NEW YORK STATE
MEDICAID PROGRAM

MANAGED CARE REFERENCE GUIDE:
ENROLLEE ROSTERS

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Section I – Purpose Statement

The purpose of this document is to assist participating managed care organizations in understanding and complying with the New York State Medicaid (NYS-Medicaid) requirements.

The guide addresses Enrollee Rosters.

This document is customized for managed care providers as an instructional as well as a reference tool.

Section II –Enrollee Rosters

Enrollee information is contained in rosters compiled by the State Department of Health (SDOH) for the Plans. The enrollee roster is the vehicle by which data such as Plan enrollment, and county of fiscal responsibility are distributed to the Plan.

Rosters are available on the HCS (Health Commerce System) for the Plan according to the SDOH Medicaid Monthly Schedule which is produced in November for the year ahead. All plans are required to utilize an Internet Service Provider (ISP) to access the HCS for purposes of accessing the Medicaid and roster site.

The Internet site through which to access the HCS is:
https://commerce.health.state.ny.us/hcs/index.html

The HCS requires each user to possess a User ID and password to enter the roster application. This is a secure site with access granted by the Commerce Accounts Management Unit (CAMU). If you do not have a User ID and password, you should email the CAMU at camu@its.ny.gov, or call 1-866-529-1890, option 1. You will not be granted access to this site without proper authorization.

Enter your **User ID and password**

Once you are signed in, select **My Content, All Applications,** and then **Managed Care Roster/Report Download.** Once you have selected the Rosters Home Page, you will be able to select the files you have access to.

The specifications for the enrollee rosters are on the following pages.

A list of the County/District codes is provided in Appendix A and a list of Insurance Coverage codes can be found in Appendix B at the end of this document. These lists of codes will help you to interpret information included on your enrollee rosters.

Questions about information contained in a Roster, receipt date for Rosters, or the Medicaid Monthly Schedule may be directed to the State Department of Health's Division of Health Plan Contracting and Oversight at (518) 473-1134.

Monthly Managed Care Roster File Layout and Field Descriptions

The Monthly Managed Care Recipient Roster lists every Medicaid recipient who is eligible for Medicaid as of the pulldown or processing date and enrolled in a managed care plan for the upcoming month.

There are two roster reports generated each month. One (Primary) is produced around ten days prior to the beginning of the effective month of the report, which is the weekend of the pulldown (for example, June 22nd for the July roster).

A second roster is produced the first full weekend after the beginning of the effective month (for example, July 6th for the July roster). The second report shows only additional enrollees who were not included on the first roster. These enrollees generally are added because their Medicaid eligibility recertification occurred later than the processing date (pulldown date) of the first roster, but was completed before the first day of the effective month. As a result, they were not reflected on the first roster, but added via the second roster production.

Data Elements

The following data is reported for each enrollee on the roster:

CIN – Enrollee's Medicaid Client Identification Number

Social Security Number – Enrollee's Social Security Number

Enrollee's Name

Enrollee's Sex

F – Female
M – Male
U - Unborn

Language Code

Enrollee's Date of Birth

Case Name – Name of the adult the assistance case is authorized under

Enrollee's Address

Care of Name – Name of the person in care of the enrollee

Mailing Address – Mailing address associated with the "Care of" contact

Case Number – Case number assigned by the local district

Local Office Code

Expiration Date – End of the month in which the roster expires

Medicaid Coverage

Code which defines the enrollee's type of Medicaid eligibility.

A	Full Medicaid Coverage
B	Full Medicaid Coverage except Long Term Care (LTC)
G	PCP Guarantee Coverage
L	Perinatal Family
P	Prepaid Capitation Plan (PCP) Coverage
Q	PCP/HR Coverage
R	PCP Guarantee/HR
T	HR/UT
U	Family Health Plus
W	Family Health Plus/Guarantee
Y	Aliessa Alien
1	Community Coverage w/Community Based LTC
2	Community Coverage without LTC
6	Community Coverage without LTC (legal alien during 5-year ban)

Note[1]: Generally local districts are expected to change recipients' fee for service coverage code from "A", "B", "L", "T", "Y", "1", "2" or "6" to "P" when enrolled in a Medicaid managed care plan; however, failure to do so does not change the validity of plan enrollment.

Note[2]: Coverage Codes G, R, U, W are no longer active.

Aid Category - Defines the type of medical assistance the enrollee is eligible for with the Medicaid program. This code is used to derive the rate code under which the capitation claim is paid (Aid to Dependent Children, HR, SSI).

