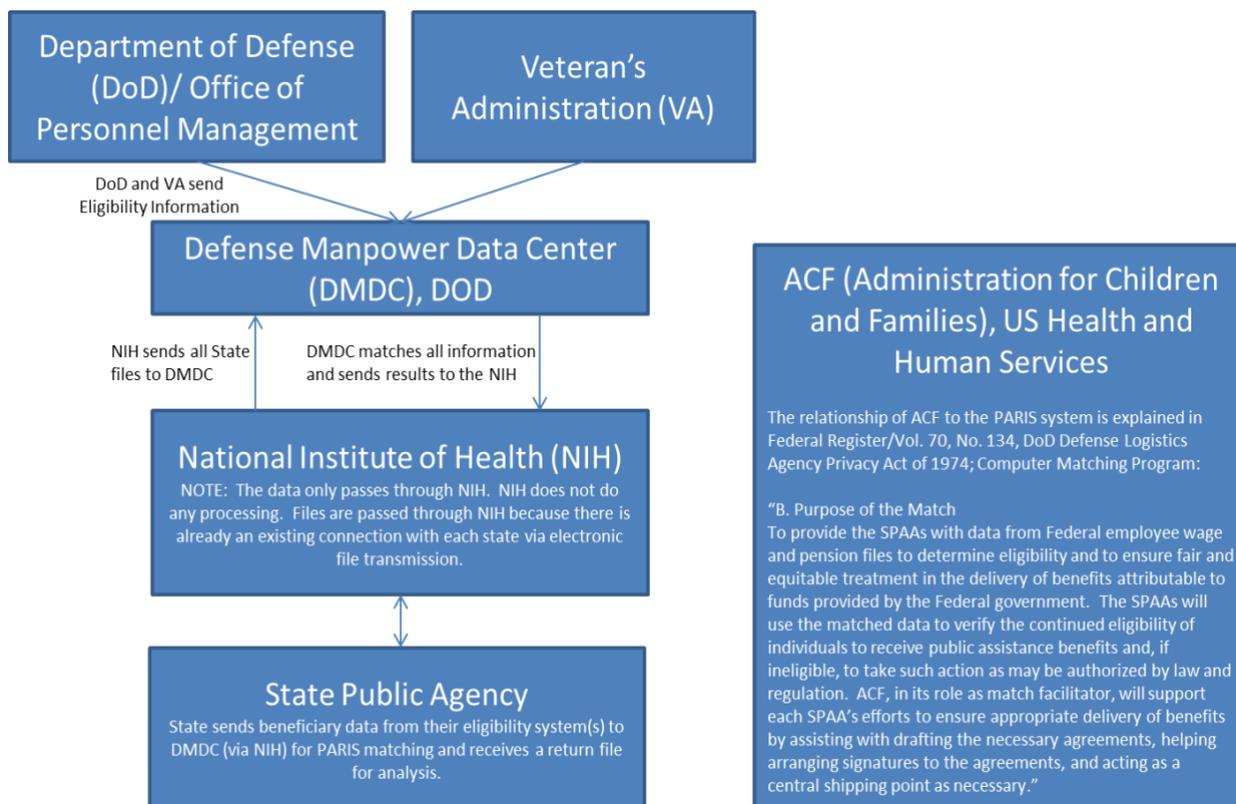
In June 2017, Maryland began the planning process for a PARIS interface so that the Maryland Health Connection could automate quarterly data matches from PARIS. PARIS conducts the following matches:

- An Interstate match, which compares participating states' data against each other and determines if an individual is collecting benefits in more than one state.
- A Federal match, which determines whether anyone receiving benefits is also collecting a salary or retirement pension as a current or former U.S. military or civil service employee.
- A Veterans Administration (VA) database match to determine if an individual is collecting VA benefits.

The following processes take place to process PARIS data matches for Medicaid participants in Maryland Health Connection:

- Maryland Health Connection creates work items for caseworkers in the Worker Portal when it receives the quarterly PARIS match file with data matches for Medicaid participants.
- The work items generate to caseworkers' queues when the caseworker clicks a button to receive work.
- Caseworkers access the work items to review the PARIS data, contact the household to determine if the benefits received impact the participants' eligibility for Maryland Medicaid and take appropriate action if needed.
- Depending on the PARIS data for the participants, caseworkers will either cancel Maryland Medicaid coverage, or initiate an unscheduled redetermination outside the standard 12-month cycle or allow the Medicaid coverage to continue because the customer resides in Maryland or otherwise satisfied the eligibility requirement in question.