01	FP Default	58	Infant – Continuous Coverage (200% FPL (FP)
10	FA-Family Assistance	59	CAP/MA Guarantee (FNP) State/Local (Disabled 10/22/07)
11	ADU-U (FP)	60	Safety Net – Aged (FP)
12	IV-E and Non IV-E (FP)	61	Safety Net – Blind (FP)
16	TANF with Deprivation (FP)	62	Safety Net – Disabled (FP)
17	TANF without Deprivation (FP)	63	Safety Net – (FP)
18	Safety Net w/out deprivation (FP)	64	Colorectal and Prostate Treatment Program (FNP)
19	Safety Net - Non-Cash (FP)	66	Emergency Shelter (FP)
20	Supplemental Payment (NYC) (FNP) 100 % Local (TA) or 100% State (MA)	67	Safety Net w/deprivation (FP)
21	LIF W/out Depriv/SCC (FP)	68	FHP Singles/Childless Couples (FP)
22	RESERVE FOR FUTURE USE	69	FHP Parents/19-20 years olds (FP)
23	MA-CW (FP)	70	FHP Pregnant Woman 100%
24	MA-Aged (FP)	71	Child 6-18 (110-154% FPL) (FP)
25	MA-Blind (FP)	72	FHP Pregnant Woman 200% FPL (FP)
26	MA-Disabled (FP)	74	Breast and Cervical Cancer Treatment Program (under 65)
27	ADC Medically Needy (FP)	75	Breast and Cervical Cancer Treatment Program (65 and over)
28	Public Home (FNP)	76	Legal Alien (FNP)
30	Presumptive Eligibility for Children (FP)	77	Breast Cancer Treatment Program (Male (FNP)
31	Poverty Level Child (FP)	78	LIF/SN/TL – Cash (FP)
32	LIF Related w/deprivation (FP)	79	LIF/SN/TL – NC (FP)
35	Presumptive Eligibility Home Care (FNP) State/Local	81	Child Continuous Coverage (100-133% FPL) (FP)
36	RESERVE FOR FUTURE USE	82	Medicaid Buy In – Disabled Basic Group
37	Alien Eligibility (FNP) State/Local	83	Medicaid Buy In – Medically Improved
38	Alien Eligibility (FP)	86	Child 6-18 (111-154% FPL) (FP)
39	FNP Related Parent Living Child (FP)	87	Family Planning Extension Program Post-Partum (FNP)
40	Public Shelter Resident (FNP) 100% Local	88	Inpatient OMH (FNP)
41	Presumptive Eligibility Prenatal A (FP)	89	Inpatient Prisoner (FP)
42	Presumptive Eligibility Prenatal B (FP)	90	FHP S/CC 0 < 100% or S/CC (FP)
43	Prenatal Care (FP)	91	TANF/SN/LIF w/out deprivation and SN NC/SCC (FP)
44	Infant (223% FPL) (FP)	92	MA Formerly Foster Care (effective October 2018)
45	Child 1-6 (154% FPL) (FP)	H0	Adult Group (19-64) S/CC 101-138% (FP) (100/0/0)
47	Child Welfare (FNP) 100% Local	H1	Adult Group (19-64) Parent + Caretaker Relatives > LIF <133 OR 19-20 > LIF < 133
48	Child Continuous Coverage (FP)	OR	138-155% MOE (FP) (50/25/25)
49	Expanded - Continuous Coverage	P1	LIF W/OUT Depriv (FP)
50	SSI Aged (FP)	P2	LIF Related W/Depriv (FP)
51	SSI Blind (FP)	P5	Safety Net W/Out Depriv (FP)
52	SSI Disabled (FP)	P7	ADC Medically Needy (FP)
53	SSI Pend Aged (FP)	P8	LIF/SN/TL – CASH (FP)
54	SSI Pend Disabled (FP)	P9	LIF/SN/TL – NC (FP)
55	SSI Pend Disabled (FP)		
56	Family Planning Coverage		
57	Poverty Level Infant (FP)		

Individual Disposition Status Code - Indicates whether recipient's case is active or closed. Valid code values are:

07	Active
08	Inactive
10	Inactive/Sanctioned
11	Denied
13	Deceased
15	Deleted
20	Case Closed

Medicaid Exception Code - There are two occurrences of Recipient Restriction Exception codes on the roster. The hierarchy below determines which code(s) appear on the roster when a client has more than two codes.

H1-H9
N1-N7
30
05
08
11
06
12
02
03
04
09
10
13
55
56
58
59

Note: The above list reflects the hierarchy as of June 2018.

Medicare Code - Indicates the type of Medicare coverage for an enrollee.

2 Part A,
3 Part B,
1 Both Part A and B

Note: Any enrollee with Medicare coverage in a mainstream managed care plan or special needs plan must be disenrolled prospectively (based on the pulldown dates).

Health Insurance Claim Number (HICN) or MCR Number (MBI) – Enrollee's Medicare Number

Note: *Prior to June 2018, this field always displayed the HICN. As a result of CMS' Social Security Number Removal Initiative, HICN was replaced by MBI. For the transition period of April 1, 2018 through December 31, 2019, a MBI or HICN may be displayed in this field. After December 31, 2019, the MBI will be displayed in this field, or a "MBI Pending" message will be displayed if an enrollee has Medicare but the MBI has not yet been provided.*

Benefit Package - Benefit package number according to the list below.