Figure 1.¹ PARIS Data Flow Chart



2. Data Analysis

The Department is in the early stages of evaluating the impact of the PARIS matching initiative. The Department anticipates that the number of participants with a PARIS match will level off over time. The number of preliminary quarterly matches may be higher than what can be expected after the process has been in place for a year or more as enrollment files are verified with greater frequency and as other states close the cases that repeatedly create matches even though the participant lives in Maryland. Additionally, the impact of a match on enrollment is not immediate. Participants identified in a PARIS match are not automatically disenrolled, and the decision regarding whether to cancel Maryland Medicaid coverage or initiate an unscheduled redetermination outside the standard 12-month cycle is made only after a caseworker reviews an individual case. As a result, a participant identified in a quarterly data run, e.g., December, may not lose coverage until a few months later when a caseworker has received and reviewed requested verifications from the customer. Participants who are disenrolled or subject to unscheduled redetermination receive system-generated notices and can appeal the adverse action.

¹ System Information. Public Assistance Reporting Information System, An Office of the Administration for Children and Families. <https://www.acf.hhs.gov/paris/system>.

Table 1 presents the number of participants in each file who received an eligibility cancellation within one of the noted months, as well as the total number and percentage of participants who received a cancellation in the measurement period. Of the 24,489 participants with a PARIS match in the December 2017 file, 48.7 percent had an eligibility cancellation event by August 2018. The Department further analyzed the 11,920 participants in the December file whose coverage ended to see if they re-enrolled by August 2018. Only 4.2 percent re-enrolled by August.

Of the 10,102 participants with a PARIS match in the June file, 28.1 percent had an eligibility cancellation event by August. The Department is monitoring the number of participants who subsequently return to coverage; however, findings regarding the June cohort are still being assessed.

Table 1. Number of Participants in PARIS Files with Cancelled Eligibility, by File

File	Number in File	Number Closed in February	Number Closed in March	Number Closed in April	Number Closed in May	Number Closed in June	Number Closed in July	Number Closed in August*	Total Number Closed	Percent Closed
December	24,489	1,147	1,885	2,320	2,384	1,776	1,055	1,353	11,920	48.7%
June	10,102						972	1,864	2,836	28.1%

*Latest data update available

The Department still considers these findings preliminary and will continue to monitor these files closely.

B. Periodic Data Matching (PDM) Pilot Program

On January 26, 2018, the Department began analyzing an internal data verification process called Periodic Data Matching (PDM) as a part of Maryland Health Connection system enhancements. PDM is designed as a quarterly post-eligibility verification check that matches the application information of individuals currently enrolled in Medicaid, Maryland Children’s Health Program (MCHP), MCHP Premium, and assisted Qualified Health Plans (QHPs) with data in existing verification services (e.g., Federal Data Services Hub (FDSH) and Maryland Automated Benefits System (MABS)) to identify changes that may impact eligibility. The PDM will check (1) monthly income, (2) enrollment in Medicare, and (3) death.

When the PDM identifies a discrepancy in monthly income, the Maryland Health Connection will send to the consumer a notice to verify income within 30 days or face cancellation of Medicaid coverage. An income discrepancy occurs when the consumer’s attested income is 10 percent higher or lower than the income listed on MABS, and the MABS income is above the applicable Federal Poverty Level limit for Medicaid eligibility. If an individual submits additional proof of income, and it is verified by a caseworker, the participant’s income information will be updated in the system, and the redetermination process will begin again for that member. If the participant does not submit proof of income or if the verification of income proves false, the participant may lose their coverage.

There are certain Medicaid eligibility groups that are not eligible for dual enrollment in Medicare and Medicaid. If a participant enrolled in a particular coverage group is identified as having Medicare, they will be disenrolled from Medicaid. Individuals not eligible for full Medicaid benefits while enrolled in Medicare may qualify for the partial benefit programs, Qualified Medicare Beneficiary Program (QMB)² and Specified Low Income Medicare Beneficiary Program (SLMB).³ Information regarding both programs is sent to Medicare enrolled individuals when their Medicaid coverage is cancelled.

If a Medicaid participant is identified as deceased, they will be disenrolled.

When a consumer applies for coverage through Maryland Health Connection, the individual submits an application that includes all members of their household. If the PDM identifies an issue impacting one individual in the household, all household members would either be subject to income verification or be disenrolled from coverage. Households that have been disenrolled from coverage may re-apply for benefits at any time.

There are certain exceptions to PDM. PDM will not be initiated in the following circumstances:

- If at least one household member on the application is in the process or eligible for renewal within 90 days;
- If at least one household member on the application has postpartum coverage, which will end within 90 days, is aging-out;
- If the at least one member of the household is subject to an unscheduled redetermination, e.g., due to PARIS match, PDM will not be initiated for those participant(s);
- Additionally, PDM will only be initiated for Medicaid participants who have a minimum of 90 calendar days of active coverage.

PDM has not been formally implemented and no participants have been disenrolled at the time of this report. The Department is still in the process of analyzing the PDM files.