BP code	Description
70	Family Health Plus **Note: FHP ended 12/31/2014*
71	Medicaid Advantage (NYC)
72	Medicaid Advantage Plus (NYC)
73	Medicaid Advantage (Upstate)
74	Medicaid Advantage Plus (Upstate)
75	PACE
76	Reserved for future use for MLTC Partials
77	FIDA
78	Health and Recovery Plan (OMH HARP)
79	Reserved for Developmental Disabilities Individualized Services and Supports Coordination Organization (OPWDD People First Waiver)
80	Reserved for FIDA-IDD
97	Prepaid Mental Health Plan
01-62, 66	Benefit Package Code for County (all other programs not listed above)

Capitation Code – Indicates enrollment in plan. "3" = enrolled

PCP Begin Date – Enrollee's most recent effective enrollment date

Rate Code and Derivation Chart - Four-digit code assigned during claims processing which represents enrollee's age, sex and aid categories. This corresponds to the capitation premium group. This field is suppressed for Special Needs, Medicaid Advantage, and Integrated Care Plans.

Case Type	Aid Category	Age Months	Sex	Age Year	Rate Code
TANF/SN	10, 11, 12,16, 17, 18, 19, 21, 23, 27, 31, 32, 39, 43, 44, 45, 48, 49, 57, 58, 63, 67, 78, 79, 81, 86, 90, 91, 92, H0, H1, P1, P2, P5, P7, P8, P9	0-251	M/F	0-20	2201
TANF/SN	10, 11, 12,16, 17, 18, 19, 21, 23, 27, 31, 32, 39, 43, 44, 45, 48, 49, 57, 58, 63, 67, 78, 79, 90, 91, 92, H0, H1 P1, P2, P5, P7, P8, P9	252-999	M/F	21+	2205
SSI	24, 25, 26, 50, 51, 52, 53, 54, 55, 60, 61, 62, 82, 83	0 - 999	M/F	0+	2209
Default (When the above rules are not met)					2200
FHP* **FHP program ended 12/31/14*	68, 69, 70, 72	228-785	M/F	19-65	2232

Guarantee Date - The date through which capitation payments are guaranteed to the plan (calculated as 6 months subsequent to the initial enrollment date).

Note: Guarantee Dates were no longer populated after 12/31/2013.

Authorization Through Date - The date through which the enrollee is eligible for Medicaid benefits

Recertification Date - The date of the onset of the recertification process for an enrollee. *This date is available for New York City enrollees only.*

Transaction Date - The date of the most recent capitation transaction for the enrollee on file

Copay Exempt Flag – Indicates whether the enrollee is copay exempt

Excess Income - The amount taken from enrollee's current budget.

Note: If the Family Indicator is 'F', all the AC clients on the roster with the same case number enrolled in the same plan will have same surplus amount on the surplus field, but the provider should collect the surplus only once for the whole house hold.

Note: This field will be populated only for MLTC program plans that have spend down consumers.

Family Indicator

I - There is only one AC client on the roster with a particular case number and no other active client on the roster with that same case number enrolled in the same plan

F - There are more than one AC client on the roster with the same case number enrolled in the same plan.

Insurance Code - Indicates any third-party insurance for which the enrollee is eligible

Begin Date – The date third-party insurance is applicable

End Date – The date third-party insurance is terminated

Note: This section repeats twice in the roster.

Reason Code – Code indicates reason recipient is enrolled

01 Enrollment Override
02 Voluntary Enrollment (all input methods)
05 Mandatory
07 Automated Enrollment of a Newborn
08 HX to WMS Enrollment (Entry limited to State MC Staff Only)

Fee Flag

New Indicator - Indicated for enrollees whose most recent enrollment effective date on file is equal to the roster effective date.

Monthly Managed Care Recipient Roster File Layout

Field Name	Record Positions		Field Size	Explanation
	From	To		
Trans-Dist	1	2	2	2 digit county/district code assigned by NYS to county of fiscal responsibility for enrollee.
Provider ID	3	10	8	MMIS ID number of plan in which recipient is enrolled.
Recipient ID	11	18	8	MMIS ID number of the enrollee.
Filler	19	21	3	Spaces
SSN	22	30	9	The SSN of enrollee (Provider Rosters). The Worker Id of enrollee (County Rosters).
Last Name	31	46	16	Last name of enrollee.
First Name	47	56	10	First name of enrollee.
Middle Initial	57	57	1	Middle initial of enrollee.
Sex Code	58	58	1	Sex of enrollee.
Language	59	60	2	Language spoken.
Race/Ethnicity	61	66	6	Race/Ethnicity
Date of Birth	67	74	8	Date of birth of enrollee. MMDDCCYY
Case Name	75	102	28	Name of the adult the assistance case is authorized under.
Street	103	137	35	Street address of enrollee.
City	138	152	15	City address of enrollee.
State	153	154	2	State of enrollee.
Zip Code	155	159	5	Zip Code of enrollee.
Care of Name	160	187	28	Name of person in care of enrollee.
Street	188	222	35	Street address of person in care of enrollee.
City	223	237	15	City address of person in care of enrollee.
State	238	239	2	State address of person in care of enrollee.
Zip Code	240	244	5	Zip code of person in care of enrollee.
Phone Number	245	254	10	Phone number of person in care of enrollee
Case Number	255	264	10	Case number assigned by County DSS.
Loc Off	265	267	3	Code which indicates the local DSS office.
Expiration Date	268	275	8	The date the roster expires. MMDDCCYY

	Record Positions			
Medicaid Coverage	276	276	1	Code defining whether the recipient is eligible for services through a MC plan.
Aid Category Code	277	278	2	Defines the type of medical assistance for which the enrollee is eligible within the MA program. This code is used to derive the rate code under which the capitation claim is paid.
Category Code	279	280	2	Defines the category of assistance the enrollee's eligibility is based on.
Individual Disposition Status Code	281	282	2	Code indicating if recipient's case is active or closed.
State/Federal Charge Code	283	284	2	Code indicating State/Federal charges that are in effect.
Medicaid Exception Code	285	286	2	Code used to restrict types of medical services or to place processing constraints which require claims review.
Medicaid Exception Code	287	288	2	Same as above.
Medicare Code	289	289	1	Indicates the type of Medicare coverage for the enrollee.
MCR Number	290	301	12	Enrollee's Medicare Number.
Benefit Pkg	302	303	2	Benefit package number assigned to a plan.
Capitation Code	304	304	1	Indicates recipient's enrollment/disenrollment in a plan. Always '03' for rosters.
PCP Begin Date	305	312	8	Recipient's most recent effective enrollment date. CCYYMMDD
Rate Code	313	316	4	4-digit code assigned during claims processing which represents the age, sex, and aid category of enrollee and corresponds to the capitation payment amount.
Guarantee Date	317	324	8	Date through which capitation payments are guaranteed to the plan. CCYYMMDD
Authorization Date	325	332	8	Date through which enrollee is eligible for MA benefits (indicates when recertification is necessary). CCYYMMDD
Recertification Date	333	340	8	The date of the onset of the recertification process for an enrollee

	Record Positions			
Transaction Date	341	348	8	The most recent transaction date for enrollee on file. CCYYMMDD
Co-Pay Exempt Flag	349	349	1	Indicates if the client is co-pay exempt or not. Values are 'Y' or 'N'.
Excess Income	350	359	10	The amount taken from client's current budget. **Also,** If the Family Indicator is 'F', all the AC clients on the roster with the same case number enrolled in the same plan will have same surplus amount on the surplus field, but the provider should collect the surplus only once for the whole house hold. **Note:** This field will be populated only for MLTC program plans that have spend down consumers.
Family Indicator	360	360	1	**Note:** This field will be populated only for MLTC program plans that have spend down consumers.
Filler	361	371	11	Spaces
Insurance Code	372	377	6	Indicates any insurance for which the enrollee is eligible.
Begin Date	378	385	8	Date for which insurance was applicable. CCYYMMDD
End Date	386	393	8	Date for which insurance was terminated. CCYYMMDD
Insurance Code	394	399	6	Indicates any insurance for which the enrollee is eligible.
Begin Date	400	407	8	Date for which insurance was applicable. CCYYMMDD
End Date	408	415	8	Date for which insurance was terminated. CCYYMMDD
Reason Code	416	417	2	Code indicating reason recipient enrolled/disenrolled.
Fee Flag	418	419	2	For future use.
Filler	420	427	8	Spaces.
New Indicator	428	428	1	Indicates this is first time recipient appears on roster.

Monthly Managed Care Recipient Roster File Layout

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01  PCP-ROS-HEADER.
    05  PCP-ROS-HDR-ID                    PIC X(18).
    05  FILLER                            PIC X(44).
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            05  PCP-ROS-HDR-UP-DN                PIC X(2).
            05  PCP-ROS-HDR-TYPE                 PIC X(2).
            05  PCP-ROS-HDR-ELIG-BEG-DT          PIC X(8).
            05  PCP-ROS-HDR-ELIG-END-DT          PIC X(8).
            05  PCP-ROS-HDR-CREATION-DT.
                10  PCP-ROS-HDR-CRT-CC           PIC 9(2).
                10  PCP-ROS-HDR-CRT-YY           PIC 9(2).
                10  PCP-ROS-HDR-CRT-MM           PIC 9(2).
                10  PCP-ROS-HDR-CRT-DD           PIC 9(2).
            05  PCP-ROS-HDR-EXP-DATE.
                10  PCP-ROS-HDR-EXP-MM           PIC 9(2).
                10  PCP-ROS-HDR-EXP-DD           PIC 9(2).
                10  PCP-ROS-HDR-EXP-CC           PIC 9(2).
                10  PCP-ROS-HDR-EXP-YY           PIC 9(2).
BL0510      05  FILLER                           PIC X(366).