C. Mail Return Pilot Program

a. Overview of Mail Return Pilot

² The QMB Program is available to individuals who meet certain income and asset limits. Individuals are eligible to have their Medicare copays, coinsurance, deductibles and monthly Medicare Part "B" premiums paid by the Medical Assistance Program. If an individual is enrolled in Medicare Part "B," but is not entitled to free Medicare Part "A," Medicaid will pay the Part "A" premium as a buy-in benefit.

³ The SLMB Program is available to individuals who meet certain income and asset limits. Individuals are eligible to have Medicaid pay their Medicare Part "B" premiums only.

Federal Medicaid regulations require that the Department periodically, and no later than every twelve months, redetermine the eligibility of Medicaid participants. The primary criteria for participant eligibility are: (1) U.S. citizenship; (2) Maryland residency; and, (3) meeting the federally mandated income standard.

If the Department does not act on one of these three major components, it will be out of compliance with federal government and state regulations. It is the responsibility of Medicaid participants to report all changes, including address, within ten business days of the change pursuant to state regulations.⁴ When changes of address are not reported and mail is returned with no forwarding address, it is not known whether the participant continues to meet the residency requirement for Medicaid, and participants may be disenrolled.

Historically, returned mail items required manual intervention by case workers, who received on average 6,000⁵ pieces of returned mail per month. In January 2018, the system functionality was built in the Maryland Health Connection to automate the return mail process for Medicaid participants, with the intention of disenrolling individuals whose mail has been returned. Formal implementation of this initiative will result in increased operational efficiency.

Due to concerns from stakeholders about this process, the Department has embarked on analyzing the data in collaboration with MCOs since January 1, 2018. The Department has requested that MCOs and providers remind their patients to update their information with the Department when they change their address. The Department has provided the MCOs with a monthly file of their participants who had mail from the Department returned. The Department has not disenrolled any participants during this pilot phase. The Department anticipates continuing the Mail Return Pilot through the end of calendar year 2018.

The Department has proposed the following Mail Return process. At the time of this report, only Steps 1 and 2 have been implemented:

Step 1: On the first of each month, Maryland Health Connection generates a list of participants whose mailed items were returned during the previous month and shares that list with the MCOs.

Step 2: MCOs then have a 60-day period to conduct outreach (according to their respective processes) and obtain the participant's updated address or proof of care. MCOs must submit the information via the Department's New Address or Proof of Care forms to the Department at least five business days prior to the end of the 60-day period.

Potential Next Steps to Implement Post-Pilot:

⁴ COMAR 10.09.24.12B(1)

⁵ This number does not include electronic notifications that are undeliverable, as the notice will be sent by regular mail after three failed email attempts.

Step 3: The Department will then update the participant's information in the Maryland Health Connection system, and the participant will continue receiving coverage. If MCOs do not provide an updated address, proof of care, or if the participant does not report an address change, their coverage will be terminated after the 60-day period. Participants meeting the aforementioned exceptions will be automatically excluded from disenrollment after the 60-day period.

Step 4: Maryland Health Connection will send a cancellation notice to participants being removed from Medicaid as a result of returned mail. The notice will contain the language: "Mail for this individual was returned and a change of address was not reported as required by COMAR 10.09.24.12B."

Step 5: Maryland Health Connection will send a disenrollment transaction to the Medicaid Management Information System (MMIS) with the cancel reason code 551 ("whereabouts unknown").

Step 6: Case comments will be added on the participant application regarding the returned mail disenrollment and the returned mail will be noted in the audit trail.

Certain participants are exempted from the automatic disenrollment under the mail returns process, including:

- Newborns;
- Homeless participants having indicated "No Home Address" on their applications;
- Participants whose applications have not been completed in the verification process;
- If coverage for at least one participant/household member is ending in the next 60 days; and,
- Households in which at least one participant is changing age brackets, aging-out, or is in postpartum processing.

The Department anticipates that the changes to automate mail returns will result in fewer participants removed from Medicaid services than the current manual system because of exceptions being applied to the automated mail return process that are not applied to the current manual process.