        01  PCP-ROS-RECORD.
            05  PCP-ROS-927-TRANS-DIST           PIC X(02).
            05  PCP-ROS-048-PROV-ID-NUM          PIC X(08).
            05  PCP-ROS-010-CIN                  PIC X(08).
            05  PCP-ROS-031-SSN                  PIC X(09).
            05  PCP-ROS-NAME.
                10  PCP-ROS-005A-LAST-NAME       PIC X(16).
                10  PCP-ROS-005B-FIRST-NAME      PIC X(10).
                10  PCP-ROS-005C-MI              PIC X(01).
            05  PCP-ROS-012-SEX                  PIC X(01).
            05  PCP-ROS-010-DOB.
                15  PCP-ROS-DOB-MM               PIC X(02).
                15  PCP-ROS-DOB-DD               PIC X(02).
                15  PCP-ROS-DOB-CC               PIC X(02).
               15  PCP-ROS-DOB-YY               PIC X(02).
            05  PCP-ROS-DOB-NUM  REDEFINES PCP-ROS-010-DOB
                                                 PIC 9(08).
BL1208      05  PCP-ROS-070-CASE-NAME            PIC X(28).
BL0510      05  PCP-ROS-008-STREET               PIC X(35).
            05  PCP-ROS-883-CITY                 PIC X(15).
            05  PCP-ROS-884-STATE                PIC X(02).
            05  PCP-ROS-009-ZIP                  PIC X(05).
BL0510      05  PCP-ROS-110-CO-NAME              PIC X(28).
BL0510      05  PCP-ROS-120-STREET               PIC X(35).
BL0510      05  PCP-ROS-130-CITY                 PIC X(15).
BL0510      05  PCP-ROS-140-STATE                PIC X(02).
BL0510      05  PCP-ROS-150-ZIP                  PIC X(05).
BL0510      05  PCP-ROS-PHONE                    PIC X(10).
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            05  PCP-ROS-928-CASE-NUM           PIC X(10).
            05  PCP-ROS-014-LOC-OFF            PIC X(03).
            05  PCP-ROS-EXPIR-DATE.
                10  PCP-ROS-EXPIR-MM           PIC X(02).
                10  PCP-ROS-EXPIR-DD           PIC X(02).
                10  PCP-ROS-EXPIR-CC           PIC X(02).
                10  PCP-ROS-EXPIR-YY           PIC X(02).
            05  PCP-ROS-EXPIR-NUM  REDEFINES PCP-ROS-EXPIR-DATE
                                               PIC 9(08).
            05  PCP-ROS-027-MAID-COV           PIC X(01).
            05  PCP-ROS-015-AID-CAT            PIC X(02).
BL1208      05  PCP-ROS-110-CAT-CD             PIC X(02).
BM0203      05  PCP-ROS-120-INDIV-STATUS       PIC X(02).
            05  PCP-ROS-022-MAID-EXC-CD        OCCURS 2 TIMES
                                               PIC X(02).
            05  PCP-ROS-023-MARE-CD            PIC X(01).
            05  PCP-ROS-004-MCR NUMBER         PIC X(12).
            05  PCP-ROS-BNFT-PKG               PIC X(02).
            05  PCP-ROS-CAP-CODE               PIC X(01).
BM1099      05  PCP-ROS-FROM-DATE              PIC X(08).
            05  PCP-ROS-RATE-CODE              PIC X(04).
            05  PCP-ROS-GUAR-DATE              PIC X(08).
            05  PCP-ROS-GUAR-NUM  REDEFINES PCP-ROS-GUAR-DATE
                                               PIC 9(08).
            05  PCP-ROS-AUTH-DATE              PIC X(08).
            05  PCP-ROS-AUTH-NUM  REDEFINES PCP-ROS-AUTH-DATE
                                               PIC 9(08).
BM0203      05  PCP-ROS-RECERT-DATE            PIC X(08).
BM0203      05  PCP-ROS-RECERT-NUM  REDEFINES PCP-ROS-RECERT-DATE
BM0203                                         PIC 9(08).
BM1099      05  PCP-ROS-LAST-TRANS-DT          PIC X(08).
            05  PCP-ROS-RESP-WORKER            PIC X(05).
            05  PCP-ROS-ASSOC-PROV             PIC X(08).
            05  PCP-ROS-146-IND                PIC X(01).
           05  PCP-ROS-147-CLM-GEN            PIC X(01).
            05  PCP-ROS-549-PLAN-CD            PIC X(02).
BL1211      05  PCP-ROS-COPAY-EXEMPT           PIC X(01).
BL0512      05  PCP-ROS-EXCESS-INCOME          PIC X(10).
BL0512      05  PCP-ROS-FAMILY-IND             PIC X(01).
BL0512      05  FILLER                         PIC X(15).
      *** TPHI INSURANCE INFORMATION ***
            05  PCP-INSUR-INFO                 OCCURS 2 TIMES.
BM0705          10  PCP-ROS-018-INS-CD         PIC X(06).
                10  PCP-ROS-INS-DATES.
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                    15  PCP-ROS-019A-BGN-DATE   PIC X(08).
                    15  PCP-ROS-019B-END-DATE   PIC X(08).
               05  PCP-ROS-NYC-RID               PIC X(11).
               05  PCP-ROS-NEW-IND               PIC X(01).
               05  PCP-ROS-RECERT                PIC X.
               05  PCP-ROS-REASON                PIC X(02).
               05  PCP-ROS-FEE-FLAG              PIC X(02).
BL0110         05  PCP-ROS-LANGUAGE              PIC X(02).
BL0807         05  PCP-ROS-ETHNIC-AFL            PIC X(06).
BL0407         05  PCP-ROS-150-CHRG-IND          PIC X(02).
BL0308         05  PCP-ROS-EPI-IND               PIC X(01).
BL0110         05  FILLER                        PIC X(13).
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Monthly Disenrollment Report

The Disenrollment Report provides managed care plans with a list of those enrollees on the previous month's roster who were disenrolled from the MCO, transferred to another MCO, or whose enrollments were removed from the file. The Disenrollment Report does not include enrollees who were dropped from the roster due to loss of Medicaid coverage (unless the local district also ends the enrollment on file). Enrollees who have lost eligibility, but remain enrolled, are listed on the Error Report. They will not be reflected on the Disenrollment Report, even when they are removed from the Error Report (coverage lapsed greater than 90 days).

Data Elements:

CIN – Client Identification Number or Medicaid Identification Number of disenrolled individual.
Social Security Number
Name
Sex
Date of Birth (DOB)
Address Local Office Code Disenrollment Reason Code – see (1) below
Case Number – Individual's case number, assigned by local district
Disenrollment From Date – Effective date of disenrollment/transfer
Disenrollment Reason – see (2) below
Aid Category – Defines the type of medical assistance for which the disenrolled member is eligible.

Those recipients whose Disenrollment Reason is indicated as "Disenrolled" are clarified by use of a Disenrollment Reason Code. These codes are:

59	Lost Eligibility – No Automated Re-Enrollment within 90 Days
63	Medicare Recipient
65	Plan Termination
66	Recipient retroactively disenrolled (plan must void claims subsequent to the disenrollment date
85	Death
86	Enrollee request
93	Enrollee exempt/excluded from managed care enrollment
95	Lost MA eligibility
97	Moved out of plan's service area

Note: A general disenrollment reason is indicated for all enrollees on this report. Reasons indicated are:

Disenrolled (see reason codes listed above)
Enrolled in Another Plan – Enrollee transferred to another plan
Enrollment Deleted – Enrollment removed from file (i.e., Enrolled in error)
Undeterminable - Enrollment/disenrollment transactions need to be manually reviewed to determine reason

Monthly Disenrollment Report, PIC Format

LABEL RECORDS ARE STANDARD BLOCK
CONTAINS 25 RECORDS RECORD
CONTAINS 180 CHARACTER DATA RECORD
IS PCP-DIS-RECORD.

```
01      PCP-DIS-RECORD.

   05  PCP-DIS-TRANS-DIST                          PIC X(02).
   05  PCP-DIS-PROV-ID-NUM                         PIC X(08).
   05  PCP-DIS-CIN                                 PIC X(08).
   05  PCP-DIS-SSN                                 PIC X(09).
   05  PCP-DIS-NAME.
      10  PCP-DIS-LAST-NAME                        PIC X(16).
      10  PCP-DIS-FIRST-NAME                       PIC X(10).
      10  PCP-DIS-MI                               PIC X(01).
   05  PCP-DIS-SEX                                 PIC X(01).
   05  PCP-DIS-DOB.
      10  PCP-DIS-DOB-MM                           PIC X(02).
      10  PCP-DIS-DOB-DD                           PIC X(02).
      10  PCP-DIS-DOB-YR                           PIC X(04).
   05  PCP-DIS-C-O-NAME                            PIC X(16).
   05  PCP-DIS-STREET                              PIC X(28).
   05  PCP-DIS-CITY                                PIC X(15).
   05  PCP-DIS-STATE                               PIC X(02).
   05  PCP-DIS-ZIP                                 PIC X(05).
   05  PCP-DIS-CASE-NUM                            PIC X(10).
   05  PCP-DIS-LOC-OFF                             PIC X(03).
   05  PCP-DIS-FROM-DT.
      10  PCP-DIS-FROM-YR                          PIC X(04).
      10  PCP-DIS-FROM-MM                          PIC X(02).
      10  PCP-DIS-FROM-DD                          PIC X(02).
   05  PCP-DIS-REASON-CD                           PIC X(02).
   05  PCP-DIS-REASON                              PIC X(25).
   05  PCP-DIS-AID-CAT                             PIC X(02).
   05  FILLER                                      PIC X(01).
```

Monthly Error Report

The purpose of the error report is to track on an interim basis those enrollees who lost Medicaid eligibility because their case was closed, or because their Medicaid coverage "expired" (no action was taken by the local department of social services to either end or reauthorize the enrollee's eligibility), but who remain enrolled in the plan.