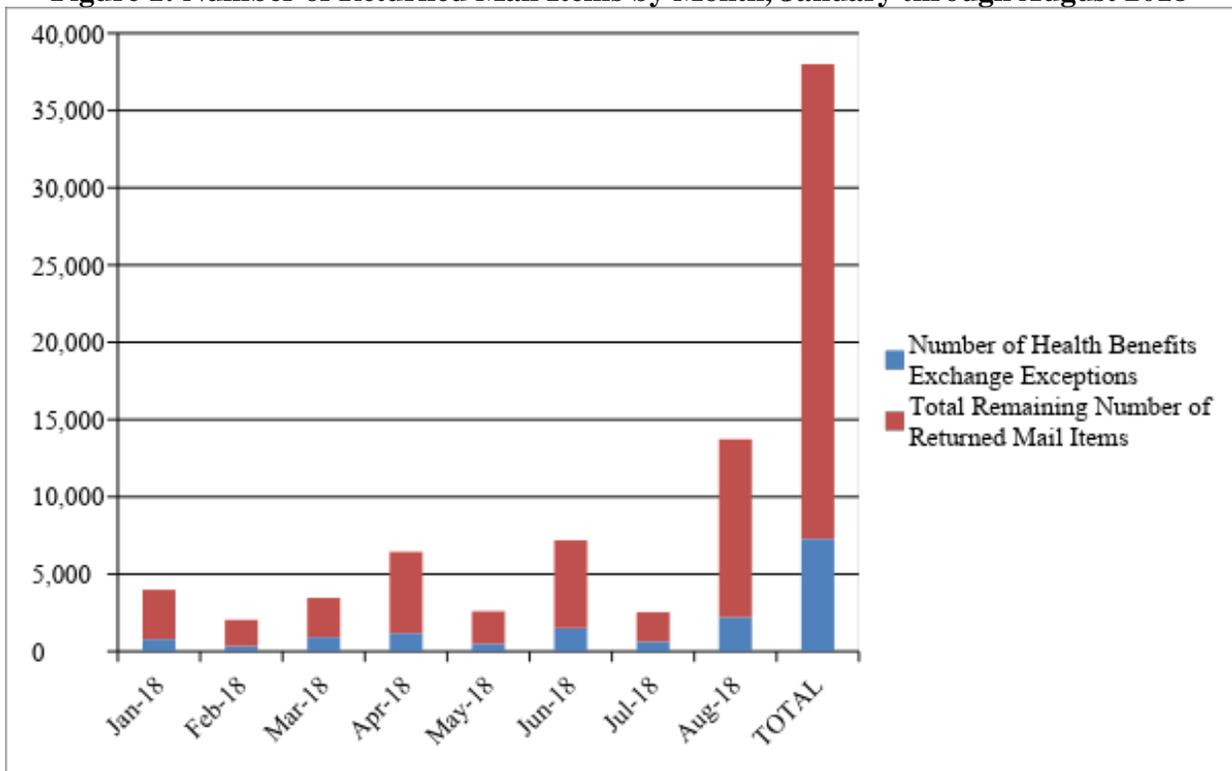
b. **Data Analysis**

From February to August 2018, approximately 37,999 pieces of mail were returned (see Table 2 and Figure 1). Of those, 7,293, or 19.2 percent, qualified for an exception and would not be disenrolled under the proposed Mail Return Process.

Table 2. Number of Returned Mail Items by Month, February through August 2018

Month	Total Number of Returned Mail Items	Number of Health Benefits Exchange Exceptions	Total Remaining Number of Returned Mail Items	Percent of Returned Mail with a Health Benefits Exchange Exception
February 2018	2,039	341	1,698	16.7%
March 2018	3,460	926	2,534	26.8%
April 2018	6,443	1,182	5,261	18.3%
May 2018	2,594	501	2,093	19.3%
June 2018	7,193	1,504	5,689	20.9%
July 2018	2,534	630	1,904	24.9%
August 2018	13,736	2,209	11,527	16.1%
TOTAL	37,999	7,293	30,706	19.2%

Figure 1: Number of Returned Mail Items by Month, January through August 2018



The Department also analyzed the total number of returned mail items by MCO. Priority Partners had the highest number of mail items returned after exceptions and Aetna had the lowest. Amerigroup had the highest percent of mail with exceptions.

Table 3. Number of Returned Mail Items by MCO, February through August 2018

MCO	Total Number of	Number of Health Benefits	Total Remaining Number of	Percent of Returned Mail with a Health
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	Returned Mail Items	Exchange Exceptions	Returned Mail Items	Benefits Exchange Exception
Aetna	314	59	255	18.8%
Amerigroup	8,630	2,044	6,586	23.7%
Jai	1,306	182	1,124	13.9%
Kaiser	1,656	288	1,368	17.4%
MedStar	2,582	430	2,152	16.7%
MPC	7,901	1,527	6,374	19.3%
Priority Partners	9,623	1,790	7,833	18.6%
UHC	3,656	578	3,078	15.8%
UMHP	2,331	395	1,936	16.9%
TOTAL	37,999	7,293	30,706	19.2%

The Department has undertaken an initiative in cooperation with the MCOs to reduce the number of people who would be disenrolled due to a mail return. Every month, the Department sends each MCO a file with a list of everyone in their MCO who has had returned mail. MCOs then send in their list of individuals who have updated their address with the MCO or who the MCOs can attest received services that month. The MCOs submitted 5,396 cases with an address change. They also submitted 6,937 cases with an attested service from February through August 2018. The Department is still in the process of analyzing this data in order to ensure participants are not counted multiple times in multiple data sets.