The enrollees are indicated on the Error Report with the following messages:

No PCP Cov or Eligibility Expired – Indicates recipients whose Medicaid eligibility has either lapsed or was terminated prior to the last day of the previous month.

Eligibility Ended (last day of previous month) – Indicates recipients whose Medicaid eligibility expired the last day of the month before the roster month. If the recipient remains on the Error Report (that is, no action taken to end or reauthorize eligibility), the message will change to (1) above, in subsequent months.

Eligibility Ended (last day of previous month) (Closed) – Indicates recipients whose Medicaid eligibility was terminated effective the last day of the month before the roster month. If the recipient remains on the Error Report for subsequent months, the message will change to (1) above.

County Codes Do Not Match

Indicates recipients who are receiving Medicaid in one fiscal district, but enrollment is in another fiscal district (usually due to a change of address). These discrepancies must be reconciled between the two districts, and until that is done, the case is reflected on the Error Report.

Generally, recipients who have lost Medicaid eligibility will appear on the Error Report for the first time for reasons (2) and (3) indicated above. However, recipients who were on the previous month's roster and whose eligibility ends effective prior to the last day of the previous month, will appear on the Error Report for the first time with reason (1) indicated above. Also included in (1) will be the carryovers from (2) and (3). Thus, these reason codes alone cannot be used to identify all of the recipients who were on the previous month's roster and are now on the Error Report.

All of the above enrollees are removed from the monthly roster, but their Medicaid records continue to reflect managed care enrollment for 90 days, even though the recipient is not actively enrolled in Medicaid. The Error Report provides a means of tracking these recipients for a 90-day period. If the recipient is recertified or reopened as Medicaid

eligible within that period, this allows the recipient to be automatically reinstated on the roster, without the need to actively re-enroll in the plan.

Note:
In New York City, the expired cases are automatically closed after 90 days, and their PCP enrollment terminated. These expired cases drop from the Error Report (no Medicaid coverage or PCP enrollment). Prepaid Capitation Plan (PCP) enrollment for closed cases is terminated after 90 days as well.

Upstate, expired cases are not automatically closed. However, their PCP enrollment is automatically terminated after 90 days. PCP enrollment for closed cases is terminated after 90 days as well, and they too, are dropped from the Error Report.

Recipient ID: Enrollee's Medicaid Identification Number

County: Enrollee's district of financial responsibility for Medicaid eligibility

Aid Category: Defines the type of medical assistance the enrollee is eligible for with the Medicaid program.

Case Number: Enrollee's case number assigned by the local district

Error Message – see (1)– (6) above.

Monthly Error Report – PIC Format

```
01 PROV-ERR-RECORD.
    05 PROV-IREF-NAME        PIC X(25)
    05 PROV-IREF-CIN         PIC X(08)
    05 PROV-IREF-CNTY        PIC X(02)
    05 PROV-IREF-AID-CAT     PIC X(02)
    05 PROV-IREF-CASE        PIC X(10)
    05 PROV-PCP-CIN          PIC X(08)
    05 PROV-PCP-CNTY         PIC X(02)
    05 PROV-PCP-CASE         PIC X(10)
    05 PROV-PROV-ID          PIC X(08)
    05 PROV-ERR-MSG          PIC X(28)
    05 PROV-RESP-WRKR        PIC X(05)
```

Medicaid Eligibility Verification System (MEVS)

New York State has implemented the Medicaid Eligibility Verification System (MEVS) as a method for providers to verify recipient eligibility prior to provision of Medicaid services. Plans may use MEVS, if necessary, to verify information about Medicaid eligibility.

The Identification Card (Common Benefit or Connect) no longer constitutes full authorization for provision of medical services and supplies. A recipient must present an official Common Benefit Identification Card or Connect Card to the provider when requesting services. The verification process through MEVS can be completed to determine the recipient's eligibility for Medicaid services and supplies.

The verification process through MEVS can be completed using any one of the following methods:

- **the MEVS Terminal (OMNI 3750)**
- **a telephone verification process**
- **direct CPU link or batch transmissions**

Verifications can be completed within seconds with a touchtone telephone or an MEVS terminal. Information available through MEVS will provide you with:

- The eligibility status for a Medicaid recipient for a specific date;
- The county having financial responsibility for the recipient (used to determine the contact office for prior approval and prior authorization); and
- Any Medicare or third-party insurance coverage that a recipient may have for the date of inquiry, including managed care coverage.

MEVS is convenient and easy to use – it is available 24 hours a day, seven days a week. MEVS provides current eligibility status information for all Medicaid recipients and is updated on a daily basis.

The MEVS manual is available at and can be downloaded from www.emedny.org. The manual contains different sections discussing the Common Benefit Identification Card, the verification equipment, procedures for verification, a description of eligibility responses, and test transactions.

Section III – Appendices

Appendix A – County / District Codes

An alphabetical listing of all counties and their corresponding district codes is listed below. These codes are also available at www.emedny.org. Select Provider Manuals under "Information for All Providers."

County Code	County	County Code	County
01	Albany	32	Ontario
02	Allegany	33	Orange
03	Broome	34	Orleans
04	Cattaraugus	35	Oswego
05	Cayuga	36	Otsego
06	Chautauqua	37	Putnam
07	Chemung	38	Rensselaer
08	Chenango	39	Rockland
09	Clinton	40	St. Lawrence
10	Columbia	41	Saratoga
11	Cortland	42	Schenectady
12	Delaware	43	Schoharie
13	Dutchess	44	Schuyler
14	Erie	45	Seneca
15	Essex	46	Steuben
16	Franklin	47	Suffolk
17	Fulton	48	Sullivan
18	Genesee	49	Tioga
19	Greene	50	Tompkins
20	Hamilton	51	Ulster
21	Herkimer	52	Warren
22	Jefferson	53	Washington
23	Lewis	54	Wayne
24	Livingston	55	Westchester
25	Madison	56	Wyoming
26	Monroe	57	Yates
27	Montgomery	66	New York City
28	Nassau	77	Other State Territory
29	Niagara	97	OMH
30	Oneida	98	OPWDD
31	Onondaga		

Appendix B – Insurance Coverage Codes

Third Party Health Resources

Insurance codes are used to identify Third Party Resources (TPR) other than Medicaid and Medicare, under which a client has insurance coverage, including managed care. Such coverage must be utilized for payment of medical services prior to submitting claims to Medicaid. Insurance and coverage codes are also available at: www.emedny.org.

Select **Provider Manuals** under "Information for All Providers."

Under **MEVS**, information specific to managed care will be reported to you when you request an eligibility verification for a Medicaid recipient.

The MEVS response via the Verifone Omni 3750 terminal or alternate access will be INS and COV codes followed by a two-digit insurance code and up to 20 alphabetic coverage codes or the word ALL indicating what services are covered. The telephone response will be insurance and coverage codes and a two-digit insurance code, and up to 20 messages or ALL indicating what services are covered.

Please refer to the MEVS Provider Manual for more detailed information on eligibility verifications, which can be found on the eMedNY website at: https://www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx

The MEVS response will include information on a maximum of two third party insurance carriers. If a Medicaid recipient is covered by more than two carriers you will receive a response of ZZ as an insurance code which indicates additional insurance. To obtain coverage information when there are more than two carriers, call 1-800-343-9000.

Other insurance codes are available at www.emedny.org.

Select **Provider Manuals**

The codes are listed in the Information for All Providers section, under **Third Party Information**

Insurance Coverage Codes

MEVS will only return coverage codes for Medicaid Managed Care Plans. These codes identify which services are covered by the client's managed care plan.

Code	Description	Explanation
A	Inpatient Hospital	All inpatient services are covered, except psychiatric care.
B	Physician In-Office	Services provided in the physician's office are generally covered.
C	Emergency Room	Self-Explanatory
D	Clinic	Both hospital based and free-standing clinic services are covered.
E	Psychiatric Inpatient	Self-Explanatory
F	Psychiatric Outpatient	Self-Explanatory
G	Physician In-Hospital	Physician services provided in a hospital or nursing home are covered.
H	Drugs No Card	Drug coverage is available, but a drug card is not needed.
I	Lab/X-Ray	Laboratory and x-ray services are covered.
J	Dental	Self-Explanatory
K	Drugs Co-pay	Although the insurance carrier expects a co-payment, you may not request it from the recipient. If the insurance payment is less than the Medicaid fee, you can bill Medicaid for the balance, which may cover the co-payment.
L	Nursing Home	Some nursing home coverage is available. You must bill until benefits are exhausted.
M	Drugs Major Medical	Drug coverage is provided as part of a Major medical policy
N	All Physician Services	Physician services, without regard to where they were provided, are covered.
O	Drugs	Self-Explanatory
P	Home Health	Some home health benefits are provided. Continue to bill until benefits are exhausted.
Q	Psychiatric Services	All psychiatric services, inpatient and outpatient, are covered.
R	ER and Clinic	Self-Explanatory
S	Major Medical	The following services are covered: physician, clinic, emergency room, inpatient, laboratory, referred ambulatory, transportation and durable medical equipment.
T	Transportation	Medically necessary transportation is covered.
U	Coverage to Complement Medicare	All services paid by Medicare, which require a coinsurance or deductible payment, should be billed to the insurance carrier prior to billing Medicaid.
V	Substance Abuse Services	All substance abuse services, regardless of where they are provided, are covered.
W	Substance Abuse Outpatient	Self-Explanatory
X	Substance Abuse Inpatient	Self-Explanatory
Y	Durable Medical Equipment	Self-Explanatory
Z	Optical	Self-Explanatory
All	All of the above	All services are covered.